COLORADO
Department of Public Health & Environment

Guidelines for Prevention & Control of Influenza Outbreaks in Long-term Care Facilities

2021-2022 Season

Pathogen: Influenza (flu) is a respiratory illness caused by influenza viruses. There are two main types of influenza virus (types A and B), and human influenza viruses cause seasonal flu epidemics each year. Anyone can become infected with influenza, and the virus can cause serious health complications for individuals of any age. However, adults that are 65 years of age and older, individuals who are immunocompromised and/or have chronic medical conditions, pregnant women, and children <5 years of age are at higher risk of developing serious influenza-related complications.

Incubation Period: About 2 days, but can range from 1 to 4 days.

Symptoms may include: Fever, chills, cough, pharyngitis (sore throat), rhinorrhea (runny or stuffy nose), muscle or body aches, headache, fatigue. Vomiting and diarrhea are symptoms that are more common in children than adults. Not everyone infected with influenza will develop a fever.

Transmission/Communicability: Direct and indirect contact with contaminated nasal and oral secretions through coughing and sneezing. Droplets can land in the mouths or noses of people nearby. Less often, the virus can be spread by contact with a contaminated surface or object. Infected persons can spread flu to others up to about 6 feet away. Infected persons are usually contagious in the first 3-4 days after illness begins, but some people, especially young children and people with weakened immune systems, might be able to infect others for a longer time. Influenza is more commonly transmitted during peak respiratory illness months during the fall, winter, and early spring.

Treatment/Vaccination: Everyone 6 months of age and older should get a seasonal flu vaccine each year, with rare exceptions. The general recommendation of the CDC is to be vaccinated no later than the end of October. Further CDC guidance on flu vaccination can be found here. Antiviral treatment and prophylaxis are available for influenza; for more details, see the Dosage of Antiviral Medications for Treatment and Prophylaxis of Influenza section on page 7.

The definition of a residential care facility includes nursing homes, assisted living facilities, long-term care facilities and skilled nursing facilities. Independent living communities may consider these guidelines to be applicable if there is an occurrence of illness among residents that share common areas for dining and social activities.

Influenza & COVID-19

During the 2021-2022 respiratory illness season, it is expected that influenza and SARS-CoV-2, the virus that causes 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 SARS-CoV-2, and for these viruses to cause simultaneous or separate outbreaks in long-term care facilities (LTCFs). Testing for both influenza and SARS-CoV-2 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 Residential Care Facility (RCF) Comprehensive Mitigation Guidance until testing confirms a diagnosis.

While influenza and COVID-19 share several symptoms, there are key differences between the two. CDC compares Similarities and Differences between Flu and COVID-19. Notably, both influenza and SARS-CoV-2 are spread from person-to-person via respiratory droplets produced when the infected individual coughs, sneezes or talks. SARS-CoV-2 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 immunocompromised or who have been very ill. Additionally, it is possible for asymptomatic or presymptomatic individuals to transmit SARS-CoV-2 and therefore testing is highly recommended to distinguish between influenza and COVID-19 to inform an appropriate public health response. According to the CDC, available data suggest that people with mild-to-moderate COVID-19 remain infectious no longer than 10 days after symptom onset.

According to the CDC, both viruses may present with the following symptoms: 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 more frequently.

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 influenza vaccination of all staff and residents is critical to help reduce the transmission of influenza, which 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: Seasonal Influenza Vaccination Resources for Health Professionals.

As of 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 2021-22 season, please contact the CDPHE Immunization Branch at 303-692-2700 or visit Influenza vaccine requirements for health care workers.

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]
- **Suspected influenza outbreak**: One resident with a positive flu test among one or more residents with undiagnosed respiratory illness with symptom onset occurring within a 1-week period.*
- **Confirmed influenza outbreak**: at least two residents with a positive influenza test within a 1-week period.

