COLORADO
Department of Public Health & Environment

Influenza outbreak guidelines

Prevention and control in long-term care facilities

2022-2023 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 get flu, and serious complications related to flu can happen at any age. However, adults 65 years of age and older, people of any age that are immunocompromised and/or have chronic medical conditions, pregnant women, and children <5 years of age are at higher risk of developing serious flu-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 with flu will have 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. People who have flu can transmit flu to others up to about six feet away. People who have flu 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 transmit the virus to others for a longer time. Flu 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. CDC recommends vaccination during September or October for most people who need one influenza vaccine dose for the season. This season, CDC recommends that adults over age 65 years should preferentially receive a higher dose or adjuvanted flu vaccine. More information from CDC on flu vaccination this season 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.

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 and 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 may be difficult to distinguish 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 transmitted from person to person via respiratory droplets produced when a person with the virus 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 individuals with COVID-19 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 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 visitors, residents and healthcare personnel who have flu. Influenza vaccination is the primary strategy of preventing complications and transmission of influenza among residents and staff of LTCFs. 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. This season CDC recommends that adults over age 65 years should preferentially receive a higher dose or adjuvanted flu vaccine. These include the quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated influenza vaccine (aIIV4). If none of these is available, any other age-appropriate influenza vaccine can be used for this age group. 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 Health care worker influenza vaccine requirements.

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 and SARS-CoV-2 Testing

If a resident or healthcare personnel (HCP) presents with symptoms of influenza-like illness (ILI), first refer to the COVID-19 COVID-19 long-term care facilities guidelines document testing guidelines 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).

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. See CDC guidance for more information on repeat testing. 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), and 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 COVID-19, 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 among residents, visitors and staff. These include:
    a. Covering of the mouth and nose with a tissue when coughing or sneezing
    b. Disposing of used tissues immediately after use (no-touch receptacles may be provided)

c. Performing hand-washing after having contact with respiratory secretions and contaminated objects/materials.
d. Using non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic handwash provided by the facility.

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 COVID-19 long-germ care facility guidelines first for guidelines on testing staff with respiratory illness symptoms and return-to-work criteria. Staff with confirmed influenza may only return to work at least 24 hours 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 of 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 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.
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.
    a. Ideally, symptomatic influenza-positive residents should be confined to their rooms (isolated) or limited to the affected unit (cohorted) until antiviral treatment is completed.
    b. 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.
    c. 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).
    d. Asymptomatic residents with close contact to a known positive resident should wear a surgical mask/face mask when indoors and around others for 48 hours following the last exposure.
    e. 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.
    f. 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, and use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure)
    b. Contact precautions: Gloves and gown 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 work in unaffected units at the same time 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 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. 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 illnesses 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) and all other respiratory symptoms (i.e., cough) are improving. 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**: For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at Policy & Memos to States and Regions | CMS
    a. Counsel patients and their visitor(s) about the risks of an in-person visit.
    b. Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
    c. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
    d. Visitors should be instructed to only visit the patient room. They should minimize their time spent in other locations in the facility.
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 (also included at the end of this document):
    - ☐ Illness onset date
    - ☐ Duration of illness
    - ☐ Wing/room (residents)
    - ☐ Symptoms
    - ☐ Hospitalizations/ deaths
8. **Limiting new admissions**: During an existing viral respiratory outbreak, 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**: All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
    a. Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for influenza in healthcare settings, including those patient-care areas in which aerosol-generating procedures (AGPs) are performed.
        - Refer to List N on the EPA website for EPA-registered disinfectants that eliminate the influenza virus; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a difficile sporicidal agent is recommended to disinfect the rooms of patients with *C. difficile* infection).
    b. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
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. People who live in nursing homes and other long-term care facilities are at higher risk for influenza complications and therefore are considered a priority group for antiviral treatment of influenza.

a. 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®)
b. Amantadine and rimantadine are NOT recommended for use because of high levels of antiviral resistance among circulating influenza A viruses.
c. Per current NIH guidance, antiviral treatment of influenza should be the same in all patients with or without a SARS-CoV-2 co-infection.

Treatment

All long-term care facility symptomatic residents who have confirmed or suspected influenza should receive influenza antiviral treatment as soon as possible.

Providers should not wait for laboratory confirmation of influenza test results before administering antiviral treatments. If lab results indicate that the patient is negative for influenza and positive for COVID-19, treatment with influenza antivirals should be stopped.

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 (in the section titled “Co-circulation of Influenza and SARS-CoV-2”).

Chemoprophylaxis

Antiviral chemoprophylaxis is recommended for all medically eligible residents (regardless of whether they received influenza vaccine) who are not exhibiting influenza-like illness once an influenza outbreak is confirmed. Chemoprophylaxis can be considered for staff according to IDSA Influenza Clinical Practice Guidelines. 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 (in the section titled “Co-circulation of Influenza and SARS-CoV-2.)”.

