COVID-19 and HAI Updates and Q&A Webinars for Long-Term Care and Congregate Residential Settings

June 2nd , 2023

Housekeeping

- All attendees in listen-only mode
- Submit questions via Q&A pod to **All Panelists**
- Slides and recording will be made available later
- For continuing education credit, complete evaluation survey upon end of webinar
  - Must be registered individually to receive credit

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Agenda

- Upcoming Webinars
- Questions from 05/25/23
- *Candida auris*: Infection Prevention and Control of an Emerging Fungal Pathogen
- Open Q & A

Slides and recording will be made available after the session.

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Upcoming Infection Prevention and Control Q&A

1:00 pm - 2:00 pm

Date	Infection Control Topic	Registration Link
Friday, June 23rd	Injection Safety & Point of Care Testing OR Antimicrobial Stewardship	TBD
Friday, July 7th	Wound Care	TBD
Friday, July 21st	Healthcare Laundry	TBD
Friday, August 4th	Training, Audit, Feedback	TBD
Friday, August 18th	Respiratory Protection	TBD

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Registration Open!

- Target Audience :
  - Physicians, pharmacists, nurses, quality directors, infection preventionists, facility leadership, and public health professionals across inpatient, outpatient, and long-term care settings
- Parke Regency Hotel and Conference Center in Bloomington Normal
- Registration Fee: $45
  - Covers a light breakfast and lunch
- Offering up to 6 hours of CE

https://www.eventbrite.com/e/2023-illinois-summit-on-antimicrobial-stewardship-tickets-617275195727

IDPH Updated Long-Term Care Guidance
Q & A: Questions from 05/25/23

06/2/2023

Thomas C. Roome,
Infection Control Coordinator

Mike Bierman,
Infection Prevention Consultant

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Future Webinar Topics:

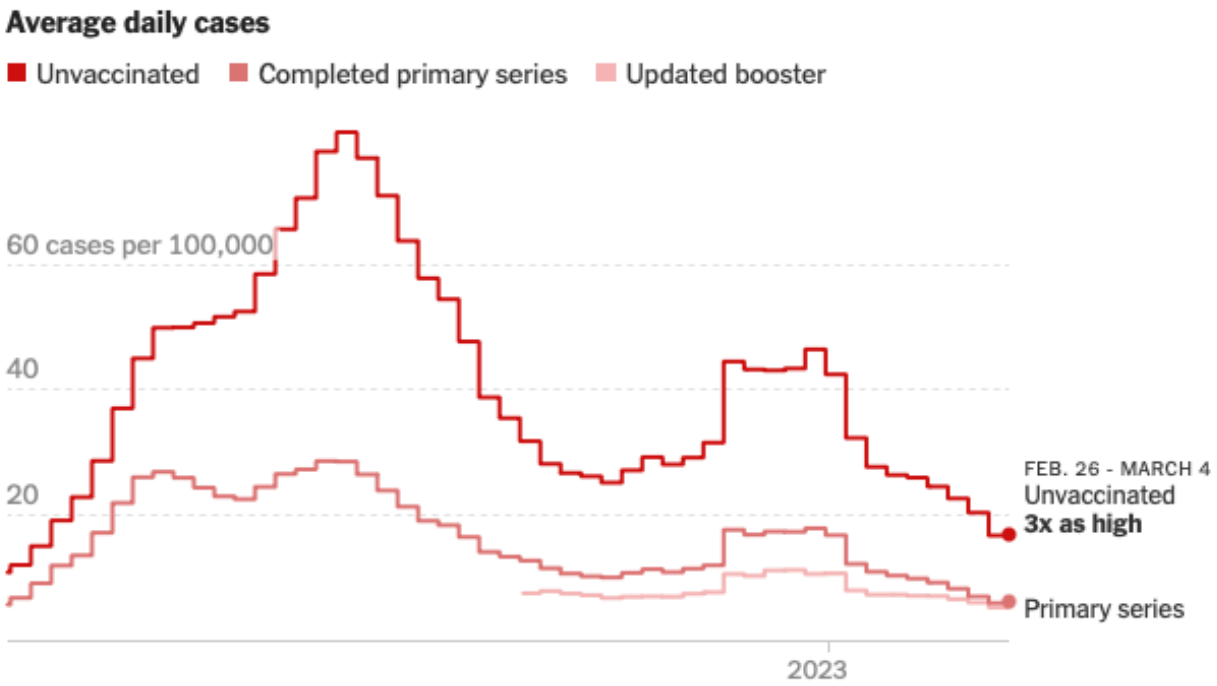
- The IDPH HAI/AR Infection Prevention Team is currently planning topics for future Friday Webinars, and we want to hear from **YOU**!
- What topics would you like to be covered in the webinar? What would be helpful?
- We will be sending out a survey to get your input. Please keep an eye out for that and be sure to fill it out!

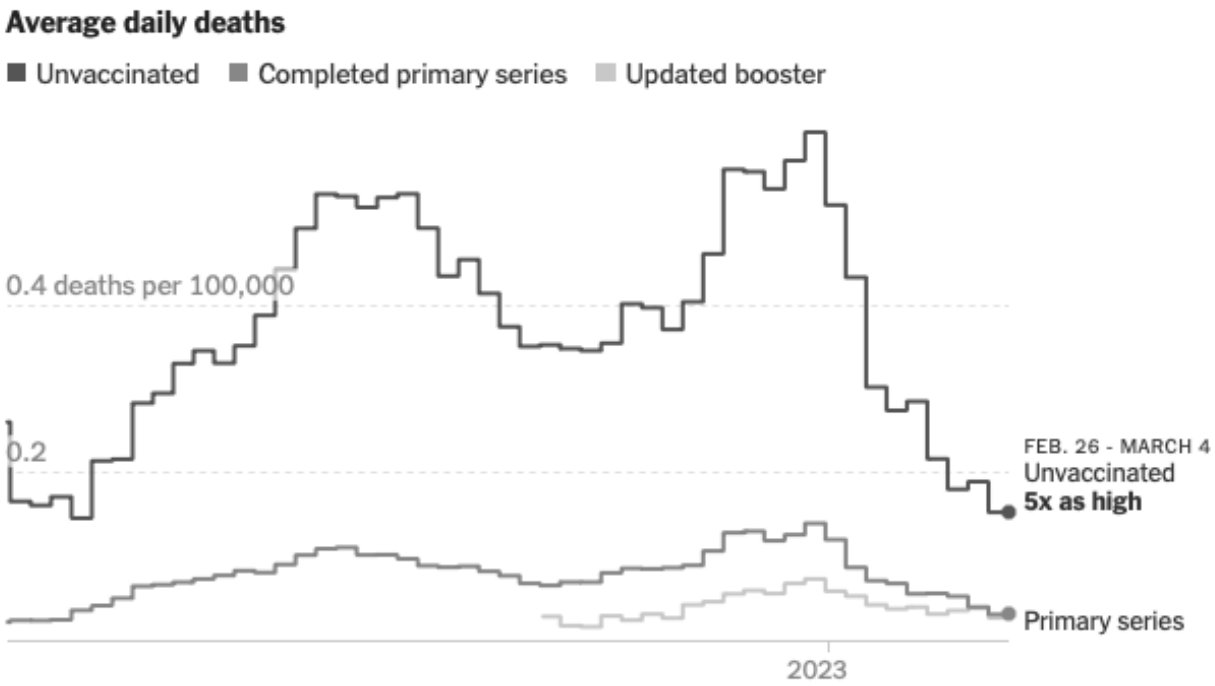
Has CMS Removed the Requirement that Staff be Vaccinated for COVID-19?

- There are no longer vaccine mandates in place by CMS or the state of Illinois.
- However, vaccination is still the most important tool to prevent COVID-19 outbreaks and surges.
- A recent study showed that the bivalent/updated vaccines were effective at preventing symptomatic COVID-19 infections.
  - 52% in persons 18-49,
  - 43% in persons 50-64,
  - and 37% in persons ≥65.

Source: CDC MMWR Early Estimates of Bivalent mRNA Booster Dose Vaccine Effectiveness in Preventing Symptomatic SARS-CoV-2 Infection Attributable to Omicron BA.5– and XBB/XBB.1.5–Related Sublineages Among Immunocompetent Adults — Increasing Community Access to Testing Program, United States, December 2022–January 2023
https://www.cdc.gov/mmwr/volumes/72/wr/mm7205e1.htm?s_cid=mm7205e1_w

Rates of COVID-19 Infection and Death for Vaccinated *v.* Unvaccinated Americans (per 100,000 population)





Are Unvaccinated Staff still Mandated to Obtain a COVID Test Weekly?