**The occurrence of respiratory illness among residents should first be considered suspect for COVID-19. If influenza or other respiratory illnesses such as RSV are circulating locally, these pathogens should also be considered suspect until testing proves otherwise. Co-infections of SARS-CoV-2 and other viral respiratory pathogens can and may occur.*

Influenza & SARS-CoV-2 Testing

If a resident or healthcare personnel (HCP) presents with symptoms of ILI, first refer to the COVID-19 RCF Comprehensive Mitigation Guidance for further instruction on testing for COVID-19. It is recommended that a symptomatic resident or staff member should be tested for both SARS-CoV-2 and influenza, or follow-up testing should be done for influenza if the SARS-CoV-2 test result is negative. Testing for other respiratory pathogens is also recommended to determine potential co-infection or outbreaks of other respiratory illnesses (i.e. RSV). Residents who are not symptomatic do not need to be tested for influenza.

It is possible for co-infection with influenza and SARS-CoV-2 to occur, therefore testing is the best method to inform proper infection control and clinical management. In the event of an influenza outbreak, it is recommended that all residents with symptoms of respiratory illness should be tested for influenza in addition to SARS-CoV-2 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. 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. All 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); 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 rapid influenza diagnostic test results are positive.

Testing for other respiratory pathogens is recommended if symptomatic residents are negative for both influenza and SARS-CoV-2, and if influenza and SARS-CoV-2 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 Influenza Transmission: 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:

- Administration of influenza vaccine
- Implementation of respiratory hygiene and cough etiquette
- Appropriate management of ill healthcare personnel
- Adherence to infection control precautions for all patient-care activities
- Implementing environmental and engineering infection control measures

Prevention Strategies

More information on these core prevention strategies can be found in CDC's Prevention Strategies for Seasonal Influenza in Healthcare Settings.

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's Respiratory Hygiene/Cough Etiquette in Healthcare Settings.
3. Promote and provide influenza vaccination for healthcare personnel and residents.
4. Defer to the COVID-19 RCF Comprehensive Mitigation Guidance first for guidelines on testing staff with respiratory illness symptoms and return-to-work criteria. 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) and other symptoms are improving.
5. Exclude visitors with symptoms of respiratory infection (e.g., fever, cough, sore throat) when influenza and/or SARS-CoV-2 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. Precautions should be in place for at least two incubation periods (8 days) following the date of symptom onset of the last case of illness. If there are no new cases of illness in that time period, the outbreak can be considered over. Outbreak control measures should be immediately applied while waiting for test results - do not wait for a positive test to respond. If the test is negative and there are other symptomatic residents in the facility, outbreak control measures should still be applied.

1. **Until testing proves otherwise**: All ILI cases should be treated as potential COVID-19 cases and facilities should defer to the COVID-19 RCF Comprehensive Mitigation Guidance 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 SARS-CoV-2 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 SARS-Cov-2.
2. **Source control**: Refer to the document, Cohorting FAQ's for Long-Term Care Facilities, 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 should be confined to their rooms or limited to the affected cohort for 5 days after illness onset **and** until 24 hours after they no longer have a fever (without the use of fever-reducing medicines) **and** other symptoms (e.g., cough) are improving.
- 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).
- 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 infection and may not present with fever.
- 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.

3. **Infection Control**: For all residents with undiagnosed respiratory illness, defer to the COVID-19 RCF Comprehensive Mitigation Guidance and CDC's Protecting Healthcare Personnel for further instruction on use of personal protective equipment (PPE). Once influenza has been confirmed as the cause of the outbreak, the following infection control precautions should be implemented:
   a. Standard precautions (hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure)
   b. Contact precautions: gloves, gown and mask should be worn upon entry to the resident's room, during resident care, and should be properly discarded before exiting the resident's room; room placement decisions should consider balancing health risks to other patients; if multiple-resident rooms, ≥6 feet spatial separation between beds is advised; limit patient out-of-room transport to medically-necessary purposes; use disposable or dedicated patient-care equipment; if common use of equipment for multiple residents is unavoidable, clean and disinfect this equipment before using with another resident; prioritize cleaning and disinfection of resident rooms; use contact precautions during cleaning and disinfection; ensure resident rooms are frequently cleaned and disinfected; focus cleaning and disinfection on frequently- touched surfaces and equipment in the immediate vicinity of the resident.
   c. 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 the provision of 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 in the COVID-19 RCF Comprehensive Mitigation Guidance.
      - Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, or engage in activities or procedures outside the residential 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.
4. **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 SARS-CoV-2 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 SARS-CoV-2 positive and influenza positive patients. However, if at any point the mask is removed, it cannot be reused unless it is properly disinfected. More information on use of PPE can be found in the COVID-19 RCF Comprehensive Mitigation Guidance.
5. **Surveillance**: Implement daily active surveillance for new respiratory illness among all residents, healthcare personnel and visitors. Refer to the COVID-19 RCF Comprehensive Mitigation Guidance document 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 for at least two incubation periods (8 days) following the date of symptom onset of the last case of illness. If no new flu cases have occurred during this 8-day time period, the outbreak may be