- Residents that develop ILI while on prophylaxis should be switched to treatment doses of antiviral medications empirically if treatment is indicated. Antiviral treatment can be started within the first 48 hours of symptom onset (fever with either cough or sore throat) if lab results are still pending, and can be discontinued or treatment 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. See the IDSA Influenza Clinical Practice Guidelines under section “XXI. Which healthcare personnel should receive antiviral chemoprophylaxis during an institutional outbreak?” for more information.
- Antiviral chemoprophylaxis should be considered for personnel for whom influenza vaccine is contraindicated. All other personnel should receive vaccination.

- Close monitoring and early treatment in response to fever and/or respiratory symptoms 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.

Surveillance

As soon as the outbreak is identified (suspected or confirmed), report the outbreak to your local public health agency; local public health will report the outbreak to CDPHE. Conduct daily active surveillance (e.g., line list and/or calendars) for new illness among residents and staff (note if there is spread between units and/or resident rooms). A line list template can be found here. When at least two incubation periods (8 days) after symptom onset of the last case of illness have passed, the outbreak may be considered closed.

This online REDCap outbreak report form may be used to report influenza outbreaks, as well as other non-COVID-19 respiratory disease outbreaks. Alternatively, an influenza outbreak report form for long-term care facilities is also included in this document, but the REDCap report form is preferred. Notifications of outbreaks, submission of outbreak report forms and questions regarding influenza outbreaks may be sent to Diane Garcia (diane.garcia@state.co.us) and to cdphe_flu_rsv@state.co.us. When the outbreak has ended (two incubation periods or 8 days have passed with no new influenza cases since the date of symptom onset of the last case of illness), submit a final outbreak report form with updated information.

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 2022, it is not known with a high degree of certainty which influenza viruses will be circulating during the 2022-2023 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:

Influenza Vaccine: CDC – Who Needs a Flu Vaccine | ACIP Influenza Vaccine Recommendations

CDC Influenza Updates: Influenza (Flu)

Frequently Asked Influenza (Flu) Questions: 2022-2023 Season | **CDC**

Similarities and Differences between Flu and COVID-19 | **CDC**

COLORADO
Department of Public Health & Environment

Influenza outbreak guidelines

Checklist for long-term care facilities

2022-23 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 (>100º 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 and 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 and 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.
  - Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which AGPs are performed.
  - Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a difficile sporicidal agent is recommended to disinfect the rooms of patients with C. difficile infection).
  - Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
- ☐ 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 until at least 24 hours has 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.
- ☐ Ensure staff are wearing a mask that covers their nose and mouth at all times (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

- ☐ For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at Policy & Memos to States and Regions | CMS.
  - Counsel patients and their visitor(s) about the risks of an in-person visit.
  - Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.

- Facilities should provide instruction before visitors enter the patient's room on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.

- [ ] Visitors should be 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

- [ ] As soon as the outbreak is identified (suspected or confirmed), report the outbreak to your local public health agency; local public health will report the outbreak to CDPHE.
- [ ] Conduct daily active surveillance (e.g., line list and/or calendars) for new illness among residents and staff (note if there is spread between units and/or resident rooms). A line list template can be found here.
- [ ] When the outbreak has ended (two incubation periods or 8 days have passed with no new influenza cases since the date of symptom onset of the last case of illness), submit a final outbreak report form with updated information.

This online REDCap outbreak report form may be used to report influenza outbreaks, as well as other non-COVID-19 respiratory disease outbreaks. Alternatively, an influenza outbreak report form for long-term care facilities is included in this document, but the REDCap report form is preferred.

Notifications of outbreaks, submission of outbreak report forms and questions regarding influenza outbreaks may be sent to Diane Garcia (diane.garcia@state.co.us) and to cdphe_flu_rsv@state.co.us.

COLORADO
Department of Public Health & Environment

Influenza outbreak report form

for long-term care facilities

2022-23 Season

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 there any other active outbreaks in the facility? Select answer			What type?	
Facility information				
Facility name:			Phone:	
Facility type: Select answer		Other:		
Address:		Email:		
City:	Zip:		County:	
Person reporting:			Title:	
Outbreak information				
Number:	**Residents**		**Staff**	
- in facility				
- with ILI (with or without a positive influenza test)				
- hospitalized				
- vaccinated for flu this season				
- tested				
- with positive tests				
Influenza type:	Select answer	Other:	Select answer	Other:
Type of tests performed:	☐ Rapid	Qty performed:	☐ Rapid	Qty performed:
	☐ PCR	Qty performed:	☐ PCR	Qty performed:
	☐ Unknown	Qty performed:	☐ Unknown	Qty performed:
Date of symptom onset or positive test of the *first* case of influenza detected in this outbreak:				
Date of symptom onset or positive test of the *final* case of influenza during this outbreak:				
Status of outbreak (see definitions above): Select answer				
Prophylaxis was given to (check all that apply):	☐ Residents ☐ Residents of selected units only ☐ Residents in the entire facility		☐ Staff ☐ Unknown ☐ No prophylaxis was given	

Questions? Contact your local health department

To report an outbreak: Submit completed form to CDPHE (cdphe_flu_rsv@state.co.us) or Diane Garcia (diane.garcia@state.co.us)