COLORADO
Department of Public Health & Environment

Guidelines for Prevention and Control of Influenza Outbreaks in Long-Term Care Facilities

2020—2021 Season

Influenza & COVID-19

During the 2020-2021 respiratory illness season, it is expected that influenza and COVID-19 will be co-circulating in Colorado communities. The symptomatic presentations of influenza and COVID-19 can be very similar and it may be difficult to distinguish between them based on symptoms alone. Additionally, it is possible for individuals to be co-infected with both influenza and COVID-19, and occur as simultaneous or separate outbreaks in long-term care facilities (LTCFs). Testing for both influenza **and** COVID-19 is highly recommended to confirm a diagnosis if a resident or multiple residents present with respiratory illness symptoms. Measures for prevention and response of outbreaks of respiratory illness should consider both influenza and COVID-19 and defer to the COVID-19 outbreak guidance for long-term care facilities until testing confirms a diagnosis.

While influenza and COVID-19 share several symptoms, there are key differences between the two. This CDC website compares COVID-19 and influenza with the best available information to date. Notably, both influenza and COVID-19 are spread from person-to-person via respiratory droplets produced when the infected individual coughs, sneezes or talks. Research thus far has shown that COVID-19 is more transmissible than influenza. The incubation period for influenza can range from 1 to 4 days with peak viral shedding occurring 1 day before symptom onset and up to 3 days after. Adults are generally most infectious for 3-4 days after symptom onset but may be contagious for up to 7 days. The incubation period for COVID-19 is typically 5 days, however symptoms may occur as soon as 2 days and up to 14 days after infection. Evidence thus far indicates that infected individuals may be contagious for 10 days after symptom onset, or potentially longer in individuals who are severely compromised or who have been very ill. ***It is important to note that how long someone is able to spread the SARS CoV-2 virus to other people is still under investigation***.

Current CDC reports indicate that both viruses may present with: fever or feeling feverish/chills; cough; shortness of breath or difficulty breathing; fatigue; sore throat; nasal congestion; muscle pain or body aches; headache; vomiting and diarrhea. COVID-19 may differ from influenza in that it may present with change or loss of taste or smell. Much is still unknown about COVID-19, therefore it is essential to continuously refer to the CDC for the latest updates.

Influenza vaccination

Transmission of influenza in the community to long-term care facilities occurs via infected visitors, residents and healthcare personnel. Influenza vaccination is the primary strategy of preventing complications and transmission of influenza among residents and staff of LTCFs. Due to the circulation of SARS CoV-2, the virus that causes COVID-19, influenza vaccination of all staff and residents is critical to help reduce the transmission of multiple respiratory viral illnesses that can lead to complications, hospitalization and death among medically vulnerable populations. All staff and residents should receive the annual influenza vaccine early in the fall before the influenza season begins and at the latest by the end of October. If a new resident is admitted after seasonal vaccinations have been administered and they have not been vaccinated previously, vaccination should be provided to the new resident as soon as possible. Influenza vaccination should be made available throughout the influenza season or until supply is no longer available. Additional CDC guidance and resources on influenza vaccination for healthcare professionals are found here: https://www.cdc.gov/flu/professionals/vaccination/index.htm.

Beginning in 2005, the Centers for Medicare and Medicaid Services (CMS) requires nursing homes participating in Medicare and Medicaid programs to offer influenza and pneumococcal vaccination to all residents and to document the receipt of vaccination. The requirements dictate that each resident is to be vaccinated unless there is a medical contraindication, the resident refuses, or the vaccine is not available.

Beginning in 2012, healthcare workers who work in facilities licensed by CDPHE (including long-term care facilities) are required to have proof of influenza immunization or a medical exemption. For more information about this requirement and influenza vaccination for the 2020-21 season, please contact the CDPHE Immunization Branch at 303-692-2700 or visit: https://www.colorado.gov/pacific/cdphe/board-health-rule-influenza-immunization

Case definition for influenza-associated outbreaks in a long-term care facility:

- **Influenza-like illness (ILI)**: [Fever (>100 F) or new prostration] AND [new cough or sore throat]
- When influenza is circulating in the surrounding community of the LTCF, a high index of suspicion should be maintained. The medical director might consider loosening the ILI case definition to [fever OR new prostration OR

new cough] for an outbreak highly suspected of being due to influenza in which residents do not manifest multiple signs.

