Respiratory Outbreak Checklist For CDPH Congregate Living Facilities

Managing Flu/RSV/COVID-19 in a long-term care or congregate living facility benefits from a prompt and coordinated team approach.

Steps to control and prevent Flu/RSV/COVID-19 transmission in your facility can be initiated and completed by facility administration, nursing/ caregiving staff, and/or environmental services/ cleaning staff. These steps should be initiated when a resident or staff at your facility develops respiratory symptoms and is suspected or confirmed to have Flu/RSV/COVID-19. Symptoms concerning for Flu/RSV/COVID-19 include: fever, cough, and shortness of breath, but also include unusual symptoms such as fatigue, chills, body aches, headache, sore throat, new loss of taste or smell, vomiting, nausea, or diarrhea. In addition to these symptoms, elderly patients may present with weakness, confusion, dizziness, or a subtle change from their baseline.

Control Measure	Non-COVID-19 Respiratory Outbreak (i.e., Influenza A/B, RSV, Parainfluenza, etc.)	COVID-19 Outbreak
Required Reporting Method	☐ Immediately report confirmed cases in staff or residents to: 1) Contra Costa Public Health Department by filling out the Online Contra Costa Health Services Form, emailing a complete Confidential Morbidity Report (CMR), Subject: Flu/RSV Case at "Name of congregate facility" CoCoCD@cchealth.org, or by calling Contra Costa Public Health at 925-313-6740 and following prompts for reporting 2) Update Sharepoint daily	☐ Immediately report confirmed cases in staff or residents to: 1) Contra Costa Public Health Department by filling out the Shared Portal for Outbreak Tracking (SPOT) (Preferred method), or by calling Contra Costa Public Health at 925-313-6740 and following prompts for reporting 2) Update Sharepoint daily
Outbreak Surveillance	☐ 7 Days with no new cases in residents or staff	☐ 14 Days with no new cases in residents or staff

Control Measure	Non-COVID-19 Respiratory Outbreak (i.e., Influenza A/B, RSV, Parainfluenza, etc.)	COVID-19 Outbreak
Threshold for reporting to Public Health and Outbreak Definition	**Reporting to Public Health** ≥1 lab confirmed case with 2 or more residents with ILI identified within 72 hours of each other in residents **Outbreak Definition** ≥2 lab confirmed cases identified within 72 hours of each other in residents and epi linkage	**Reporting to Public Health** ≥2 cases of probable or confirmed COVID-19 among residents identified within 7 days OR ≥2 cases of suspect, probable or confirmed COVID-19 among HCP AND ≥1 case of probable or confirmed COVID-19 among residents, with epi-linkage OR ≥3 cases of acute illness compatible with COVID-19 among residents with onset within 72h period **Outbreak Definition** ≥2 cases of probable or confirmed COVID-19 among residents, with epi-linkage OR ≥2 cases of suspect, probable or confirmed COVID-19 among HCP AND ≥1 case of probable or confirmed COVID-19 among residents, with epi-linkage, AND no other more likely sources of exposure for at least 1 of the cases *Epi-linkage among residents is defined as overlap on the same unit or ward, or other patient care location, or having the potential to have been

		cared for by common HCP within a 7-day period of each other. * Epi-linkage among HCP is defined as having the potential to have been within 6 feet for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms.
Infectious Period	24 Hours prior to onset of symptoms through 7 days from symptom onset. Those with weakened immune systems may be able to transmit virus for an extended period of time. Incubation period: 1-4 days	48 Hours prior to onset of symptoms through 10 days from onset of symptoms, plus 24 hours without a fever Incubation period: 2-10 days
Screening	Daily surveillance of residents for ILI during respiratory season (November-April) until at least one week after the last confirmed case of Flu or RSV	Daily surveillance of staff upon entry to facility Daily surveillance of residents for COVID-19 symptoms Passive surveillance for all visitors
Testing	(November-April) Regardless of vaccination status, test symptomatic residents using a respiratory panel or Multiplex Assay which tests for Influenza A, Influenza B and COVID-19 During outbreak- regardless of vaccination status, test symptomatic residents	Regardless of vaccination status test, symptomatic staff/residents for COVID-19 and exposed staff/residents, on day 1, 3 and 5 after exposure. Then continue to test exposed residents/staff every 3-7 days until no new cases are identified in sequential rounds of testing over 14 days. During Outbreak- Should discuss with your assigned Public Health Nurse if it's appropriate to focus testing to exposed staff/residents and expand if needed A facility-wide approach with testing and quarantine for exposed should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission NOTE: Admission testing in skilled nursing facilities is now at the discretion of the facility per the most recent CDC guidance updated on May 8, 2023