considered over. The line list template on the Long-Term and Residential Care Facilities page (under CDPHE Forms & Checklists → Outbreak Forms) can be used to track outbreaks of respiratory pathogens, including influenza, COVID-19 and RSV.

6. **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 are outlined in the COVID-19 RCF Comprehensive Mitigation Guidance and should be adhered to first until testing confirms the cause of the outbreak. If statewide visitation guidelines for COVID-19 are updated during influenza season, this document will be updated accordingly.
7. **Documentation**: At minimum, the facility should collect and document the following information for each ill resident and staff member using the Influenza-Associated Outbreaks in Long Term Care Facility Line List (included at the end of this document):
   - ☐ Illness onset date
   - ☐ Duration of illness
   - ☐ Wing/room (residents)
   - ☐ Symptoms
   - ☐ Hospitalizations/ deaths
8. **Limiting new admissions**: Follow the guidelines on new admissions in the COVID-19 RCF Comprehensive Mitigation Guidance 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.
9. **Group Activities**: Group activities should not occur among affected residents/units until the outbreak has resolved.
10. **Hospital Transfers**: If a resident is transferred to the hospital, notify the hospital that the resident is coming from a facility where an outbreak of influenza is occurring. Ensure the resident wears a cloth face covering or mask (which covers both the nose and the mouth) during transport (if tolerated).
11. **Increase Frequency of Cleaning and Disinfection**: Clean and disinfect more frequently than usual (i.e. every 12 hours vs. every 24 hours), emphasizing commonly touched surfaces such as doorknobs and handrails. Begin the disinfection process in areas of lower likelihood of viral contamination and progress to areas with a higher likelihood of viral contamination. Select an EPA-registered disinfectant that has microbicidal activity against the influenza and other viral pathogens most likely to contaminate the environment and cause outbreaks (List N refers to disinfectants that are effective against SARS-CoV-2 and other respiratory pathogens).
12. **Common Medical Equipment**: Consider designating specific items of equipment (blood pressure cuffs, glucometers, etc.) to each resident. If supply does not allow for such designation, designate medical equipment to affected patients or affected units. Each piece of equipment should be adequately cleaned and disinfected (following manufacturers instructions) after each use and before using on the next resident.
13. **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 in adults:
      - oseltamivir phosphate (available as a generic version or under the trade name Tamiflu®),
      - zanamivir (trade name Relenza®)
      - peramivir (trade name Rapivab®) (treatment only)
      - baloxavir marboxil (trade name Xofluza®)
    - Amantadine and rimantadine are NOT recommended for use because of high levels of antiviral resistance among circulating influenza A viruses.
    - Per current NIH guidance, antiviral treatment of influenza should be the same in all patients with or without a SARS-CoV-2 co-infection.
14. **Report Outbreak to Public Health**: An influenza outbreak report form is included in this document. If the outbreak is for another non-influenza respiratory illness, this same outbreak report form may be used. Please specify the pathogen or illness occurring. Notifications of outbreaks, submission of outbreak report forms and questions regarding non-COVID-19 respiratory illnesses may be sent to CDPHE at cdphe_flu_rsv@state.co.us.

Treatment

All long-term care facility symptomatic residents who have confirmed or suspected influenza should receive influenza 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 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, or those at high risk for complications from influenza. According to CDC, people who reside in long-term care facilities are considered at high risk for complications from influenza.

