

**Recommendations for the Prevention and Control of Influenza
in California Skilled Nursing Facilities (SNF) during the
COVID- 19 Pandemic**

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Introduction

Skilled nursing facility (SNF) residents are at increased risk for severe disease, hospitalization, and death from infections caused by influenza viruses and the severe acute respiratory syndrome-coronavirus-2 (SARS-CoV-2, the virus that causes coronavirus infectious disease-19 [COVID-19]). The 2020-2021 influenza season will be complicated by the ongoing COVID-19 pandemic and the potential for concurrent COVID-19 and influenza outbreaks in SNFs. Influenza seasons vary in severity from year to year, based on the characteristics of the circulating influenza virus strains and how well the vaccine matches the circulating strains. Preliminary data on the effect of SARS-CoV-2 co-circulation with influenza show varied patterns and limit predictions of the severity of the 2020-2021 influenza season in the United States^{1,2,3}. Although very minimal circulation of influenza viruses was reported while SARS-CoV-2 was predominant during the 2020 influenza season in the southern hemisphere¹, co-infection with influenza and SARS-CoV-2 was common in a report from China³ and the risk of death in patients with co-infection was 5.92 (95% CI, 3.21-10.91) times greater than among those who tested negative for both influenza and SARS-CoV-2 in England². California SNF must therefore prepare now to prevent and manage influenza outbreaks in addition to COVID-19 outbreaks during the coming months.

During the 2020-2021 influenza season, it is more important than ever for SNF to optimize all available effective influenza prevention and outbreak control interventions^{5,6}. Safe and effective influenza vaccination of SNF residents and healthcare personnel (HCP) and prompt initiation of antiviral therapy and chemoprophylaxis have proven effectiveness in protecting vulnerable SNF residents against the adverse effects of influenza infection⁶; in addition, higher influenza vaccine uptake in the elderly was associated with lower COVID-19 deaths in Italy⁴. Nonpharmaceutical interventions (NPI) such as universal masking, spatial distancing, avoiding group gatherings, closing schools and limiting travel implemented for prevention of COVID-19 may contribute to prevention of influenza^{1,7,8}, but do not replace influenza vaccination and antiviral therapy and chemoprophylaxis.

Recommendations for the Prevention and Control of Influenza in California Skilled Nursing Facilities (SNF) during the COVID-19 Pandemic provides recommendations to prevent and manage influenza outbreaks in SNFs in the context of SARS-CoV-2 co-circulation. These recommendations may also apply to other long-term care facilities (LTCF), for example, congregate living health facilities and intermediate care facilities. This guidance document updates and replaces *Recommendations for the Prevention and Control of Influenza California Long-Term Care Facilities* October 2019.

What is new about this document?

New information related to COVID-19 in SNF has been added to the “Most Important Messages.” Table 1 summarizes similarities and differences between clinical characteristics of influenza viruses and SARS-CoV-2.

Recommendations for planning and implementation in Tables 2 and 3 now include COVID-19 considerations; many of the same infection control practices to prevent transmission of SARS-CoV-2 will also prevent transmission of influenza. SNFs should continue to monitor the [Centers for Disease Control and Prevention \(CDC\) influenza](http://www.cdc.gov/flu/) (www.cdc.gov/flu/) and [COVID-19 websites](http://www.cdc.gov/coronavirus/2019-nCoV/index.html) (www.cdc.gov/coronavirus/2019-nCoV/index.html) and [CDPH guidance](http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx) (www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx) for updates. Updated recommendations for administration of influenza vaccine to individuals with COVID-19 will be posted on the CDC website [Vaccination Guidance During a Pandemic](http://www.cdc.gov/vaccines/pandemic-guidance/index.html) (www.cdc.gov/vaccines/pandemic-guidance/index.html).

How should SNFs use this guidance document?