Control Measure	Non-COVID-19 Respiratory Outbreak (i.e., Influenza A/B, RSV, Parainfluenza, etc.)	COVID-19 Outbreak
Cohorting	☐ Isolate a positive case in a single room and implement **Droplet and Standard Precautions**. ☐ Residents with influenza may be cohorted in the same room as long as they have the same organism and other respiratory illnesses have been ruled out.	☐ Ensure residents are cohorted in the appropriate isolation rooms: ☐ **Isolation Zone: COVID positive residents** ☐ Implement **Airborne and Contact Precautions** for residents who have COVID-19 like symptoms with testing pending.
Isolation and Quarantine	☐ **Isolate** resident for at least 7 days after onset of symptoms or 24 hours after resolution of all respiratory symptoms other than cough -- whichever is longest. ☐ If after 7 days the patient continues to have fever or illness, you may need to extend **Droplet and Standard Precautions** past 7 days; consult with Public Health as needed. ☐ Consider **quarantine** for those exposed and implement **Standard** and **Droplet** precautions for 4 days, if unable to start prophylaxis.	☐ CDPH facility residents who test positive (symptomatic or asymptomatic) should be isolated, regardless of their vaccination status until the following conditions are met: • At least **10 days** have passed since symptom onset; AND • At least 24 hours have passed since resolution of fever without the use of fever-reducing medications; AND • All other symptoms have improved • **NOTE:** Isolation should be extended to 20 days for individuals who had critical illness (e.g., required intensive care) • Quarantine is not required for asymptomatic, newly admitted, or readmitted residents, regardless of vaccination status.

Staff Isolation	Exclude **all** symptomatic staff from work **until 24 hours after fever is resolved** without the use of fever reducing medicine (acetaminophen, ibuprofen, naproxen and/or aspirin products).	Work restrictions are 5 days with at least one negative diagnostic test same day or within 24 hours prior to return OR 10 days without a viral test During a staffing crisis <5 days with most recent diagnostic test result to prioritize staff placement Quarantine: No work restriction with **negative** diagnostic test upon identification (but not earlier than 24 hours after exposure) and if negative, test at days 3 and 5.
Control Measure	**Non-COVID-19 Respiratory Outbreak (i.e., Influenza A/B, RSV, Parainfluenza, etc.)**	**COVID-19 Outbreak**
Visitation	Visitation is allowed during an outbreak. Visitors are required to wear the PPE that is required for the zone they are visiting. Outdoor visitation is preferred if weather permits.	
Communal Dining and Activities	Close **group activities and communal dining** until at least **4 days (96 hours)** after the last identified case.	Ensure all group activities and communal dining should be closed while contact tracing. ***Communal activities and dining may occur in the following manner:*** o Residents who are not in isolation may eat in the same room without physical distancing, regardless of vaccination status. o Residents who are not in isolation may participate in group/social activities together without face masks or physical distancing, regardless of vaccination status. o Residents who have been exposed should not participate in communal dining since

		masks must be removed during eating and drinking. ➢ Residents who have been exposed, must wear a mask for 10 days following the most recent exposure, even during group activities.