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.
- 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	One 600 mg dose via intravenous infusion for a minimum of 15 minutes	One dose
Baloxavir	Prophylaxis	40 to <80 kg: One 40 mg dose >80 kg: One 80 mg dose	One dose
	Treatment	40 to <80 kg: One 40 mg dose >80 kg: One 80 mg dose	One dose

Influenza Antiviral Medications: Summary for Clinicians

*An adjustment in the dose of Oseltamivir is recommended for persons with creatinine clearance between 10-60mL/min.

**Zanamivir is NOT recommended for those persons with underlying airway disease.

These guidelines can also be found here: Flu information for providers and schools | Department of Public Health & Environment

The guidelines follow the CDC's Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities

As of November 2021, it is not known with a high degree of certainty which influenza viruses will be circulating during the 2021-2022 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: Influenza (flu) | Department of Public Health & Environment

Additional Resources:

CDC Influenza Vaccine: Who Needs a Flu Vaccine

CDC Influenza Updates: Influenza (Flu)

CDC Influenza FAQ's: 2020-2021 Flu Season Summary

ACIP Influenza Vaccine Recommendations

CDC: Similarities and Differences between Flu and COVID-19

Eighth Amended Notice of Public Health Order 20-20 (Sept. 28, 2021)

COLORADO
Department of Public Health & Environment

Influenza Outbreak Checklist for Long-term Care Facilities

2021-22 Season

The following checklist is to be used in conjunction with the latest "Guidelines for Prevention and Control of Influenza-Associated Outbreaks in Long Term Care Facilities: 2021-2022 Season" from the Colorado Department of Public Health and Environment (CDPHE). This checklist may serve as a tool to prevent and control outbreaks of influenza in long-term and residential care facilities.

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]
- **Suspected influenza outbreak**: One resident with a positive flu test among one or more residents with undiagnosed respiratory illness with symptom onset occurring within a 1-week period.
- **Confirmed influenza outbreak**: at least two residents with a positive influenza test within a 1-week period.

***The occurrence of respiratory illness among residents should first be considered suspect for COVID-19. If influenza or other respiratory illnesses such as RSV are circulating locally, these pathogens should also be considered suspect until testing proves otherwise. Co-infections of SARS-CoV-2 and other viral respiratory pathogens can and may occur.*

Influenza Symptoms may include:

- Rhinorrhea & sneezing (nasal discharge or runny nose)
- Pharyngitis (sore throat)
- Muscle or body aches
- Chills
- Headache
- Fatigue
- Decreased appetite
- Coughing
- Wheezing and/or difficulty breathing
- Fever (may or may not present as a symptom in adult patients)
- Vomiting & diarrhea may occur, but are more commonly seen in pediatric cases

Outbreak Checklist

If one or more residents present with respiratory symptoms, first defer to the COVID-19 RCF Comprehensive Mitigation Guidance document until testing confirms the cause of the illness or outbreak. Do not wait for confirmation of a diagnosis to implement infection control precautions. The following checklist should be referred to if testing indicates an outbreak of influenza only. If there is a co-outbreak of COVID-19 and influenza (or other respiratory illness such as RSV), COVID-19 outbreak response measures supersede those of influenza and should be followed accordingly.

Residents

- ☐ Residents with symptoms of respiratory illness are confined to their rooms (isolated) or limited to the affected unit (cohorted) until the outbreak is over.
  - Symptomatic residents should be confined to their rooms or limited to the affected unit for 5 days after illness onset **and** until 24 hours after they no longer have a fever (without the use of fever-reducing medicines) **and** other symptoms (e.g., cough) are improving.
  - 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 infection and may not present with fever.
- ☐ Do not 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 the patient wear a mask and communicate information about the 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 [at least two incubation periods (8 days) after the date of symptom onset of the last case of illness].
- ☐ Continued viral shedding can occur up to four weeks among patients who are immunocompromised, therefore the time period for recommended precautionary protocols may be extended for these individuals for this time frame.