  - Note: If COVID-19 is circulating in the community, the case definition for COVID-19-like illness should also be considered when assessing patients with respiratory symptoms.
  - COVID-19-like illness (CLI) case definition: [Fever (>100 F) AND cough or shortness of breath or difficulty breathing
- **Suspected influenza outbreak:** two cases of ILI within a 1-week period without a positive test for influenza. During the time when influenza is circulating locally, the occurrence of acute febrile respiratory illness in several residents within a short time frame should be considered highly suspect for influenza until testing proves otherwise, regardless of whether the affected residents have been vaccinated.
- ***Confirmed influenza outbreak**: at least **two** residents with a positive influenza test.
  **Note: This outbreak definition is different from previous seasons due the co-circulation of COVID-19; the previous definition required only one positive influenza test among 2 or more residents with ILI.*

Influenza & COVID-19 testing

If a resident or healthcare personnel (HCP) presents with symptoms of ILI, first refer to the testing guidelines established by CMS for further instruction on testing for COVID-19. It is recommended that a symptomatic resident or staff member should be tested for both COVID-19 and influenza, or follow-up testing should be done for influenza if the COVID-19 test result is negative. Testing for other respiratory pathogens is also recommended to determine potential co-infection or outbreaks of other respiratory illnesses (ie RSV, pneumonia).

In the event of an influenza outbreak, it is recommended that at least 2–5 residents with influenza-like illness should be tested for influenza in addition to COVID-19 within 1–2 days of symptom onset. If there are simultaneous outbreaks of COVID-19 and influenza in the facility, testing should be done continuously to confirm whether any resident with ILI is positive for COVID-19, influenza, or both. It is possible for co-infection with influenza and COVID-19 to occur, therefore testing is the best method to inform proper infection control and clinical management. The CDPHE State Lab will provide COVID-19 testing for outbreak responses and will have a limited number of flu tests available for select outbreaks during the peak months of the influenza season. Contact your local health department for more information on RT-PCR testing availability through the state public health laboratory. Early and late season influenza outbreaks should be confirmed by RT-PCR.

Once a suspect or confirmed outbreak has been identified, outbreak prevention and control measures should be implemented immediately. Until confirmatory testing results in a diagnosis, the outbreak response should follow COVID-19 measures for infection control and prevention.

In order of priority, the following influenza tests are recommended: reverse transcription polymerase chain reaction (RT-PCR); immunofluorescence; rapid influenza diagnostic tests.

Due to the potential for false positive results, especially if it is not currently influenza season, perform confirmatory testing using RT-PCR if immunofluorescence or rapid influenza diagnostic test results are positive.

Testing for other respiratory pathogens is recommended if symptomatic residents are negative for both influenza and COVID-19, and if influenza and COVID-19 are not currently circulating in the community.

Reporting an outbreak

Influenza outbreaks in long-term care facilities are reportable conditions in Colorado. Please report all suspected and confirmed influenza outbreaks to your local health department or to CDPHE. Reference the attached flow chart for influenza and COVID-19 outbreak reporting contact information and instructions.

Prevention of Transmission of Influenza: General Principles

Healthcare facilities should use a multi-faceted approach to decrease the risk of transmission of influenza to protect residents and staff. This includes:

1. Administration of influenza vaccine
2. Implementation of respiratory hygiene and cough etiquette
3. Appropriate management of ill healthcare personnel

4. Adherence to infection control precautions for all patient-care activities
5. Implementing environmental and engineering infection control measures

More information on these core prevention strategies can be found in CDC's "Prevention Strategies for Seasonal Influenza in Healthcare Settings" at: http://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm

LTCFs should prevent the transmission of influenza using the following strategies. These strategies will also help prevent the transmission of other respiratory viruses, such as COVID-19.

1. Maintain communication between LTCFs and acute-care facilities to ensure that transfers are not admitted with unrecognized respiratory infections. Facilities should defer to the COVID-19 protocol for new admissions. Confirmed influenza cases can be transferred into the facility if acute symptoms are resolved or the accepting facility is able to maintain appropriate infection control precautions.
2. Maintain good hand hygiene practices and implement respiratory hygiene and cough etiquette strategies. For further information, see CDC website at http://www.cdc.gov/flu/professionals/Infectioncontrol/resphygiene.htm
3. Promote and provide influenza vaccine for healthcare personnel and residents.
4. Defer to the COVID-19 return-to-work criteria for staff that have undiagnosed respiratory illness symptoms. Staff that have confirmed influenza may only return to work until at least 24 hrs after they no longer have a fever (without the use of fever-reducing medicines such as ibuprofen or acetaminophen).
5. Exclude visitors with symptoms of respiratory infection (e.g., fever, cough, sore throat) when influenza and/or COVID-19 are circulating in the community. If visitation is allowed in your facility, all visitors must be screened for symptoms of COVID-19 (fever or chills, cough, shortness or breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea) prior to entering the facility. This form can be used to collect the necessary information.

