OHA Responsive Testing Algorithm for High-Priority MDROs

Candida (Candidozyma) auris and carbapenemase producing organism (CPO) testing

Summary of CDC Guidance for Tier 2 Organisms

In general, CDC recommends broad screening (point prevalence survey (PPS) or full unit/facility testing) for inpatient healthcare exposures of the index patient in the 30 days[1] prior to the identification of the target organism.

Exceptions:

1. Length of stay was very short (<24 hours)
2. An ACH unit with short average length of stay where patients are ambulatory and not mechanically ventilated, and patient has been discharged >7 days prior.

Prioritize:

- Healthcare settings with high-acuity patients and longer lengths of stay (e.g., longterm acute care hospitals, ventilator-capable skilled nursing units, ICU burn units, units caring for solid organ or hematopoietic transplant patients)
- Any setting where the index case likely acquired the organism (e.g., no prior risk factors before hospitalization)
- If considering a risk-factor-based approach instead of PPS, prioritize presence of risk factors:
    - Bedbound, high levels of care, receipt of antimicrobials, mechanical ventilation, indwelling devices or lines.

Link to CDC Novel and Targeted MDRO Containment Guidance

Cases identified via preventive screening at all facility types

Consider no additional testing if all the following conditions are met:

- Patient on appropriate transmission based (e.g., contact) precautions and effectively managed at or prior to admit (e.g., admission screening or effective interfacility transfer notification)
- No IPC concerns identified (e.g., appropriate disinfectants, no breakdowns in PPE use, etc.)
- For preventive point prevalence surveys (PPS), high participation rate with no additional cases identified

If these conditions are not met, then defer to guidance on the following pages based on facility type. If patient CRE/CPO status is known by the facility at admit or due to preventive screening, and appropriate infection control measures are taken, response may be limited to a phone call or email assessing this information.

[1] If information is available about the time the organism was most likely acquired (e.g., international hospitalization), then all facilities since CPO acquisition should be considered for screening. This may be greater or less than 30 days.

Exclusions and considerations for all facility types

- Across all facility types, consider excluding the following patient populations unless epi strongly indicates they should be tested:
    - patients admitted <24 hours,
    - patients on secure psychiatric units or with severe psychiatric symptoms,
    - or who may otherwise experience undue stress or trauma or cause physical harm to staff attempting to obtain consent and/or a swab.
- Across all facility types, test patients who meet the criteria but have since discharged/transferred to another acute care or skilled nursing facility.
- Across all facility types, note that ICAR observances may alter screening recommendations
- Decisions about which healthcare contacts to test should be made in collaboration with the affected healthcare facility and based on the relevant epidemiology, public health investigation, and resources available.

Self-collection

If a patient does not consent to having a rectal swab collected by staff but is able to follow instructions for self-collection, self-collection is an acceptable alternative.

Alternate Sites

Alternate sites for testing are available as indicated by epi (e.g., transmission suspected through wound care, shared respiratory equipment, etc.). Capacity for alternate sites is very limited. Alternate site testing requires a different testing method and form. Consult with OHA prior to offering alternate site collection.

Testing of known positive cases

Generally, people who test positive for either *C. auris* or a CPO are considered positive for the rest of their lives and should not be retested. If a patient tests positive for one of these organisms and has an exposure that puts them at risk for the other organism, then testing for the other organism is recommended. In the absence of risk factors such as international travel or out of state healthcare, testing a *C. auris* or CPO patient for the other organism is not recommended.

For example, if a patient has a CPO detected from a clinical specimen and while investigating you identify that the patient was hospitalized outside of Oregon in an area with high prevalence of *C. auris*, then *C. auris* testing of the CPO case is recommended.

Empiric transmission-based precautions during responsive surveillance testing

All known positive cases of *C. auris* and CPO should be placed on appropriate transmission-based precautions (e.g., contact precautions, see the OR CRO/CPO Toolkit). Patients who are tested as a part of a containment response do not necessarily need to be placed on empiric contact precautions while test results are pending.

For all additional questions related to *C. auris* and CPO response, contact an OHA MDRO Epidemiologist.

Oregon Responsive Screening Algorithm by Facility Type

	Always Test the Following Patients:		Point Prevalence Survey (full unit/facility):		Additional Targeted Testing:
LTACH/vSNF	• Shared room/bath/toilet • Subsequent residents of index patient's room(s) if inpatient and admitted >24 hours • High-risk patients: ○ Proximity to index (same hall/unit) ○ shared risk factors with index (e.g., mechanical ventilation, wound care)	→	If yes to any of the following: • organism likely acquired at this facility • index case with long length of stay • index case ever off contact precautions • IPC concerns identified	→	NA, targeted screening is a minimum recommendation in LTACHs and vSNFs (see "always test" column)
Acute Care Hospitals	• Shared room/bath/toilet • Subsequent residents of index patient's room(s) if inpatient and admitted >24 hours	→	If yes to any of the following: • organism likely acquired at this facility • patient admitted to a high-acuity unit with longer lengths of stay (e.g., burn, transplant) • IPC concerns identified	→	If criteria for PPS are not met or patients on non-PPS units share risk factors, consider targeted screening based on shared risk factors, e.g.: • wound care • mechanical ventilation • indwelling devices/lines
Skilled Nursing Facilities	• Shared room/bath/toilet • Subsequent residents of index patient's room(s) if inpatient and admitted >24 hours	→	If yes to any of the following: • patient admitted for >24 hours	→	If patients on non-PPS units/halls share risk factors, consider targeted screening based on shared risk factors, e.g.: • wound care • indwelling devices/lines

	Always Test the Following Patients:		Point Prevalence Survey (full unit/facility):		Additional Targeted Testing:
Other Congregate Care	No testing unless indicated by epi or an IPC breach is identified. Provide written notification to and recommendations to facility if patient receives assistance with activities of daily living. For testing in adult foster homes, notify ODHS. Testing can be provided by contract nurse.	→	Ongoing transmission suspected.	→	• Transmission suspected • IPC breach identified • High-risk care provided • Risk factors present (shared room/bath/toilet, adjacent rooms, frequent inpatients, bed found, past year international healthcare or travel)
Outpatient Settings**	No testing unless indicated by epi or an IPC breach is identified. Provide written notification to and recommendations to facility. **Outpatient settings include outpatient dialysis, outpatient surgery, clinics, and other outpatient settings.	→	NA	→	• Transmission suspected • IPC breach identified If testing is recommended, offer testing through patients' primary care provider, home health, or self-collection at home.