This document is intended to provide SNF guidance for developing and implementing an influenza prevention and control plan applicable to all influenza seasons, including the 2020-2021 season. For the most up-to-date guidance on influenza vaccine, SNF staff should refer to [CDC and Advisory Committee on Immunization Practices \(ACIP\) recommendations](http://www.cdc.gov/flu/professionals/antivirals/index.htm)⁶ published annually before each influenza season. Refer to updated guidance on [use of antiviral agents](http://www.cdc.gov/flu/professionals/antivirals/index.htm) (www.cdc.gov/flu/professionals/antivirals/index.htm) for influenza treatment and chemoprophylaxis and for diagnostic [testing](http://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm) (www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm).

Planning for influenza in SNF begins by providing information to residents and families at the time of admission, and to HCP at the time of hire and during annual performance reviews. Before influenza begins circulating in the local community, SNF must be ready with sufficient influenza vaccine and standing orders for administration, hand hygiene supplies, personal protective equipment (PPE), antiviral medication orders, and established lines of communication between the SNF and the local health department. Establishing a strong collaborative relationship with the local health department facilitates needed support in the event of an outbreak, vaccine or antiviral agent shortages, or if unanticipated events emerge within a given season. Evaluating the experiences at the conclusion of each influenza season will inform the plan for the following year.

CDPH guidance and recommendations are presented in tables:

Table 1 summarizes [similarities and differences](http://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm) (www.cdc.gov/flu/symptoms/flu-vs-covid19.htm) between clinically relevant characteristics of influenza viruses and SARS-CoV-2. The overlap of clinical presentations and contribution of asymptomatic transmission of SARS-CoV-2 makes it difficult to manage residents based on symptoms alone. Each SNF must therefore develop plans for: testing symptomatic residents for both influenza and SARS-CoV-2; implementation of transmission-based precautions; determining resident room placement while avoiding movement of residents between COVID-19 cohorts; and prompt initiation of influenza antiviral agents therapeutically and prophylactically when an influenza outbreak is identified in a facility. Availability of [multiplex tests for influenza viruses and SARS-CoV-2](http://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm)

(www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html) will improve efficiency of diagnosis.

Table 2: Planning for Influenza Illness and Outbreaks in SNFs provides guidance relevant to three groups of individuals: residents, facility HCP, and family members and other visitors. SNFs may use Table 2 as a guide to develop, review, and update plans before the influenza season begins. Facility HCP include all paid and unpaid persons who work in a healthcare setting and provide care or support the delivery of care; also referred to as staff members (see glossary). Recommendations related to COVID 19 have been added where appropriate.

Table 3: Identifying and Controlling Influenza Outbreaks in SNF contains recommendations for identifying the presence of an influenza outbreak and implementing the plan developed using the guidance from Table 2. SNF may use Table 3 to find specific recommendations for infection control measures and accepting and transferring residents during an outbreak.

What are the most important messages for SNF leaders to understand about influenza and SARS-CoV2 during the COVID 19 pandemic?

1. Vaccination is the most effective tool for prevention of influenza and its serious complications⁵. **During the COVID-19 pandemic, it is critical that SNF optimize all available influenza prevention interventions, including vaccination of HCP and residents.** Overall, 67.9% of HCP working in long term care facilities in the U.S. were vaccinated against influenza during the 2018-2019 season, which is substantially lower than the 95% coverage in acute care hospitals (per CDC: www.cdc.gov/flu/fluview/hcp-coverage_1819estimates.htm). Planning and implementing a successful influenza vaccine program will also help inform planning for administration of COVID-19 vaccines that will likely become available in 2021.
 - While the effectiveness of influenza vaccines varies by season, these vaccines can prevent severe disease, ICU admissions, and death^{9, 10, 11}.
 - Immunizing HCP and family members against influenza provides additional protection for the very vulnerable patients in SNF who may not mount an adequate immune response to the vaccine (National Adult Influenza Summit). California was the first state to enact [regulations](#) (PDF) (www.dir.ca.gov/dosh/dosh_publications/ATD-Guide.pdf) requiring long term care facilities to provide influenza vaccine to HCP at no cost and at a convenient time and place for employees during working hours.
 - Several studies indicate that vaccine-induced immunity may wane over time; therefore, SNF can consider administering influenza vaccine in October or early November¹³ rather than in September. Re-vaccination late in the influenza season is not currently recommended.
 - Influenza vaccine will neither prevent SARS-CoV-2 infection and nor increase the risk of

infection with SARS-CoV-2, but is expected to prevent the severe disease and complications anticipated from co-infection with influenza and SARS-CoV-2. In preliminary data from Brazil, there was a significant reduction in mortality from COVID-19 in those who received influenza vaccine¹⁴.