Response to an influenza outbreak

The following recommendations should be followed for all suspected and confirmed influenza outbreaks. These recommendations are also useful in the control of other respiratory viruses.

Until testing proves otherwise:

All ILI cases should be treated as potential COVID-19 cases and facilities should defer to the COVID-19 outbreak guidance documents for infection prevention and control. The facility should follow the appropriate response measures for an influenza outbreak once testing confirms the influenza diagnosis. If testing confirms the presence of both COVID-19 and influenza, guidance measures for influenza are superseded by those of COVID-19 and the facility should follow the COVID-19 outbreak guidelines. Symptomatic residents should be tested for both influenza and COVID-19.

Source control:

Refer to the 'Cohorting FAQ's for Long-Term Care Facilities' document for more detailed information about how to proceed with cohorting if a suspect or confirmed respiratory illness outbreak occurs. Optimally, symptomatic influenza-positive residents should be confined to their rooms (isolated) or limited to the affected unit (cohorted) until antiviral treatment is completed. Symptomatic residents not taking antiviral medication should be confined to their rooms for 5 days after illness onset or until 24 hours after they no longer have a fever (without the use of fever-reducing medicines) - whichever is longer. Isolation should not impede resident care or the ability to provide social or rehabilitation services in the resident's room as long as droplet precautions are in place (see below). *Additionally, symptomatic residents should wear a surgical mask/facemask when they need to be out of their room or if they are outside of the affected unit if possible.* Avoid transferring residents with symptoms of respiratory infection to unaffected units. If there are multiple outbreaks of different respiratory illnesses, patients should be cohorted in different units by pathogen, if possible.

Infection Control:

For all residents with undiagnosed respiratory illness, defer to COVID-19 LTCF checklist and FAQ's for PPE documents for further instruction on use of personal protective equipment (PPE). Once influenza has been confirmed, the following infection control precautions should be used:

- Standard precautions (hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure)
- Droplet precautions (surgical masks/face masks should be worn upon entry to the resident's room and during resident care)

- Droplet precautions should not impede the care of residents or providing social or rehabilitation services in the resident's room. If resident movement or transport is necessary, have the resident wear a surgical mask or procedure mask, if possible.
- If an influenza diagnosis has not been confirmed, follow the criteria for COVID-19 mask use among HCP and residents here
- Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- Further guidance on the extended use and conservation of PPE can be found here.

Restricting staff movement:

Ideally, staff (including healthcare personnel as well as dietary, housekeeping laundry, and therapy staff) working in units affected by the outbreak should not concurrently work in unaffected units until the outbreak is over.

- If there are simultaneous respiratory disease outbreaks occurring in the facility, such as influenza and COVID-19, it is recommended that staff are cohorted by pathogen when treating patients (i.e. staff that only treat COVID-19 patients and staff that only treat influenza patients). If cohorting of healthcare personnel by pathogen is not possible, personal protective equipment (PPE) such as gowns and gloves should be changed in between the care and treatment of patients with different pathogens. Extended use of PPE worn on the head, such as masks or eye protection, is acceptable when treating both COVID-19 positive and influenza positive patients.

Surveillance:

Implement daily active surveillance for new respiratory illness among all residents, healthcare personnel and visitors. Defer to the COVID-19 guidelines for screening and exclusion of healthcare personnel from work that are experiencing respiratory illness symptoms until testing confirms the pathogen causing the outbreak. Personnel that are influenza positive should be excluded from resident contact until at least 24 hours after they no longer have a fever (without the use of fever reducing medicines such as acetaminophen). Continue tracking ill residents and staff, and monitoring the progression of the outbreak until at least one week after the last case of influenza occurs. This line list template can be used to track outbreaks of respiratory pathogens, including influenza, COVID-19 and RSV.

Visitors:

During the COVD-19 response, the State of Colorado is requiring long-term care facilities to meet certain criteria in order for indoor and outdoor visitation to be allowed. These criteria should be adhered to first until testing confirms the cause of the outbreak. If statewide visitation guidelines are updated during influenza season, these guidelines will be updated accordingly.

Limiting new admissions:

Follow the guidelines on new admissions in the COVID-19 LTCF checklist until testing confirms what kind of pathogen is causing the outbreak. During an outbreak of influenza, new admissions should be limited when possible. If admissions do occur, they should be housed in units or areas unaffected by the outbreak.

Antiviral Treatment and Chemoprophylaxis:

Administer influenza antiviral treatment and chemoprophylaxis to residents and health care personnel according to current CDC recommendations.