- ☐ Increase cleaning frequency of common areas and commonly touched surfaces using an EPA-approved disinfectant intended to target viral respiratory pathogens such as influenza and/or SARS-CoV-2 (List N).
- ☐ Infection control measures must be maintained until the outbreak is over[at least two incubation periods (8 days) after the date of symptom onset of the last case of illness]

Staff

- ☐ Staff are informed of influenza cases and the following infection control precautions are implemented:
  - Standard precautions
  - Contact precautions
  - Droplet precautions
  - Proper hand hygiene
  - Assessing for compliance
- ☐ Healthcare personnel that are confirmed positive for influenza are excluded from work when at least 24 hours have passed since their last fever without the use of fever-reducing medications (i.e., ibuprofen or acetaminophen) and all other respiratory symptoms (i.e. cough) are improving.
- ☐ 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 a certain unit/floor/neighborhood/POD. Do not allow staff members to work in both affected and unaffected units. Staff treating or interacting with residents should be cohorted by pathogens if possible. If this is not possible, HCP should change gowns and gloves between treating residents affected by different pathogens.
  - Symptomatic staff are excluded from resident care/contact until they no longer have a fever without the use of fever-reducing medications and all other symptoms are improving.

Visitors

- ☐ Determine whether your facility is eligible to participate in outdoor visitation and/or indoor visitation by referring to the COVID-19 RCF Comprehensive Mitigation Guidance.
- ☐ Visitors have been screened for respiratory illness symptoms. Deny entry to visitors who do not pass screening or refuse to adhere to the indoor visitation requirements outlined in the COVID-19 RCF Comprehensive Mitigation Guidance.
- ☐ Visitors are notified that an outbreak of influenza 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. This includes gowning, gloving, masking, proper disposal and proper hand hygiene.
- ☐ Visitors who are less than 12 years of age 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 2 incubation periods (8 days) after symptom onset of the last case of illness have passed; a line list template can be found here.
- ☐ Monitor the progression of the outbreak (note if there is spread between units and/or resident rooms)
- ☐ Report the outbreak (suspected or confirmed) to local or state public health; local public health will report the outbreak to CDPHE
- ☐ Complete the outbreak form and email to Molly Middletonl (molly.middleton@state.co.us) or cdphe_flu_rsv@state.co.us at CDPHE when the outbreak has ended (2 incubation periods or 8 days have passed with no new influenza cases since the date of symptom onset of the last case of illness).

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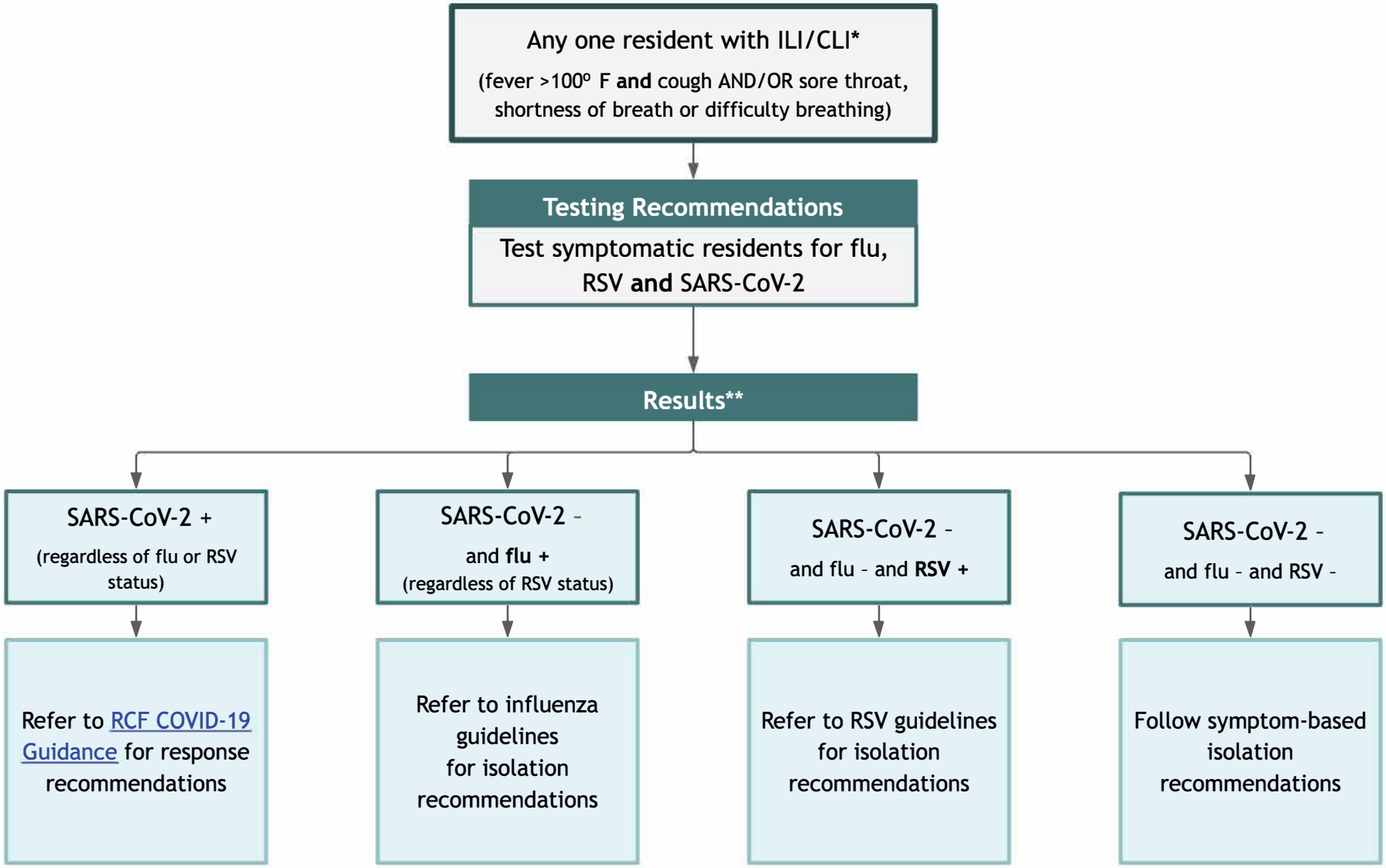
Influenza/RSV/SARS-CoV-2 Testing Flowchart