- There are no anticipated shortages in influenza vaccine supplies for this season.
2. Influenza virus is transmissible to others beginning at 24 hours before an individual has typical signs and symptoms of influenza and lasting for 3-7 days after symptom onset. Older individuals and those who are immunocompromised may not present with classic signs of influenza^{5, 6}. Since signs and symptoms of influenza and COVID-19 are similar, SNF must be vigilant for the possibility of concurrent outbreaks and **develop plans for prompt diagnostic testing of all symptomatic individuals for both influenza and SARS-CoV-2 throughout the influenza season, and even when an outbreak with either pathogen has already been confirmed in the facility.**
 3. Many COVID-19 prevention and control strategies will contribute to influenza prevention in SNFs, including:
 - Universal masking for source control, spatial distancing and avoidance of group gatherings both within the SNF and the outside community.
 - Implementation of systematic surveillance including recommended screening and testing.
 - Prompt isolation of symptomatic residents in a single room if available, or in current room with spatial separation and curtains drawn between beds.
 - Rigorous implementation of all recommended infection control practices.
 4. Implementing [Enhanced Standard precautions](http://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/Enhanced-Standard-Precautions.pdf) (PDF) (www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/Enhanced-Standard-Precautions.pdf) by using gowns and gloves, and performing frequent hand hygiene while caring for residents at increased risk of acquiring and transmitting infectious agents is necessary during high contact activities year-long and especially during influenza season and the COVID-19 pandemic.
 5. SNF must develop plans to be able to accept new admissions while maintaining capacity to care safely for other residents. This requires planning for implementing Transmission-Based Precautions and other infection control measures.
 6. When an influenza outbreak is suspected^{5, 15}, prompt and simultaneous implementation of all recommended interventions can minimize the size and scope of the outbreak and adverse impact on resident health. Outbreak management requires a collaborative effort among all HCP with specific task assignments and tracking of task completion.

- Prompt administration of antiviral agents for treatment and prophylaxis will shorten an influenza outbreak and reduce morbidity and mortality¹⁶.
- Implementation of Droplet precautions and separating influenza-infected residents (either in a single room if available, or current room with spatial separation and curtains drawn between beds) will reduce risk of ongoing transmission; **avoid movement of residents with suspected or confirmed influenza between COVID-19 cohorts.**
- Communicating with residents, HCP, and families, throughout the outbreak.
- Communicating with the local health department for additional guidance.

TABLE 1. Similarities and Differences Between Seasonal Influenza Virus and SARS-CoV2

(www.cdc.gov/flu/symptoms/flu-vs-covid19.htm)