- Routine serial testing of HCP who are unvaccinated or not up to date is **no longer recommended**

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Testing of Asymptomatic Residents and HCP with a Close Contact or Higher-Risk Exposure:

- Asymptomatic residents and HCP with a close contact or higher-risk exposure with someone with SARS-CoV-2 infection should have **a series of three viral tests** unless they have recovered from COVID-19 in the prior 30 days.

- For those who have **recovered in the prior 31-90 days**, an **antigen test instead of a nucleic acid amplification test (NAAT) (e.g., PCR) is recommended**. This is because some people may remain NAAT positive, but not be infectious during this period.

- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. **This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.**

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What is “Up to Date” for COVID-19 Vaccinations?

Recommendation for Everyone Aged 6 Years and Older:

- **Everyone 6 years and older <u>should get 1 updated</u> Pfizer-BioNTech or Moderna COVID-19 vaccine**, regardless of whether they’ve received any original COVID-19 vaccines.

CDC Interim COVID-19 Immunization Schedule

Source:
CDC, Use of COVID-19 Vaccines in the United States:
Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC

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What is “Up to Date” for COVID-19 Vaccinations?

Recommendations for People Who ***May*** Get Additional ***optional*** Updated COVID-19 Vaccines:

- **People aged 65 years and older *may*** get 1 additional dose of COVID-19 vaccine 4 or more months after the 1st updated COVID-19 vaccine.

- **People who are moderately or severely immunocompromised *may*** get 1 additional dose of updated COVID-19 vaccine 2 or more months after the last updated COVID-19 vaccine. Talk to your healthcare provider about additional updated doses.

- **These additional doses do NOT affect someone's up to date status.**

Source:
CDC, Use of COVID-19 Vaccines in the United States:
Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC

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Updated HCP Masking

- When the COVID-19 New Hospital Admission Level is **NOT HIGH** Facilities may choose to make masking optional for HCP, *outside of the following situations:*
  - When caring for someone with known or suspected COVID-19.
    - During aerosol generating procedures on such residents, and for 60 min afterward.
  - In affected areas of the facility when in outbreak.
  - For 10 days following a higher risk exposure or a positive test.
- Masking ***policies*** should be updated before making any changes to masking ***practices***.
  - Otherwise, you may be cited for failing to follow your own facility policies.

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Updated Resident Masking

- Resident masking during HIGH COVID-19 New Hospital Admission Levels is now at ***facility discretion***.

  "Facilities might tier their interventions based on the population they serve […] Except when experiencing an outbreak within the facility, facilities with residents or patients that generally do not leave the facility might consider implementing masking only for staff and visitors."

  Source: CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

- However, residents should still mask if:
  - They have suspected or confirmed COVID-19
    - (If leaving their room is a medical necessity)
  - The facility/unit they reside on is in outbreak.
  - They've been exposed to someone with COVID-19 (I.e. mask for 10 days)
  - If masking is otherwise recommended by public health.

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Definition of Outbreak

- The definition of outbreak has **NOT** changed; a single case of COVID-19 still requires investigation.

- An investigation (contact tracing & testing) is triggered by a single COVID-19 case whenever there is the ***potential*** for transmission in the building.
  - (I.e. when you have a single case with exposures)

- However, until you have COVID-19 ***transmission*** within the facility, a state of outbreak is not yet *confirmed* to exist.
  - (By definition, more than one case would be required)

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Discontinuation of Outbreak Testing on one Unit, while Continuing to Test on Others

- When in outbreak and using a broad approach, if one unit/area of the facility goes 14 days without a new case, the facility *may* discontinue testing on that unit/area.

- There are a few considerations here:
  - The more movement between units (residents, staff etc.) the more they should be thought of ***as a single unit***.
    - It may be wise to continue to take precautions in such instances.
  - Generally, the entire facility wouldn't have to mask/be tested due to an outbreak, unless it's facility wide. However, *this only works if the residents don't continually interact with those from affected units.*
  - Testing would need to be resumed if another case was identified on that unit.

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Table 2: Work Exclusions and Restrictions for HCP with COVID-19 Infection

Vaccination Status	Conventional	Contingency	Crisis (Must notify LHD and OHCR)[2]
	Work Exclusion and Required Testing	**Work Exclusion and Required Testing**	**Work Exclusion and Required Testing**
Vaccination status does not affect work exclusions or restrictions	Ideally, HCP should be excluded from work for 10 days . HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms. No testing required to return to work if off work for 10 days. **OR** A facility may choose to exclude the HCP from work for seven days with required testing. • May return to work seven days *after exposure* (day 0) if they do not develop symptoms and all viral testing is negative. • At least seven days have passed since *symptoms* first appeared if a negative viral test* is obtained within 48 hours prior to returning to work and • at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) have improved. HCP who **was asymptomatic throughout their infection** and are not moderately-to-severely immunocompromised could return to work after the following criteria have been met: o At least seven days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7). *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later	HCP may return if at least five days have passed since the date of their first positive viral test (day 0). May return after five days if asymptomatic or have mild to moderate symptoms that are improving and fever-free for 24 hours. Health care facilities may choose to confirm resolution of infection with a negative NAAT (molecular) or a series of two negative antigen tests taken 48 hours apart*. Antigen testing is preferred if testing asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days due to PCR sensitivity.	Allowed to work but should have duties prioritized. No additional testing is required to return to work.

[1]Either an antigen test or NAAT can be used as a clearance test to return to work; however, antigen testing is preferred because a NAAT test may remain positive for some time following infection.

[2]LHD – Local Health Department, OHCR = IDPH Office of Health Care Regulation

Table 3: Work Exclusions and Restrictions for Asymptomatic HCP with Exposures		
Conventional	**Contingency**	**Crisis (Must notify LHD and OHCR)**
Work Exclusion and Required Testing	**Work Exclusion and Required Testing**	**Work Exclusion and Required Testing**
Allowed to work with no testing if has recovered from COVID-19 in the prior 30 days and are asymptomatic. **Allowed to work with a series of three viral tests if recovered from COVID-19 in the prior 31-90 days.** Testing: Use an antigen test instead of a NAAT (e.g., PCR). Test immediately (not earlier than 24 hours after exposure), and if negative, again 48 hours after the first negative test, and if negative, again 48 hours after the second negative test. **Typically, this will be day 1 (where day of exposure is day 0), day 3, and day 5.**	Allowed to work **Must be asymptomatic** No additional testing is required to return to work, but the facility may need to include the returning HCP in outbreak testing if additional cases were identified from the testing of close contacts or other higher-risk exposures during the original outbreak investigation. Outbreak testing must be completed every 3-7 days until there are no more positive cases identified for 14 days. Testing would not be necessary if HCP had COVID-19 infection in prior 30 days. Facility should include HCP in testing if recovered in prior 31-90 days. No additional testing is required if no cases were identified from the testing of the close contacts or higher-risk exposures during the initial outbreak investigation.	Allowed to work **Must be asymptomatic** No additional testing is required to return to work, but the facility may need to include the returning HCP in outbreak testing if additional cases were identified from the testing of close contacts or other higher-risk exposures during the original outbreak investigation. Outbreak testing must be completed every 3-7 days until there are no more positive cases identified for 14 days. Testing would not be necessary if HCP had COVID-19 infection in prior 30 days. Facility should include HCP in testing if recovered in prior 31-90 days. No additional testing is required if no cases were identified from the testing of the close contacts or higher-risk exposures during the initial outbreak investigation.

Candida auris: Infection Prevention and Control of an Emerging Fungal Pathogen

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06/02/2023

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NEWSDESK | VOLUME 4, ISSUE 2, E74, FEBRUARY 2023

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WHO publish fungal priority pathogens list

Talha Burki

023 • DOI: https://doi.org/10.1016/S2666-5247(23)00003-4 •

Chicago Tribune

eased police presence, et outreach among or Johnson's plans for...

Illinois legislature sends bill reforming property tax sale system to Gov. J.B. Pritzker

Chicago Bears Q&A: Could the Jaylon Johnson situatio result in a trade? Will Justi

As a deadly fungus spreads across the country, is Illinois prepared?