Control Measure	Non-COVID-19 Respiratory Outbreak (i.e., Influenza A/B, RSV, Parainfluenza, etc.)	COVID-19 Outbreak
Admissions and Readmissions	☐ Close to new admissions during an outbreak until transmission is contained; for influenza, containment is generally	☐ Close to new admissions during an outbreak until transmission is contained; for COVID-19 outbreaks, containment is

	evidenced by no new cases among residents for 7 days. ☐ Admissions may be allowed during outbreak if items below are met. Consult with assigned Public Health Nurse: • Facility has implemented outbreak control measures, as appropriate, such as post-exposure or response testing, cohorting, and transmission-based precautions. • Facility has no staffing shortage. Facility must have a trained infection preventionist. Long term staffing plans should be documented. • Facility has adequate PPE, staff from all shifts have access to N95 respirator fit testing and all staff have been fit-tested.	generally evidenced by no new cases among residents for 7 days. ☐ Admissions may be allowed during outbreak if items below are met. Consult with assigned Public Health Nurse: • Facility has implemented outbreak control measures, as appropriate, such as post-exposure or response testing, cohorting, and transmission-based precautions. • Facility has no staffing shortage. Facility must have a trained infection preventionist. Long term staffing plans should be documented. • Facility has adequate PPE, staff from all shifts have access to N95 respirator fit testing and all staff have been fit-tested.
Transfers	☐ Facility should advise PH of all residents who are transported out of facility for severe illness or death. ☐ Complete the transfer form: **Interfacility Transfer Communication Form – Abbreviated (PDF)**	

Control Measure	Non-COVID-19 Respiratory Outbreak (i.e., Influenza A/B, RSV, Parainfluenza, etc.)	COVID-19 Outbreak
PPE *Any person with ILI symptoms and lab results are pending, place the resident on Standard, Airborne, and Contact precautions	**Place symptomatic residents in 'Droplet Precautions' and "Standard Precautions."** Personal Protective Equipment **(PPE)** should be worn by all employees when entering isolation rooms**:** **1) Wear a surgical mask** **2) Eye protection** **2) N95 is required if performing an aerosol generating procedure** Droplet- **Sample Isolation Sign**	**Place symptomatic residents in 'Airborne and Contact Precautions".** Personal Protective Equipment **(PPE)** should be worn by all employees when entering isolation rooms**:** **1) Wear an N95 respirator** **2) Eye protection** **3)Gown and gloves** Airborne- **Sample Isolation Sign** Contact- **Sample Isolation Sign**
Hand Hygiene	☐ When hands are contaminated, soiled, before and after eating, and after toileting wash with soap and water ☐ **Before** • Patient contact • Donning gloves • Accessing devices • Giving medication ☐ **After** • Contact with a patient's skin and/or environment • Contact with body fluids or excretions, non-intact skin, wound dressings • Removing gloves ☐ Start using the HAI Hand Hygiene Tool for Adherence Monitoring	
Masking	☐ Contra Costa County Masking Public Health Order for HCP in Skilled Nursing Facilities ☐ Universal use of N95s during outbreak (AFL 23-12)	
Environmental cleaning and Disinfection	☐ Increase cleaning frequency of hard non-porous, high-touch surfaces to every 2 hours with a commercial disinfectant that is EPA approved. ***High-touch surfaces include, but not limited to doorknobs, bed rails, call lights, bedside tables, commodes, toilets, phones, keyboards/mouse, hallway rails, elevator buttons and faucets***	
Education	Facility is providing education on hand hygiene, respiratory hygiene, and use of personal protective equipment (PPE) to all staff ☐ Education includes proper donning and doffing of PPE to prevent self-contamination ☐ Facility is monitoring hand hygiene practices among staff (Hand Hygiene Tool) ☐ Facility is monitoring appropriate use of PPE among staff (Adherence Monitoring Tool) ☐ Facility is providing education on criteria for placement in cohort zones to staff	