- Four FDA-approved influenza antiviral drugs are currently recommended for treating circulating influenza viruses:
  - oseltamivir phosphate (available as a generic version or under the trade name Tamiflu®),
  - zanamivir (trade name Relenza®)
  - peramivir (trade name Rapivab®) (treatment only, 13 yrs and older)
  - baloxavir marboxil (trade name Xofluza®) (treatment only, 12 yrs and older)
- Amantadine and rimantadine are NOT recommended for use because of high levels of antiviral resistance among circulating influenza A viruses.
- At the time of this guidance being released on September 30, 2020, there are no known contraindications of treating ILI patients with influenza antivirals who are positive for COVID-19. This information may be updated over time and it is essential to refer to the CDC for the most recent updates.

Treatment

- All long-term care facility symptomatic residents who have confirmed or suspected influenza should receive antiviral treatment immediately.
- Antiviral treatment should not wait for laboratory confirmation of influenza test results. If lab results indicate that the patient is negative for influenza and positive for COVID-19, treatment with influenza antivirals should be stopped and the course of treatment should be adjusted accordingly.
- Antiviral treatment is most effective when started within the first 2 days of symptoms. However, these medications can still be effective after this 48 hour time period, specifically among severely ill patients who are hospitalized or have progressive illness.
- Due to concerns about the development of antiviral resistant influenza viruses, treatment of symptomatic patients with antivirals should be done judiciously and should also consider current circulating levels of both COVID-19 and influenza in the surrounding community. Refer to the CDC guidelines for treatment with influenza antivirals during co-circulation of influenza and COVID-19.

Chemoprophylaxis

Antiviral chemoprophylaxis is recommended for all medically eligible residents and staff (regardless of whether they received influenza vaccine) who are not exhibiting influenza-like illness once an influenza outbreak is confirmed. Consideration may be given to restricting antiviral chemoprophylaxis to residents of a particular unit when the outbreak is clearly confined to that unit or care area. When the outbreak involves multiple units or care areas, or is widespread in the facility, antiviral chemoprophylaxis of all residents and staff is recommended upon confirmation of a positive influenza test. Refer to the CDC guidelines on clinical management of influenza during SARS CoV-2 circulation for more information.

- Residents that develop ILI while on prophylaxis should be switched to treatment doses of antiviral medications (See Table). Antiviral treatment can be started within the first 48 hours of a non-high risk patient developing ILI (fever with either cough or sore throat) if lab results are still pending, and can be discontinued or changed if the patient is positive for COVID-19 and negative for influenza. ***If there is a simultaneous outbreak of COVID-19 in addition to an influenza outbreak in the facility, testing should be done to confirm whether the resident with ILI is positive for COVID-19, influenza, or both.***
- While CDC recommends judicious use of antiviral medications for chemoprophylaxis to reduce the potential for development and spread of antiviral resistant influenza viruses, chemoprophylaxis may be considered for all employees, regardless of their influenza vaccination status (if the outbreak is caused by a strain of influenza virus that is not well matched by the vaccine).
- Antiviral chemoprophylaxis should be considered for personnel for whom influenza vaccine is contraindicated. All other personnel should receive vaccination.
- An emphasis on early treatment is an alternative to chemoprophylaxis in managing patients who have a suspected exposure to influenza virus. Health care personnel who have occupational exposures can be counseled about the early signs and symptoms of influenza. They are advised to contact their health-care provider immediately for evaluation and possible early treatment if clinical signs or symptoms develop.
- Antiviral chemoprophylaxis should be continued for at least two weeks and until approximately one week after the onset of the last known case.
- To ensure the rapid administration of antiviral medications to residents, physicians should be asked prior to influenza season to sign a facility standing order which allows the facility's Medical Director to order antiviral treatment and prophylaxis if an influenza outbreak is confirmed.

Dosage of Antiviral Medications for Treatment and Prophylaxis of Influenza

	Indication	Dose	Duration
Oseltamivir*	Prophylaxis	75 mg once per day	At least 2 weeks *and* until 1 week after the onset of the last case
	Treatment	75 mg twice per day	5 days
Zanamivir**	Prophylaxis	10 mg (2 inhalations) once per day	At least 2 weeks *and* until 1 week after the onset of the last case
	Treatment	10 mg (2 inhalations) twice per day	5 days
Peramivir	Prophylaxis	Not recommended	N/A
	Treatment	(13 yrs and older): one 600 mg dose, via intravenous infusion for a minimum of 15 minutes	One dose
Baloxavir	Prophylaxis	Not recommended	N/A
	Treatment	(12 yrs and older) 40 to <80 kg: One 40 mg dose; >80 kg: One 80 mg dose	One dose

Influenza Antiviral Medications: Summary for Clinicians
*A reduction in the dose of Oseltamivir is recommended for persons with creatinine clearance <30mL/min.
**Zanamivir is NOT recommended for those persons with underlying airway disease.