By **Adriana Pérez**
Chicago Tribune • Mar 24, 2023 at 6:13 pm

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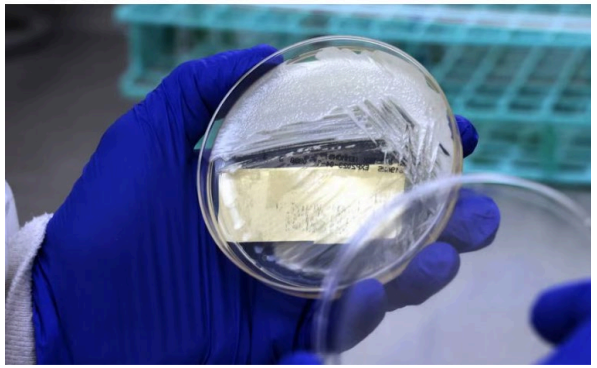

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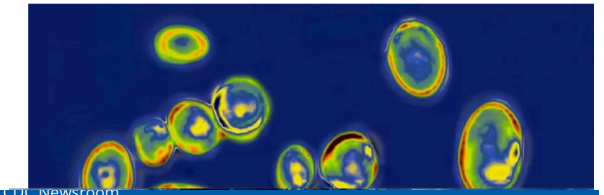
Candida auris fungal infections spreading in US at 'alarming' rate, says CDC

22 March



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CDC Newsroom Releases

Historical News Releases

Increasing Threat of Spread of Antimicrobial-resistant Fungus in Healthcare Facilities

Journal Summaries

Increasing Threat of Spread of Antimicrobial-resistant Fungus in Healthcare Facilities

Print

Press Release

For Immediate Release: Monday, March 20, 2023
Contact: Media Relations
(404) 639-3286

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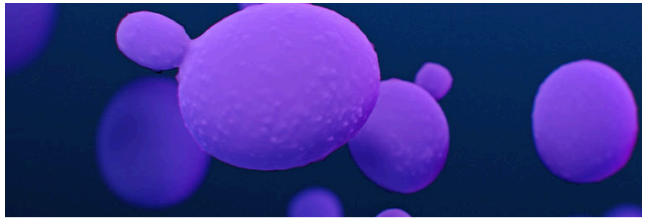
A new antifungal drug for candidaemia

Ammara Mushtaq • Farooq Kazi

Published: June, 2023 • DOI: https://doi.org/10.1016/S1473-3099(23)00307-9 • Check for updates



INFECTIOUS DISEASES | March 23, 2023

CDC issues warning about increase of drug-resistant Candida auris infections

By Lisa Howard

California had 359 cases last year of the potentially deadly fungal infection

(SACRAMENTO) The Centers for Disease Control and Prevention (CDC) has **issued a warning** about a drug-resistant strain of fungus, Candida auris (C. auris), spreading in health care facilities in the United States.

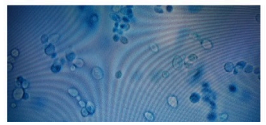
The CDC identified C. auris as an urgent threat because it is often resistant to treatment with antifungal drugs and can cause severe infections with high death rates.

Although still rare in the U.S., more than 1 in 3 patients with an invasive **C. auris infection** die from the disease.

The New York Times

Deadly Fungus Spread Rapidly During the Pandemic, C.D.C. Says

Candida auris, a drug-resistant fungus that health officials hoped to contain is now in more than half the 50 states, according to a new research paper.

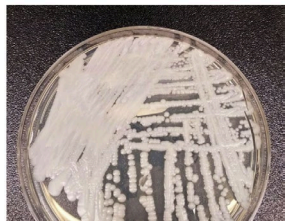


REUTERS

Public Health

Candida auris fungus spreading in U.S. hospitals - CDC

Reuters



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Candida auris: a global fungal public health threat

Jacques F Meis • Anuradha Chowdhary

Published: October 04, 2018 • DOI: https://doi.org/10.1016/S1473-3099(18)30609-1 • Check for updates

References
Article info
Linked Articles

It was only 10 years ago that the US Centers for Disease Control and Prevention (CDC) predicted the emergence of new fungal pathogens as a growing public health problem. [1] In parallel, while assessing global threats, the importance of mycology in public health has been predominantly ignored in several parts of the world. [2] For example the European Centre for Disease Prevention and Control has no mycology experts in the team and WHO's global antimicrobial

Infection Control TODAY

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CDC Discusses Candida auris: What if We Do Nothing—Or Not Enough

Published on: May 4, 2023
Tori Whitacre Martonicz

What is *Candida auris (C. auris)*?

C. auris is an emerging fungal pathogen, often with multi-drug resistance.[1]

C. auris is a separate species from *C. albicans*. Its management, treatment, and infection control measures are distinct.[1]

Usually found in healthcare settings, *C. auris* can cause severe, invasive infections, especially in medically vulnerable populations.[1]

C. auris is one of only five Multi-Drug Resistant Organisms (MDROs) to be classified by the CDC as an 'Urgent Threat', due to the hazard it poses to human health.[1]

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Why is *C. auris* a Major Concern?

More than 30% of patients with invasive *C. auris* infections will die within 30 days.[2]

Antifungals used to treat other fungal infections often don't work on *C. auris.*[2]

Some strains of *C. auris* are resistant to *all* antifungal drugs.[2]

Although only discovered in 2009, *C. auris* now found in dozens of countries.[2]

C. auris can be misidentified, resulting in inappropriate treatment and management.[2]

C. auris spreads easily, especially in healthcare settings.[2]

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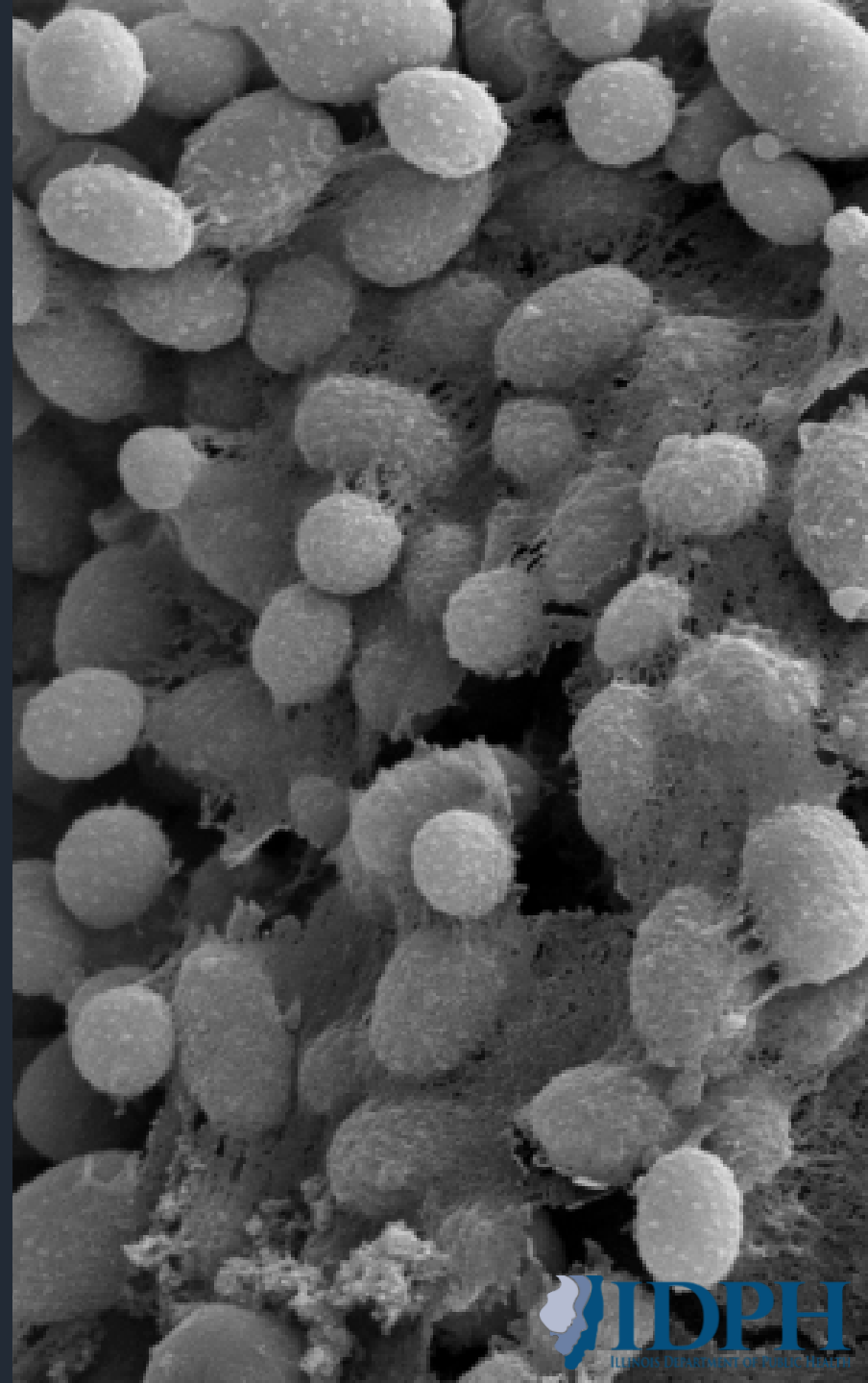
C. auris Drug Resistance:

- *Most C. auris* infections are remain susceptible to echinocandins. (i.e. Anidulafungin, Caspofungin and Micafungin)[2,3]

- *However, some strains of C. auris are resistant to* echinocandins, and certain strains are resistant to *all 3 classes of antifungals.*[2,3]

- *Because C. auris colonizes the skin,* ***antimicrobials are not effective to "de-colonize" a resident.***[2,3]
  - ***Inappropriate use of antimicrobials, can also lead to the development of further drug resistance.***[2,3]

- **Due to the potential challenges posed by resistance, CDC recommends consulting an Infectious Disease Specialist with experience treating *C. auris* infections when using antimicrobials.**[2,3]



Emergence of *C. auris* as a Human Pathogen

- *C. auris* was first described in 2009 in Japan. The first cases in the US were reported in 2016.