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

**Results of PCR testing. If POC testing is used, negative COVID-19 results should be confirmed by PCR. Defer to COVID-19 guidelines until PCR testing confirms diagnosis.

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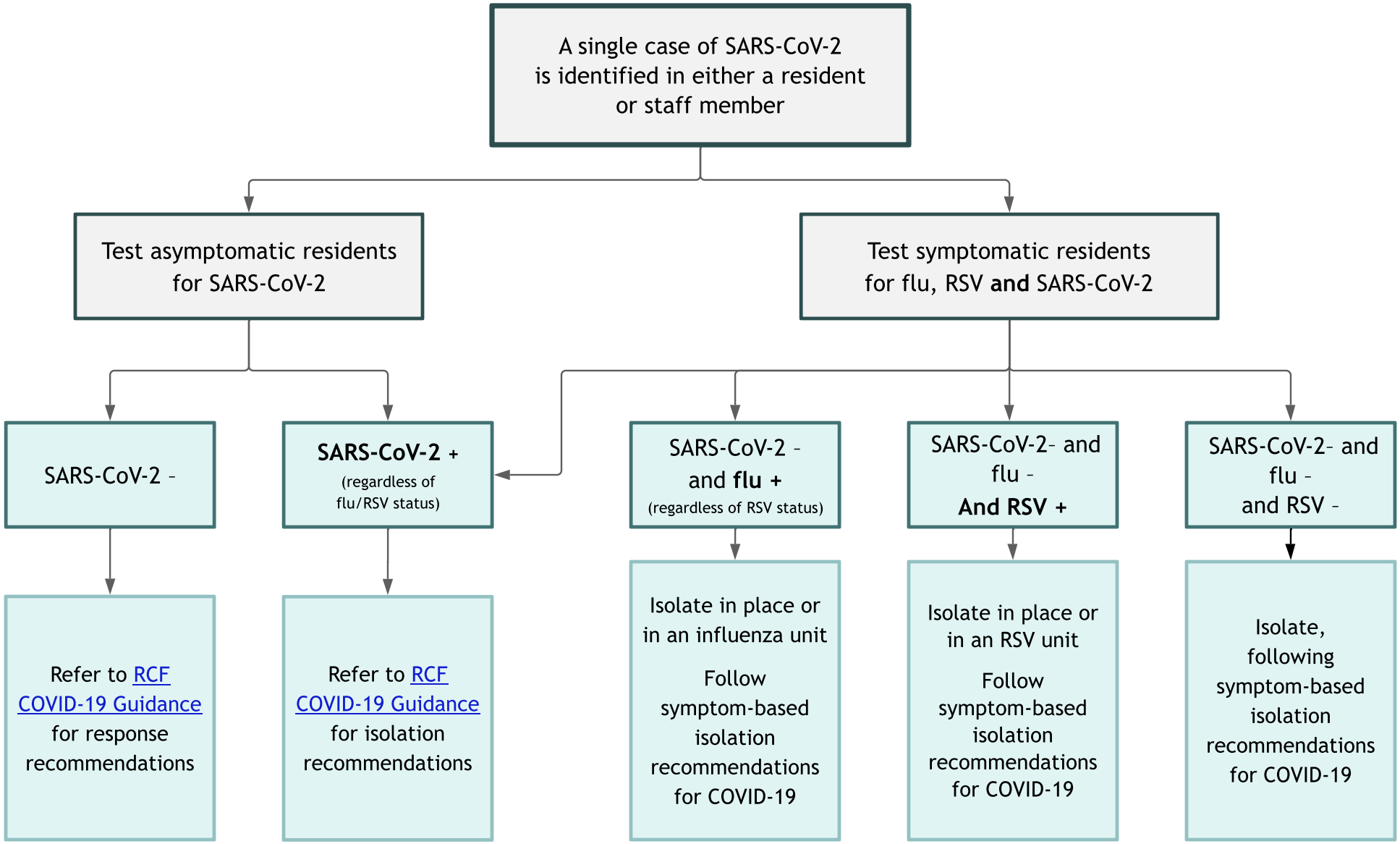
Department of Public Health & Environment