These guidelines can be found on the CDPHE web site at: https://www.colorado.gov/pacific/cdphe/influenza

The guidelines follow the CDC's Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities found at: http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm

As of October 2020, it is too early to know for sure which influenza viruses will be circulating during the 2020-2021 influenza season. State and local public health agencies can answer questions regarding current circulating influenza strains. Colorado influenza surveillance data (updated weekly from October through May) are posted at: https://www.colorado.gov/pacific/cdphe/influenza

Additional Resources

CDC Influenza Updates: https://www.cdc.gov/flu/index.htm

CDC Influenza FAQ's: https://www.cdc.gov/flu/season/faq-flu-season-2020-2021.htm

ACIP Influenza Vaccination Recommendations: https://www.cdc.gov/flu/professionals/acip/summary/summary-recommendations.htm

CDC: Similarities and differences between influenza and COVID-19: https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm#anchor_1595599580

Centers for Medicare and Medicaid Services (CMS): Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory

Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID-19 Focused Survey Tool: https://drive.google.com/file/d/1uw51NmaC6S0-vpP0HxKIIlhJZ6eQvKP1/view

Third Amended Notice of Public Health Order 20-20 (Sept. 3rd, 2020): https://drive.google.com/file/d/18Pu7yRLLJXlf2q

The following is a checklist of infection prevention steps for long-term care facilities (LTCFs) in the event of an influenza outbreak during the 2020-2021 influenza season. This checklist should be used as a supplemental tool and aid in the prevention of transmission of influenza viruses. It is intended for use in conjunction with the latest Guidelines for Prevention and Control of Influenza Outbreaks in Long Term Care Facilities from the Colorado Department of Public Health and Environment (CDPHE) available here. Notably, due to the potential for co-circulation of influenza and SARS CoV-2, the virus that causes COVID-19, long-term care facilities should adhere to the outbreak guidance and COVID-19 checklist for COVID-19 infection prevention measures until testing confirms the pathogen(s) causing the outbreak.

Case Definition for Influenza-Associated Outbreaks in Long-Term Care Facilities

Influenza-like illness (ILI) case definition for long term care facilities: [Fever (>100 F) or new prostration] AND [new cough or sore throat]

When influenza is circulating in the surrounding community of the LTCF, a high index of suspicion should be maintained. The medical director might consider loosening the ILI case definition to [fever OR new prostration OR new cough] for an outbreak highly suspected of being due to influenza in which residents do not manifest multiple signs.

S**uspected influenza outbreak**: two cases of ILI within a 1-week period without a positive test for influenza. During the time when influenza is circulating locally, the occurrence of acute febrile respiratory illness in several residents within a short time frame should be considered suspect for influenza until proven otherwise, regardless of whether the affected residents have been vaccinated.

Confirmed influenza outbreak*: at least two residents with a positive influenza test.

*Note: This outbreak definition is different from previous seasons due the co-circulation of COVID-19; the previous definition required only one positive influenza test among 2 or more residents with ILI.

Outbreak Checklist

*If one or more residents present with ILI, defer to the COVID-19 rapid response LTCF **checklist** until testing confirms the pathogenic cause of the illness or outbreak. The following checklist should be referred to if testing indicates an outbreak of influenza only. COVID-19 protocols should be followed in the event of any unconfirmed respiratory illness.*

Residents

- ☐ Residents with symptoms of influenza are confined to their rooms (isolated) or limited to the affected unit (cohorted)
    - ○ Symptomatic residents should be confined to their rooms (isolated) or limited to the affected unit until antiviral treatment is completed.
    - ○ Symptomatic residents not taking antiviral medication should be confined to their rooms for 5 days after illness onset or until 24 hours after they no longer have a fever (without the use of fever-reducing medicines), whichever is longer.
    - ○ Elderly persons and other long-term care residents, including those who are medically fragile and those with neurological or neurocognitive conditions, may manifest atypical signs and symptoms with influenza virus infection, and may not have fever.
- ☐ Don't wait for confirmation of illness to confine (isolate) or cohort symptomatic residents as ongoing transmission can occur during this time
- ☐ If transport is necessary, have patient wear a mask and communicate information about patients illness with appropriate personnel before transferring them (internal and external transports)
- ☐ New admissions should be limited or housed in unaffected areas until the outbreak is over
- ☐ Cancel group activities until the outbreak is over

- ☐ All eligible residents in the entire long-term care facility (not just currently impacted wards) should receive antiviral chemoprophylaxis as soon as an influenza outbreak is determined.
    - ○ Continued viral shedding can occur while a resident is on antiviral treatment, so infection control measures must be maintained until the outbreak is over