- Studies suggests that 4 Clades of *C. auris* simultaneously became human pathogens, on different continents.
  - Clade 1: South Asian. Clade 2: East Asian. Clade 3: South African. Clade 4: South American.

- Each Clade has distinct properties associated with drug resistance, bio-film formation, and virulence.

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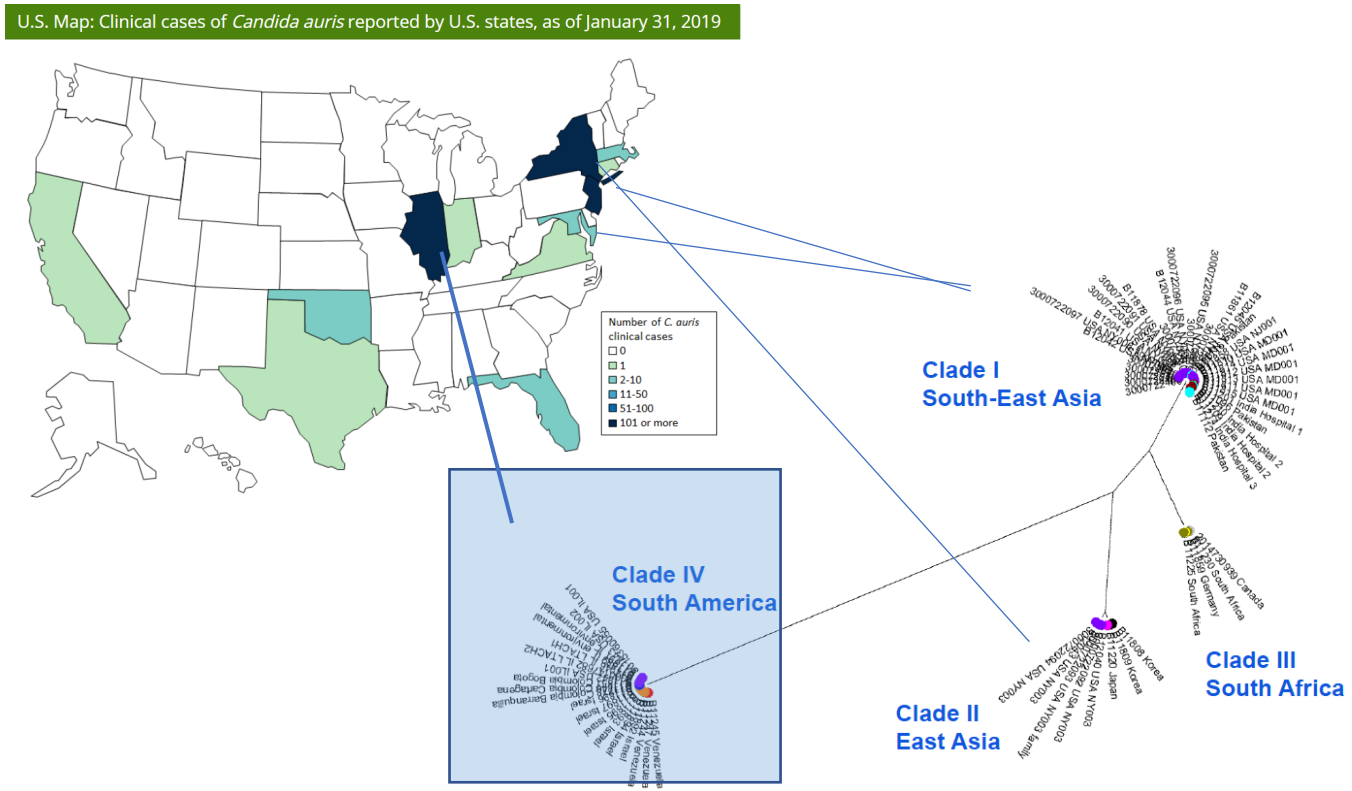
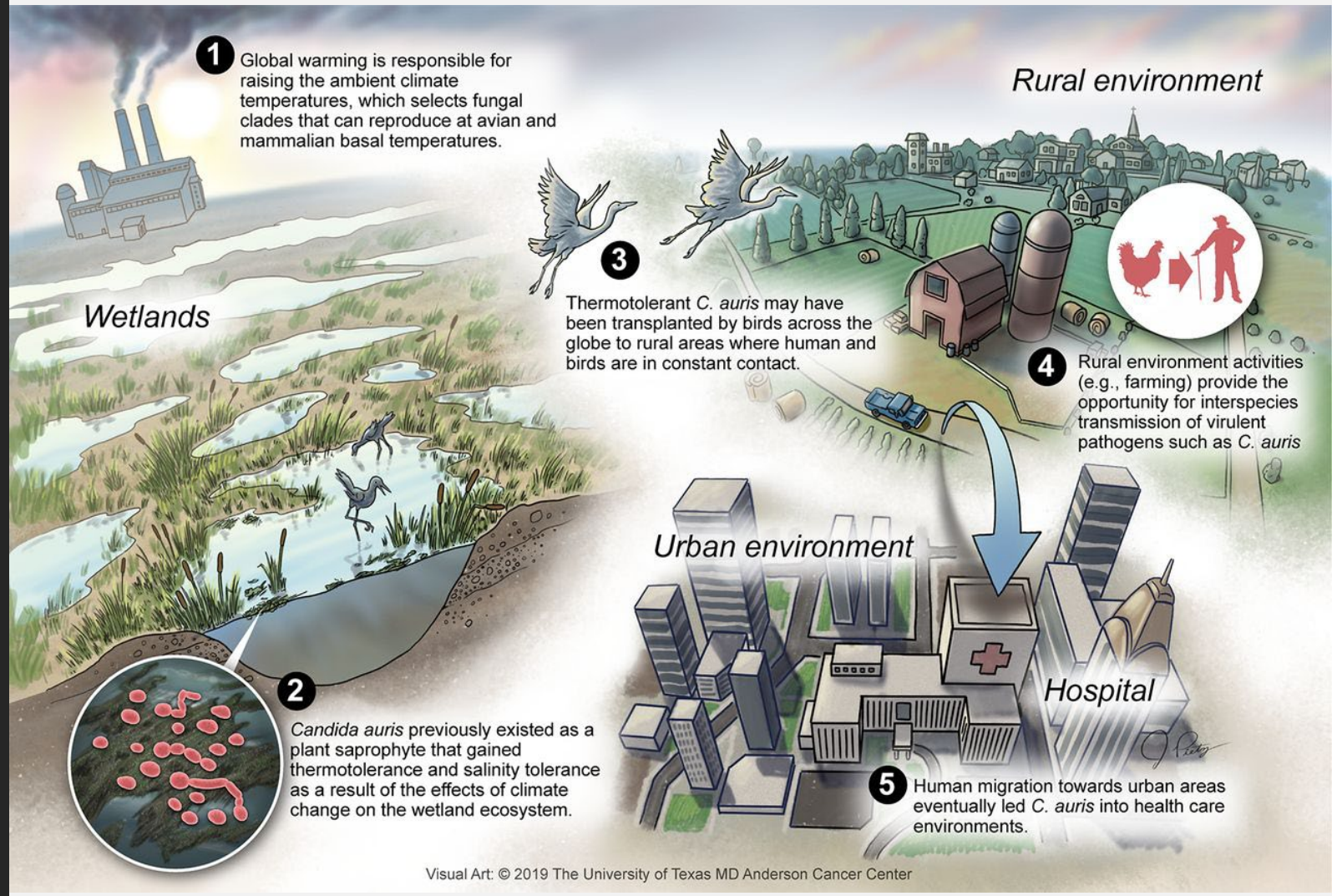
Candida Auris Emergence in the US