Chemoprophylaxis	Give antiviral chemoprophylaxis dosage for 2 weeks minimum or 1 week after last identified influenza case – whichever is longer. **Influenza Antiviral Medications: Summary for Clinicians (CDC)** https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm	Currently there are no FDA PreP authorized treatments
Treatment	See Antiviral agent dosing for the treatment and chemoprophylaxis of influenza box below	See Antiviral agent dosing for the treatment of COVID-19 box below
Vaccination	Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications.	COVID-19 vaccination is recommended for everyone ages 6 months and older in the United States for the prevention of COVID-19. CDC recommends that people stay up to date with COVID-19 vaccination by completing a primary series and receiving the most recent booster dose recommended for them by CDC. CDPH and Public Health strongly recommend that all HCP and residents remain up to date.

Antiviral agent dosing for the treatment and chemoprophylaxis of influenza in Long-Term Care Facilities

Antiviral agent dosing			Adult dosing (Creatinine clearance >60 mL per min)	Adult dosing renal impairment	Notes
Oseltamivir	Treatment, influenza A and B		75 mg twice daily for 5 days	Creatinine clearance 31-60 mL per min: 30 mg twice daily Creatinine clearance 10-30 mL per min: 30 mg once daily ESRD on dialysis (creatinine clearance <10 mL per min): 30 mg immediately and then 30 mg after each dialysis cycle in 5-day period	Common adverse events: nausea, vomiting, headache. Post marketing reports of serious skin reactions and sporadic, transient neuropsychiatric events. *IMPORTANT* Having preapproved orders from physicians or plans to obtain orders for antiviral medications on short notice can substantially expedite administration of antiviral medications. Prioritization when antiviral supply is limited: 1) For treatment, prioritize lab-confirmed infections over symptomatic, exposed residents until lab confirmation obtained. 2) If able, prioritize symptomatic, exposed residents over post-exposure prophylaxis (PEP) 3) If able, provide PEP to residents with highest degree of exposure regardless of vaccination status.
	Chemoprophylaxis, influenza A and B		75 mg once daily for minimum 2 weeks	Creatinine clearance 31-60 mL per min: 30 mg once daily Creatinine clearance 10-30 mL per min: 30 mg every other day ESRD on hemodialysis (creatinine clearance <10 mL per min): 30 mg immediately and then 30 mg after every other dialysis session in a 2 week period	
Zanamivir	Treatment, influenza A and B		10 mg (2 inhalations) twice daily for 5 days	No change	Common adverse effects: bronchospasm NOT for use in patients with lung or airway disease such as asthma or

	Chemoprophylaxis, influenza A and B		10 mg (2 inhalations) once daily for minimum 2 weeks	No change	COPD
Intravenous Peramivir	Treatment Influenza A and B		One 600mg dose, via intravenous infusion for a minimum of 15 minutes.	Creatinine clearance≥ 50 mL/min: 600mg Creatinine clearance 30 to 49 mL/min: 200mg Creatinine clearance 10 to 29 mL/min: 100mg ESRD Patients on Hemodialysis: 100mg administered after dialysis	Common adverse events: diarrhea. Post marketing reports of serious skin reactions and sporadic, transient neuropsychiatric events.
	NOT recommended for Chemoprophylaxis		NA	NA	
Oral Baloxavir	Treatment influenza A and B		Weight-based dosing: <80kg: One 40 mg dose ≥ 80 kg: One 80 mg dose	Pharmocokinetic analysis did not identify a clinically meaningful effect of renal function on the pharmacokinetics of baloxavir in patients with creatinine clearance 50mL/min and above. The effects of severe renal impairment on the pharmacokinetics of baloxavir marboxil or its active metabolite, baloxavir, have not been evaluated.	CDC does not recommend use for treatment in pregnant women or breastfeeding mothers. CDC does not recommend use as monotherapy in severely immunosuppressed persons.