Staff

- ☐ Vaccination of any staff member that is not already vaccinated for influenza is highly recommended
- ☐ Staff are informed of the influenza-positive cases and the following infection control precautions are implemented:
    - ○ Standard precautions
    - ○ Droplet precautions
    - ○ Proper hand hygiene
    - ○ Assessing for compliance
- ☐ Exclude from work healthcare personnel who develop fever and respiratory symptoms until at least 24 hours after they no longer have a fever (without the use of fever-reducing medicines such as acetaminophen)
- ☐ Staff are wearing a mask at all times, which covers their mouth and nose
    - ○ Masks worn below the nose are not effective
- ☐ All staff movement is restricted
    - ○ Designate all staff (e.g., healthcare workers, environmental services, dietary, etc.) to certain units. Do not allow staff members to work in both the affected and unaffected units.
    - ○ Symptomatic staff excluded from resident care/contact until they no longer have a fever (without fever-reducing meds)

Visitors

- ☐ Determine whether your facility is eligible to participate in outdoor visitation and/or indoor visitation
- ☐ Visitors are notified that an outbreak of influenza or ILI is occurring in the facility. Signage can be an effective way to communicate this information but must be visible
- ☐ Visitors are encouraged to perform hand hygiene upon entry into the facility and upon exiting the facility
- ☐ Visitors are educated and adhere to isolation precautions to include gowning, gloving, masking, proper disposal and proper hand hygiene
- ☐ Ill visitors should be excluded from the facility until illness has resolved

Surveillance

- ☐ Conduct daily active surveillance (e.g., line list and/or calendars) for new illness among residents and staff until at least 1 week after the last case has occurred; a line list template can be found here.
- ☐ Track ill residents and staff, and monitor the progression of the outbreak (e.g., mapping)
- ☐ Report the outbreak (suspected or confirmed) to local public health
    - ○ Inform local public health if residents develop influenza while on or after receiving antiviral chemoprophylaxis
    - ○ Local Public Health will report the outbreak to CDPHE
- ☐ Complete the outbreak form and email to Molly Middleton (molly.middleton@state.co.us) at CDPHE when the outbreak is over

Resources

CDC Interim Guidance for influenza Outbreak Management in Long-Term Care Facilities: https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm

Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html#5

For more information on the antiviral agents see https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm

Current influenza trend in Colorado: https://www.colorado.gov/pacific/cdphe/influenza

CDC Information for Healthcare Professionals for the 2020-21 Flu season: https://www.cdc.gov/flu/season/health-care-professionals.htm

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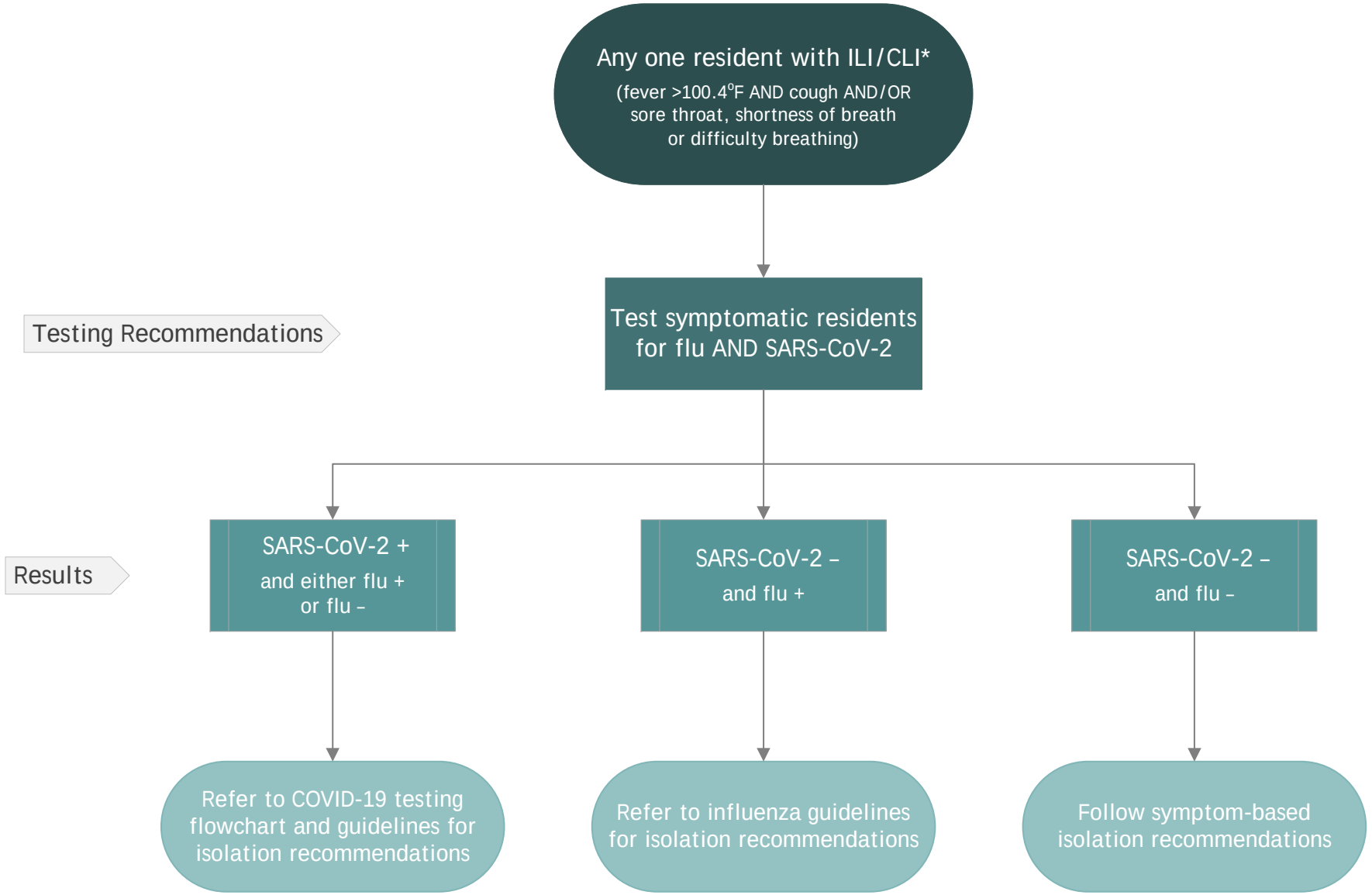
Department of Public Health & Environment