Credit: Soda MD, CDC

Proposed Mechanism for the Emergence of *Candida Auris* as a Human Pathogen Casadevall *et al.*[6]



Source: https://journals.asm.org/doi/10.1128/mBio.01397-19

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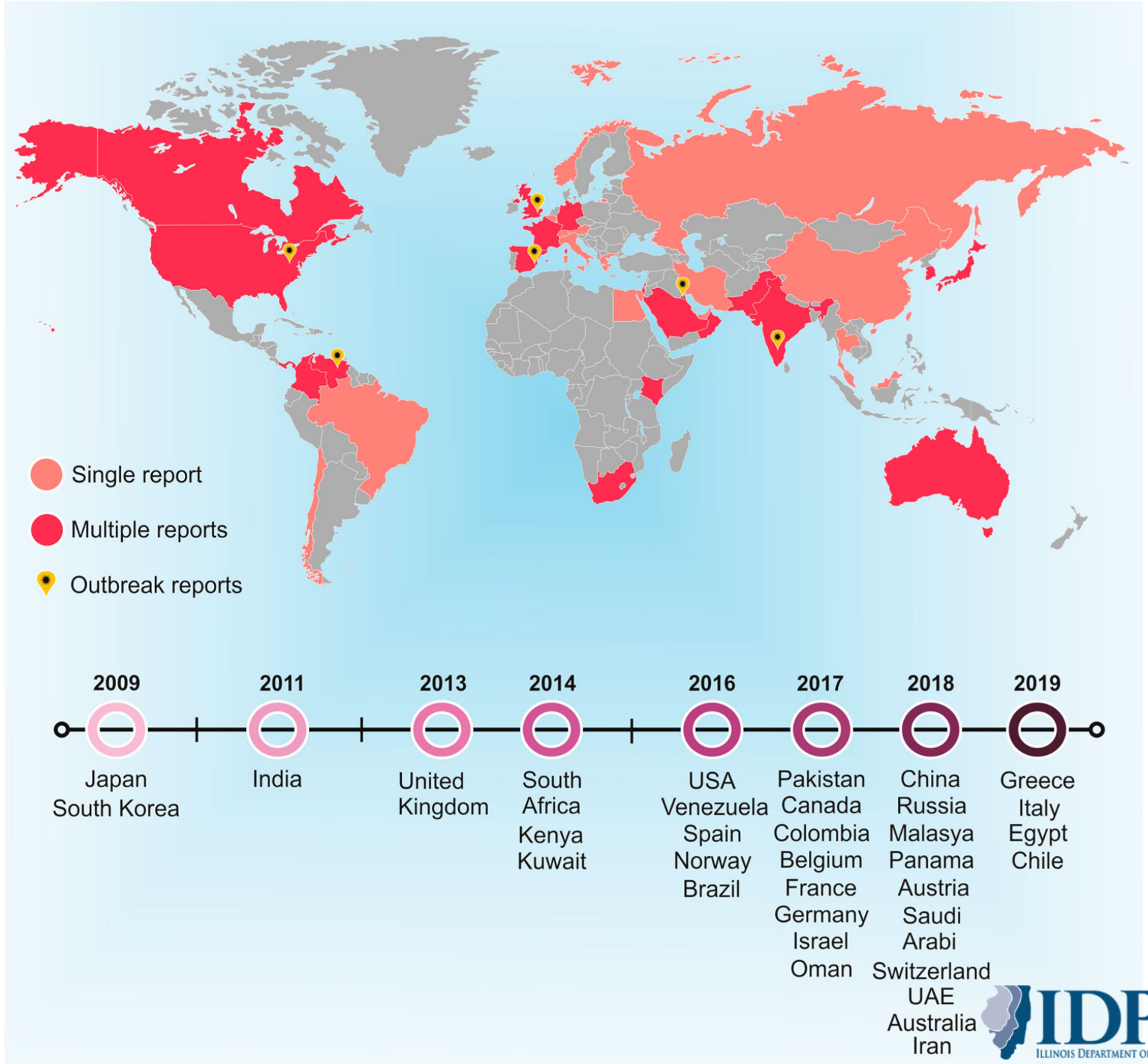
Global Distribution of *Candida auris* with Timeline 2009-2019[8]



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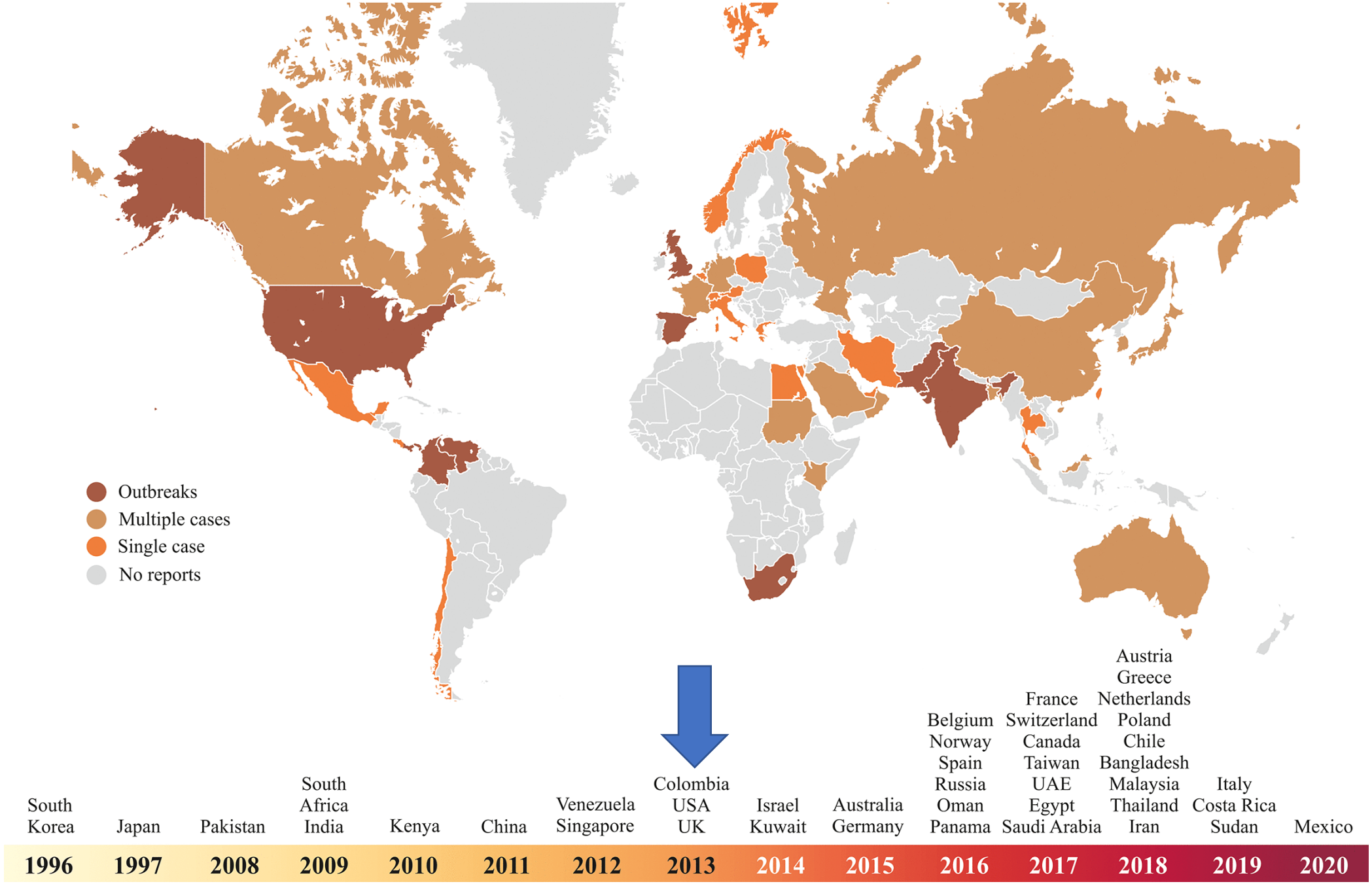
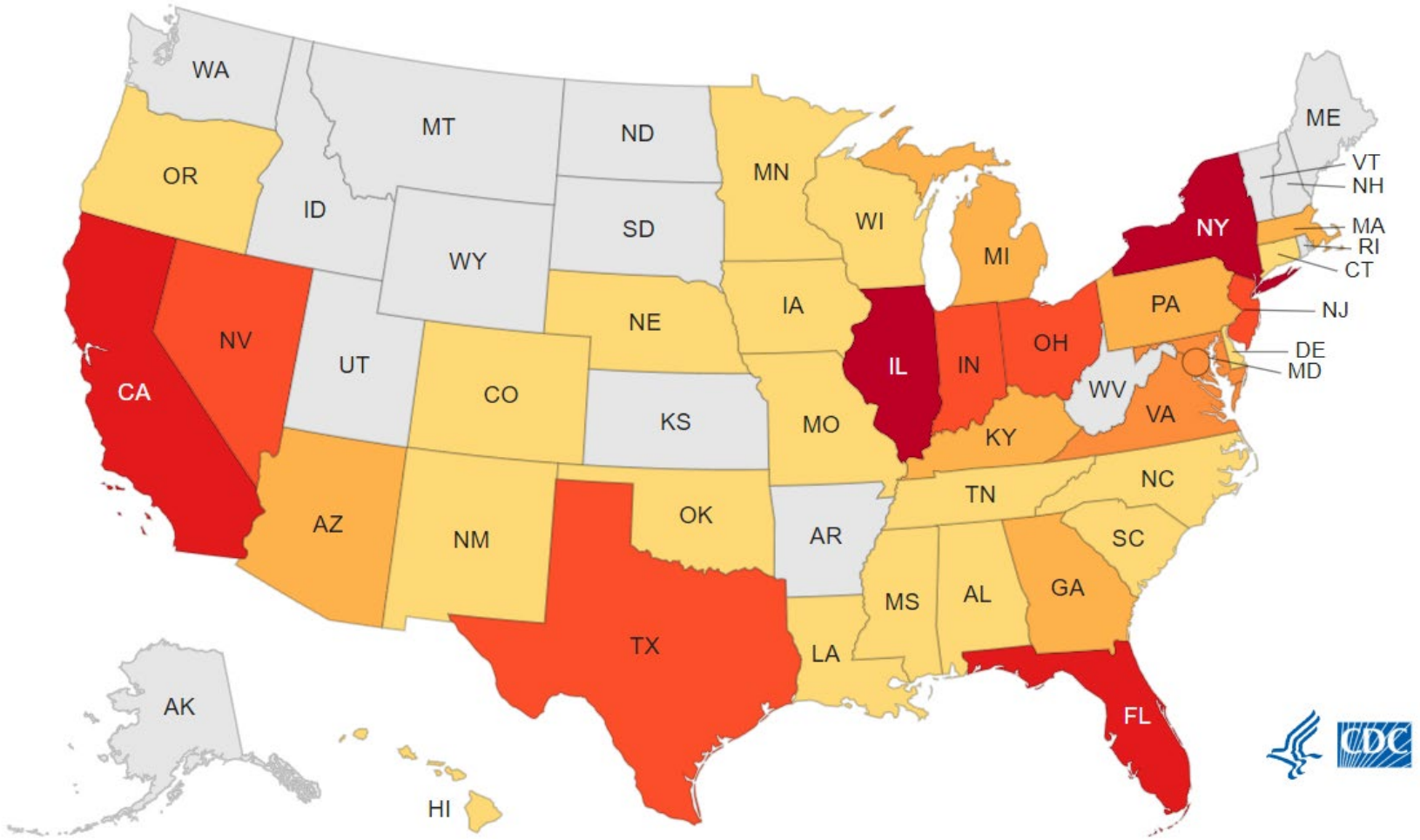