Influenza/RSV/SARS-CoV-2 Testing Flowchart



COLORADO
Department of Public Health & Environment

LTCF Outbreak Reporting Flowchart

Identify pathogen(s) involved in outbreak

- Influenza
- RSV
- Other viral respiratory (non-COVID)*
- SARS-CoV-2
- Influenza + SARS-CoV-2
- RSV + SARS-CoV-2
- Other viral respiratory* + SARS-CoV-2

Report outbreak to CDPHE, and obtain an outbreak number.

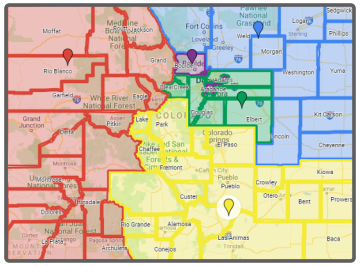
Flu/RSV team
cdphe_flu_rsv@state.co.us

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

RSV
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) or new prostration] AND [new cough or sore throat]

Influenza Outbreak

- **Suspected**: One resident with a positive flu test among one or more residents with undiagnosed respiratory illness with symptom onset occurring within a 1-week period.
- **Confirmed**: at least two residents with a positive influenza test within a 1-week period.

***The occurrence of respiratory illness among residents should first be considered suspect for COVID-19. If influenza or other respiratory illnesses such as RSV are circulating locally, these pathogens should also be considered suspect until testing proves otherwise. Co-infections of SARS-CoV-2 and other viral respiratory pathogens can and may occur.*

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	Other:	
Address:		Email:
City:	Zip:	County:
Person reporting:		Title:

Outbreak Information

Residents

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

Staff

Number of staff in facility:	Number of staff tested:			
Number of staff with ILI: (with or without a positive influenza test)	Number of staff with positive tests:			
Number of staff hospitalized:	Influenza type: Select one	Other:		
Number of staff vaccinated for flu this season:	Type of test:	☐ Rapid	☐ PCR	☐ Unknown
	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 to residents? Select one	If yes, prophylaxis was given to residents: Select one
Was prophylaxis given to staff? Select one	

Questions? Contact your local health department

Report an outbreak: Submit completed form to **CDPHE** (cdphe_flu_rsv@state.co.us | fax: 303-782-0338) ***or*** to your local health department.