Flu/COVID-19 Testing Flowchart

*ILI = Influenza-like illness
CLI = COVID-19-like illness



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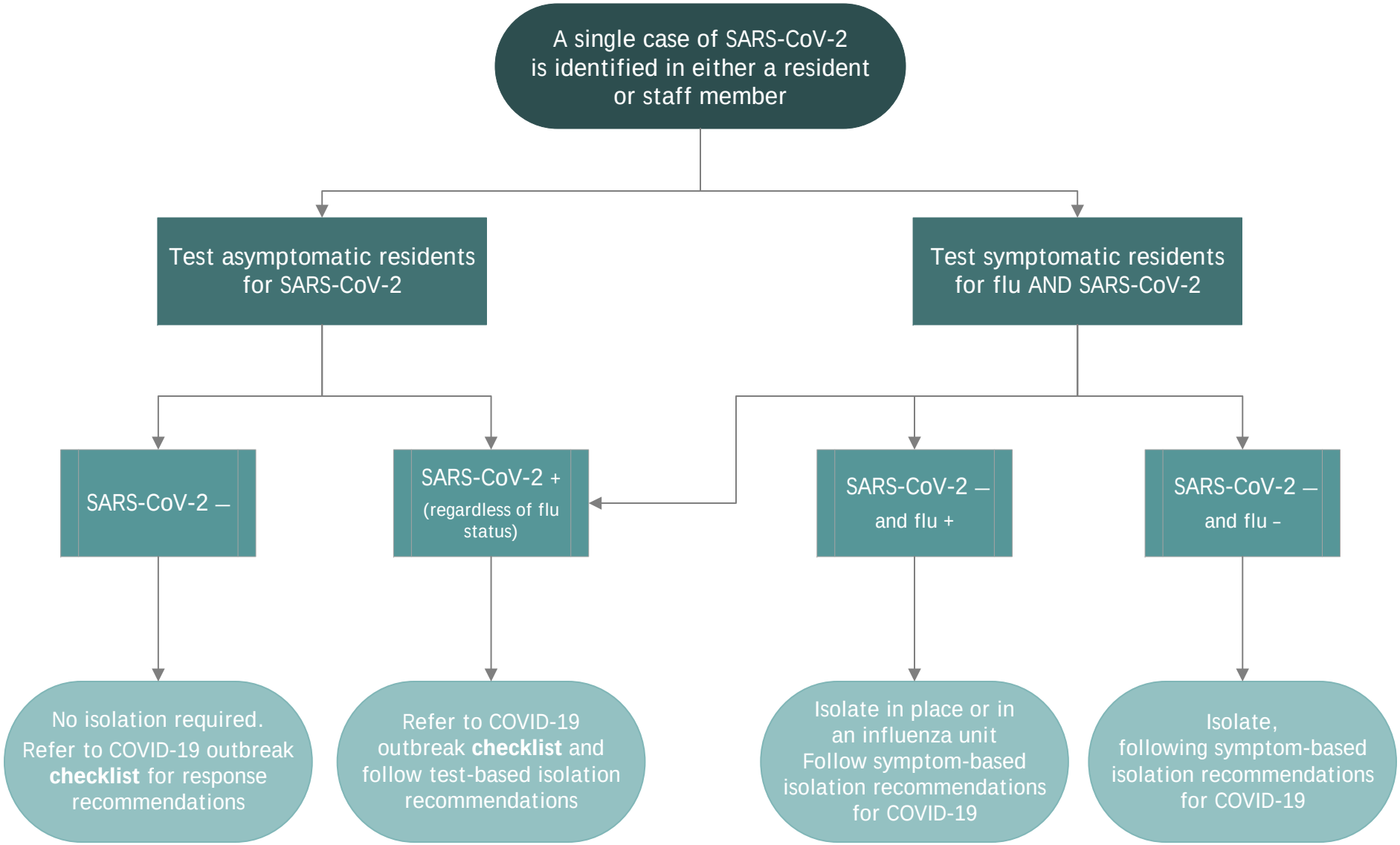
Flu/COVID-19 Testing Flowchart