Chakrabarti A, Sood P J. Med. Microbiol. 70, 001318 (2021); https://doi.org/10.1099/jmm.0.001318

Candida auris Cases by State



Number of *C. auris* clinical cases through December 31, 2022

There have been 5,654 clinical cases and 13,163 screening cases since 2013.

- 0 clincial cases and at least 1 screening case
- 1 to 10
- 11 to 50
- 51 to 100
- 101 to 500
- 501 to 1000
- 1001 or more

CDC, Tracking *Candida Auris (2023) all time,* https://www.cdc.gov/fungal/candida-auris/tracking-c-auris.html

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C. auris in Illinois:

- As of 1/20/23 there have been 2,715 cases of *Candida auris* reported to the State of Illinois.
- Most cases have been associated with stays in high acuity Long-Term Care Facilities, such as some Skilled nursing Facilities (SNFs), ventilator capable SNFs, or Long-Term Acute Care Hospitals.
- Recently, we have been seeing *C. auris* in regions and facilities that haven't had it before. As a result, some facilities/HCP may not be familiar with this organism.

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Colonization Vs. Infection:

- In addition to causing infections, *C. auris* can also 'colonize' people.[2]
- Colonization refers to when an organism lives on or in a person without causing active infection or harm. [2, 10]
- Colonized individuals may still transmit *C. auris* and contaminate their environment, although, the risk is lower compared to someone with active infection or uncontrolled secretions or excretions (such as draining wounds or diarrhea). [2, 10]
- However, individuals colonized with *C. auris* may later develop active infections, especially if they are more vulnerable by other medical conditions.[10]

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Transmission of *C. auris:*

- *C. auris* spreads by physical **contact** with a colonized/infected person or a contaminated object/surface. [1-5]
- *C. auris* has been found on many surfaces in healthcare facilities, such as medical equipment (ventilators, IV pumps, glucometers etc.), countertops, tables, windowsills, etc.
- Patients with indwelling devices are at especially high risk of colonization and infection.
  - Indwelling devices include urinary catheters, enteral feeding tubes, venous access devices etc.
- Failure to properly terminal clean a room after a *C. auris* patient has been discharged can result in the subsequent residents of that room becoming colonized or infected.

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Example: *C. auris* Outbreak in a Healthcare Setting

vSNF Floor: PPS 1 (3/2017)

PPS # 1

Black, S.R. CDC Vital Signs Town Hall
April 10, 2018

vSNF Floor: PPS 2 (1/2018)

PPS # 2

Black, S.R. CDC Vital Signs Town Hall
April 10, 2018

- In a matter of months, *C. auris* spread from a single patient to 43% of the unit. Note that 5 patients were not tested in the second Point Prevalence Screening (PPS)

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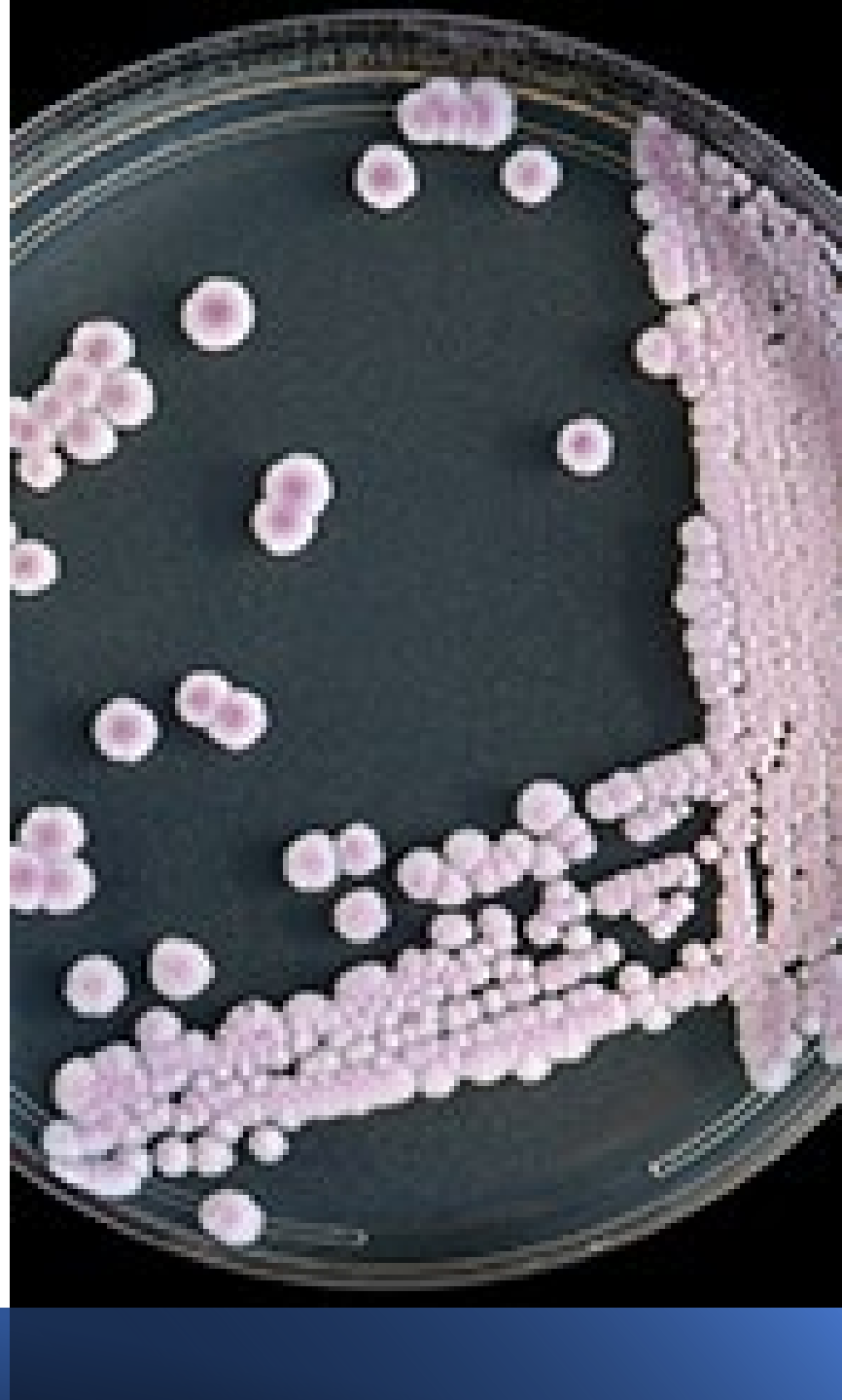
Core Elements of *C. auris* Infection Control:

- Hand Hygiene
- Environmental Cleaning
- Transmission-Based Precautions (TBP)
- Interfacility Communication[2]



Hand Hygiene:

- Since *C. auris* spreads by physical contact contaminated hands pose a serious transmission risk [1,2,3]
- Standard precautions should always be employed, and the 5 moments of hand hygiene observed.[3]
- Hand hygiene with Alcohol-Based Hand Sanitizer (ABHS) is recommended when hands are not visibly soiled.[3]
- If hands are visibly soiled, then soap and water hand hygiene is recommended. [3]

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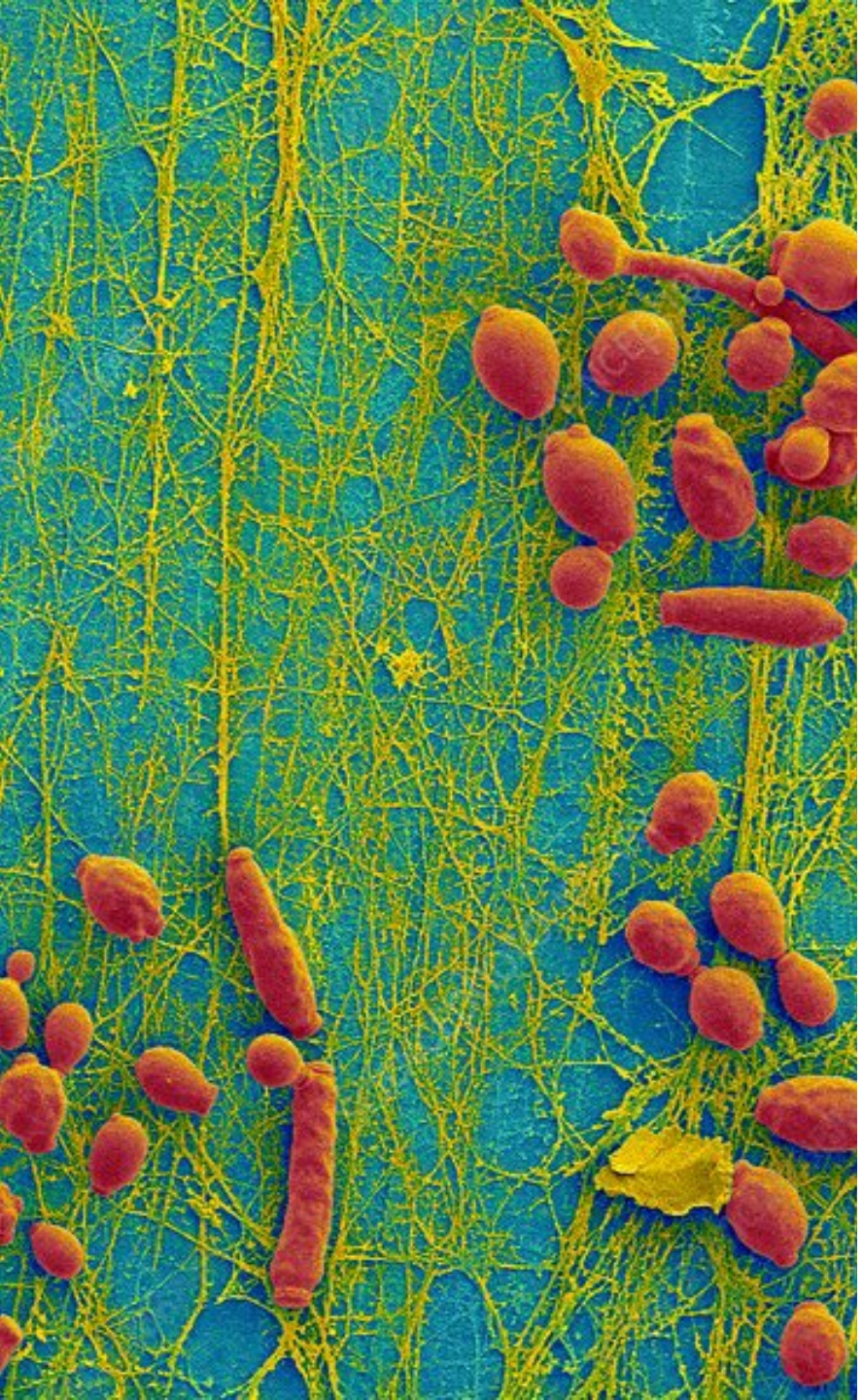

Environmental Cleaning:

- *C. auris* is a hearty organism; it can persist on surfaces for *weeks* and not all disinfectants are effective against it.[3]
- Products on EPA List P should be used to kill *C. auris* (if not available, EPA list K products *can* be used).[3]
- High-touch surfaces and shared medical equipment can harbor *Candida auris.*[3]
- *Thorough cleaning of high touch surfaces, common areas, medical equipment, and the routine and terminal cleaning of rooms is critical.*[3]
- **Facilities should determine if their current products are effective against *C. auris.* Products not used according to their IFU may not be effective .[3]**

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Environmental Cleaning: Best Practices for MDRO Prevention

- The frequency, method, and process of cleaning should be based on the risk of transmission. Risk can be assessed based on
  - Probability of contamination
  - Vulnerability of the patients/residents to infection
  - Potential for exposure

- Develop a cleaning schedule that:
  - Clearly identifies the person responsible
  - Indicates the frequency of cleaning for different surfaces/equipment/areas
  - Includes the method of cleaning (product, process etc.)
  - Has detailed SOPs for surfaces, noncritical equipment etc. in all areas of the facility
  - Is made readily available to staff

- Cleaning should be performed from cleaner to dirtier, high to low.[7]

- Checklists and logs can also be used to help guide environmental cleaning. (see 2.4.3 of Cleaning Programs)

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Transmission-Based Precautions (TBP):

Two types of TBP may be used for *Candida auris*; Contact Precautions and Enhanced Barrier Precautions.[4,5]

Otherwise, Enhanced Barrier Precautions can be used.[4,5]

Residents who have an additional condition for which Contact Precautions are recommended in CDC's Appendix A should be on Contact Precautions.

All residents with draining wounds that cannot be contained (e.g., who cannot maintain adequate hygiene) and/or diarrhea

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Auditing & Marking:

- Auditing and fluorescent marking allow facilities to verify that infection prevention and control practices are being performed and identify practices that might need improvement.
- Facilities with *C. auris* should significantly increase auditing of IPC practices, such as; **hand hygiene, PPE use, TBP, and environmental cleaning.**
- Environmental or fluorescent marking should be used to assess cleaning and disinfection practices (e.g., use of friction) to ensure they are being done appropriately.
- Data from auditing and marking should be used to target Quality Assurance and Performance Improvement measures and staff education.

Inter-facility Communication:

- If a receiving facility is unaware a resident has *C. auris*, they might place them with a roommate, leading to spread and potential harm to other residents.[3]
- When transferring a patient (to a hospital, another LTCF etc.) directly notify the receiving facility of patient's status as infected/colonized with *C. auris*.[3]
- Be sure to communicate the precautions that need to be taken.[3]
- The CDC has an '[Inter-facility Transfer Form]' for patients with MDROs, such as *C. auris*. (see resources section)

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Other Important Steps:

If there is the potential for *C. auris* exposure and transmission, testing may be indicated (i.e. Point Prevalence Screening).