	NOT recommended for Chemoprophyl axis		NA	NA	

References:

Recommendations for the Prevention and Control of Influenza in CA SNFs during the COVID-19 Pandemic
http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm#dosage
Clinical Practice Guidelines by the Infectious Diseases Society of America: 2018 Update on Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza - PMC (nih.gov)

Antiviral agent dosing for the treatment of COVID-19 in Long-Term Care Facilities

Drug	Route	Age groups authorized for treatment	Timing of Treatment	Effectiveness	Activity Against Variants Currently Circulating
Nirmatrelvir with ritonavir (Paxlovid) Orally twice daily for 5 days • For patients with normal/mild renal impairment (eGFR > 60 mL/min): 300 mg nirmatrelvir with 100 mg ritonavir • For patients with moderate renal impairment (eGFR ≥ 30 to < 60 mL/min): 150 mg nirmatrelvir with 100 mg ritonavir	Oral	12 years and older and weighing at least 40 kg	As soon as possible, but within 5 days of symptom onset	Compared to placebo, a relative risk reduction of 89% in hospitalizations or deaths.	Effective against Omicron, including BA.2 subvariant
Remdesivir (Veklury)	Intravenous	FDA approved for mild to moderately ill adult and	As soon as possible, but within 7 days	Compared to placebo, a relative risk reduction of	Effective against Omicron,

• For adults and pediatric patients weighing ≥ 40 kg: 200 mg IV on Day 1, followed by 100 mg IV daily on Days 2 and 3 • For pediatric patients ≥ 28 days old and weighing ≥ 3 kg to < 40 kg: 5 mg/kg IV on Day 1, followed by 2.5 mg/kg IV daily on Days 2 and 3.		pediatric (28 days of age and older weighing at least 3 kilograms) outpatients who are at risk of disease progression.	of symptom onset	87% in hospitalizations or deaths.	including BA.2 subvariant
Molnupiravir (Lagevrio) 800 mg Orally twice daily for 5 days	Oral	18 years and older	As soon as possible, but within 5 days of symptom onset	Compared to placebo, a relative risk reduction of 30% in hospitalizations or deaths.	Effective against Omicron, including BA.2 subvariant

References and Resources:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Treatment-Resources-for-Providers.aspx

COVID-19 Treatment Guidelines (nih.gov)

Liverpool COVID-19 Interactions (covid19-druginteractions.org)

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COVID-19 Therapeutics Decision Aid (hhs.gov)

Preliminary Report

I have read these recommendations and had the opportunity to ask questions, on behalf of the affected facility.

Facility Name:

Facility Baseline Metrics (Preliminary Report)	**Count Indicators**	**Count**
	Flu Vaccination Rate for Patients /Residents	
	Flu Vaccination Rate for Staff	
	Streptococcus Pneumoniae Vaccination Rate for Patient/Residents	
	"Up-to-date" COVID Vaccination Rate for Patients/Residents	
	"Up-to-date" COVID Vaccination Rate for Staff	

	# Staff with exemptions for Flu or COVID Vaccine	
	Date Indicators	**Date**
	Date facility temporarily closed to new admissions	
	Date facility temporarily closed to new visitors	
	Date facility temporarily closed group dining	
	Date facility temporarily postponed group activities	

Signature: _____ Date: _____
(Facility Representative)

Final Report

As a facility, we monitored all residents and staff for symptoms of ILI or ARI a total of 7 days following the last date of illness onset.
Facility Name:

Outbreak Resolution Metrics (Final Report)	**Count Indicators**	**Count**
	Number of symptomatic patients/residents prescribed antiviral TREATMENT Antiviral prescribed: _____	
	Number of patients/residents prescribed antiviral CHEMOPROPHYLAXIS Antiviral prescribed: _____	
	Number of patients/residents covered by an influenza antiviral standing order	

	Number of staff prescribed antiviral CHEMOPROPHYLAXIS Antiviral prescribed: _____	
	Date Indicators	**Date**
	Date facility re-opened to new admissions	
	Date facility re-opened to all visitors	
	Date facility group dining re-opened	
	Date normal group activities restarted	

Signature: _____ Date: _____

(Facility Representative)