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LTCF Outbreak Reporting Flowchart

Identify pathogen(s) involved in outbreak

- Influenza
- RSV
- Other viral respiratory (non-COVID)
- COVID-19
- Influenza + COVID-19
- RSV + COVID-19
- Other viral respiratory + COVID-19

Report outbreak to CDPHE and obtain outbreak number

Influenza:

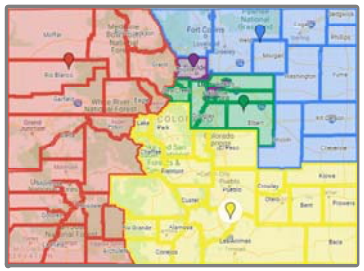
Molly Middleton
720-663-1848
molly.middleton@state.co.us

RSV and other:

Emma Schmoll
720-460-9397
emma.schmoll@state.co.us

Report outbreak to the CDPHE Epi Team

Contact your
CDPHE Epi Team:



Report outbreaks of COVID-19 to CDPHE
epi teams and obtain outbreak number
for each pathogen

CDPHE COVID-19 Contact Information

Epi Teams will contact Molly for influenza and Emma for RSV; and either the Teams or Flu/RSV Epis can assign outbreak numbers

*viral pneumonia, human metapneumovirus, etc.

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Influenza Outbreak Report Form
for Long Term Care Facilities

Influenza-like illness (ILI): [Fever (>100° F orally) or Prostration] AND [new cough or sore throat]

Influenza Outbreak

- **Suspected**: when two or more cases of ILI are detected during a period of 1 week without a positive test for influenza.
- **Confirmed**: when at least one resident has a positive test for influenza among two or more residents with ILI

NOTE: Confirmation by PCR is recommended for early/late season outbreaks due to the low influenza activity and the concern of false positive results from rapid antigen tests.

Date of report:	State-assigned outbreak #:
Are other respiratory illness outbreaks occurring in the facility? Select one...	What type?

Facility Information

Facility name:		Phone:
Facility type: Select one...	If other, specify:	
Address:		Email:
City:	Zip:	County:
Person reporting:		Title:

Outbreak Information

Residents

Number of residents in facility:	Number of residents vaccinated for flu this season:			
Number of residents with ILI: (with or without a positive influenza test)	Number of residents tested:			
Number of residents hospitalized:	Number of residents with positive tests:			
Influenza type: Select one...	Type of test:	☐ Rapid	☐ PCR	☐ Unknown
If other, specify:	Qty of tests performed:			

Staff

Number of staff in facility:	Number of staff vaccinated for flu this season:			
Number of staff with ILI: (with or without a positive influenza test)	Number of staff tested:			
Number of staff hospitalized:	Number of staff with positive tests:			
Influenza type: Select one...	Type of test:	☐ Rapid	☐ PCR	☐ Unknown
If other, specify:	Qty of tests performed:			

Date of symptom onset/detection for the first case of ILI during the outbreak:	Status of outbreak: (see definitions above) Select one...

Was prophylaxis given? Select one...

If yes, check any that apply:

- ☐ Prophylaxis given to residents
- ☐ Prophylaxis given to staff
- ☐ Prophylaxis given to residents of selected units only
- ☐ Prophylaxis given to residents in the entire facility

Contact your local health department with questions or to report an outbreak.

Submit completed form to **Molly Middleton** at CDPHE (molly.middleton@state.co.us | fax: 303-782-0338) *or* to your local health department.