Ideally, *C. auris* patients should be placed in single rooms, without roommates.

Having staff work designated areas of the facility, and reducing staff movement between units can also be a helpful tool to prevent transmission in high-risk facilities/situations (of any communicable disease).

Facilities should use the IDPH eXtensively Drug Resistant Organism (XDRO) Registry to screen new admission for previous diagnosis with a Multi-Drug Resistant Organism.

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Other Important Steps Cont.

- Facilities that have residents with *C. auris* and have had transmission in the past, should periodically perform Point Prevalence Screening (PPS) to ensure there isn't ongoing transmission.

- Your local health department and IDPH can provide information and guidance to help you implement *C. auris* infection prevention and control measures and perform testing.

- Remember*: C. auris* is a reportable disease.

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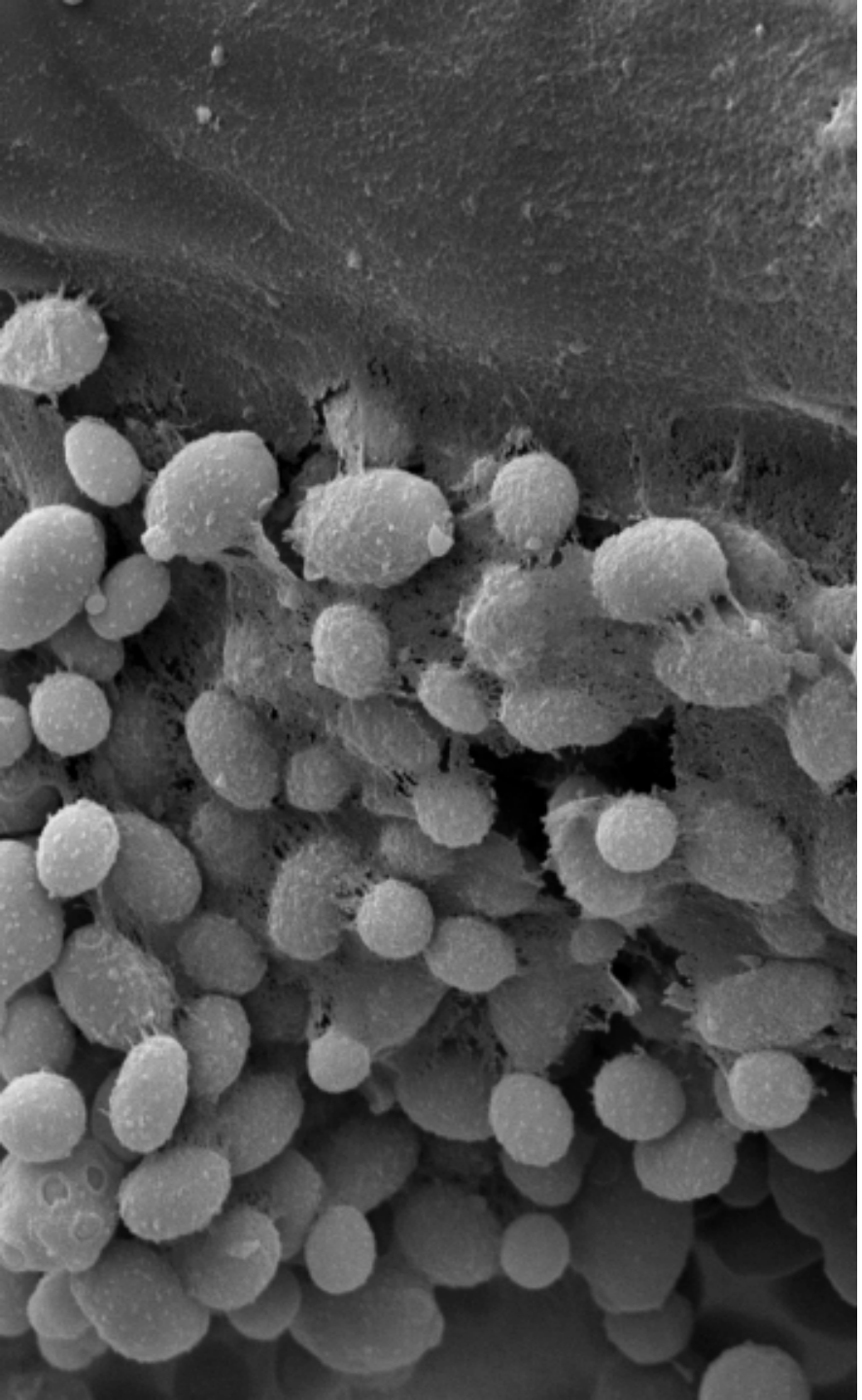

Antimicrobial Stewardship

- Stewardship is critical to prevent the development of further resistance when antimicrobial resistant organisms are present, especially one that develops resistance quickly, like *C. auris*.

- Stewardship interventions include:
  - Consult with Infectious disease (ID) experts. ID physicians can help ensure that the antimicrobials used are appropriate.
  - Don’t ”treat” colonization with antifungals
  - Tracking antimicrobial use
  - Antimicrobial timeouts

- When choosing an antimicrobial care should be taken to ensure that the drug chosen:
  - Will be effective against the pathogen.
  - Will have the narrowest spectrum possible.
  - Will be used for the shortest duration possible.
  - Will be used at the lowest dose possible.[9]

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Education, Education, Education….

- As you can see, the control of *C. auris* requires some specialized knowledge. Staff need to know the importance of and rationale behind these measures to employ them effectively.

- Providing **ALL** staff with education on hand hygiene, environmental cleaning, TBP, PPE use etc. is an important aspect of preventing and/or interrupting transmission.

- Providing in-services, online training, and IPC huddles can all be methods of staff education.

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Reporting Cases of *C. auris*

- In Illinois, cases of *C. auris should be reported* "as soon as possible during normal business hours, but within seven days"

- *C. auris* can only be reported to the XDRO Registry by select entities (i.e. IDPH and the local health departments).

- Therefore, cases of *C. auris* should be reported via INEDSS.
  - INEDSS Access to is granted ***with*** XDRO Registry access.
  - Reporting to INEDSS fulfils the requirement to report to both the state and local health departments (LHD)

- Facilities that do not have access to INEDSS should report *C. auris cases* to their LHD. The LHD will then report them to IDPH.

- If you are not already registered for the IDPH XDRO Registry, register!

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Register for the XDRO Registry:

- This link can be used to register for the IDPH XDRO Registry:
  - https://www.xdro.org/login.html

- For help with the XDRO Registry email:
  - DPH.XDRORegistry@illinois.gov

Questions, Comments?

- Please enter them in the chat section.

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Additional *C. auris* Resources:

- IDPH Hospital Report Card: *C. auris* Surveillance Report:
  - http://www.healthcarereportcard.illinois.gov/files/pdf/C_auris_2020Report_FINAL.pdf
- CDC Fact Sheet: Drug Resistant *Candida auris*:
  - https://www.cdc.gov/drugresistance/pdf/threats-report/candida-auris-508.pdf
- CDC: *Candida auris* Colonization:
  - https://www.cdc.gov/fungal/candida-auris/fact-sheets/c-auris-colonization.html
- CDC: *Candida auris* Testing:
  - https://www.cdc.gov/fungal/candida-auris/fact-sheets/c-auris-testing.html
- CDC: (*Candida auris*) Information for Infection Preventionists
  - https://www.cdc.gov/fungal/candida-auris/fact-sheets/cdc-message-infection-experts.html
- EPA: P List Disinfectant Products
  - https://www.epa.gov/pesticide-registration/list-p-antimicrobial-products-registered-epa-claims-against-candida-auris
- CDC: Inter-facility Infection Control Transfer Form (for MDRO)
  - https://www.cdc.gov/hai/pdfs/toolkits/Interfacility-IC-Transfer-Form-508.pdf

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Open Q&A

Submit questions via Q&A pod to **All Panelists**

Please do not resubmit a single question multiple times

Slides and recording will be made available after the session.

Reminders

- For continuing education credit, please fill out the evaluation survey upon end of webinar

- SIREN Registration
  - To receive situational awareness from IDPH, please use this link to guide you to the correct registration instructions for your public health related classification: http://www.dph.illinois.gov/siren

- NHSN Assistance:
  - Contact Telligen: **nursinghome@telligen.com**