| Characteristics | Influenza Virus | SARS-CoV2 |
|--|---|---|
| Signs and symptoms Same | <ul style="list-style-type: none"> Fever, chills, cough, shortness of breath or difficulty breathing, fatigue, sore throat, runny or stuffy nose, myalgias, headache, vomiting and diarrhea, cardiac complications¹⁷ | |
| Different | <ul style="list-style-type: none"> Aymptomatic infection uncommon Bacterial superinfection common Clinical appearance consistent with measured hypoxemia | <ul style="list-style-type: none"> Bacterial superinfection uncommon Measured hypoxemia worse than clinical appearance New loss of sense of taste or smell Multi-system inflammatory syndrome(MIS-C) in children and young adults Thromboembolic complications Delayed and lingering symptoms 40% of infected remain asymptomatic but can transmit to others |
| Peak symptoms | <ul style="list-style-type: none"> During days 3-7 of illness | <ul style="list-style-type: none"> During week 2-3 of illness |
| Infectivity | <ul style="list-style-type: none"> Less transmissible More frequent transmission by symptomatic individuals | <ul style="list-style-type: none"> More transmissible (completely naïve population) 40% of infections transmitted by pre- or asymptomatic individuals |
| | <ul style="list-style-type: none"> Most infectious after symptom onset | <ul style="list-style-type: none"> Most infectious period during first 5 days of symptoms |
| | <ul style="list-style-type: none"> Infectiousness begins 24 hours before symptom onset | <ul style="list-style-type: none"> Infectiousness begins 48 hours before symptom onset |
| Incubation Period | <ul style="list-style-type: none"> 1-4 days (median 2 days) | <ul style="list-style-type: none"> 14 days (median 5 days) |
| Case-Fatality Rate | <ul style="list-style-type: none"> 0.1% | <ul style="list-style-type: none"> 0.25-3.0% |
| Primary route of transmission | <ul style="list-style-type: none"> Droplet Short-range aerosol possible | <ul style="list-style-type: none"> Droplet, short-range aerosol Fomite and fecal-oral less important |
| Recommended PPE | <ul style="list-style-type: none"> Surgical mask; gown and gloves if high contact activity N95 respirator if aerosol generating procedure | <ul style="list-style-type: none"> N95 respirator, eye protection, gown, gloves AIIR if aerosol generating procedure |
| Risk Factors for Severe Disease Same | <ul style="list-style-type: none"> Chronic lung, heart, kidney disease, metabolic disease (diabetes); obesity; immunosuppression; residence in long term care facility Racial and ethnic disparities among American Indians and Alaskan Natives | |

Recs for the Prevention and Control of Influenza
in CA SNF during the COVID- 19 Pandemic

| | | |
|---|--|--|
| <p>Risk Factors for Severe Disease Different</p> | <ul style="list-style-type: none"> • >65 years and <2 years • Pregnancy (through 2 weeks postpartum) • Neuromuscular disorders | <ul style="list-style-type: none"> • Increases with advancing age • Most infants and children have mild or asymptomatic infection • Surgery during incubation period • Racial and ethnic disparities in African Americans and Latinx |
| <p>Diagnostics Same</p> | <ul style="list-style-type: none"> • For acute infection: nucleic acid amplification and antigen based assays from respiratory tract specimens, rapid POC and laboratory based, serology not helpful for diagnosis of acute infection | |
| <p>Diagnostics Different</p> | <ul style="list-style-type: none"> • Included in commercially available multiplex respiratory virus panels used in clinical labs | <ul style="list-style-type: none"> • Serology for previous infection • Influenza and SARS-CoV-2 multiplex panels becoming available |
| <p>Treatment available</p> | <ul style="list-style-type: none"> • Prophylactic and therapeutic antiviral agents shown to be beneficial | <ul style="list-style-type: none"> • Remdesivir • Steroids • Convalescent plasma (needs more research) • No chemoprophylaxis available |
| <p>Vaccine</p> | <ul style="list-style-type: none"> • Several safe and effective licensed, including high dose vaccine for ≥ 65 years of age • Recommended for all ≥ 6 months | <ul style="list-style-type: none"> • Several under development • Anticipated availability in 2021, pending demonstration of effectiveness and safety |

Table 2. Planning for Management of Influenza Illness and Outbreaks in SNF during the COVID pandemic

| ACTIONS | RESIDENTS | HEALTH CARE PERSONNEL (HCP) | FAMILY MEMBERS/VISITORS |
|---|--|---|--|
| <p>1. Educate about the impact of influenza on residents and importance of preventing illness and outbreaks using specific information for each of the three audiences: residents, HCP, family members/visitors. Include information about COVID-19 such as clinical similarities and differences, potential for co-infection (Table 1)</p> | <ul style="list-style-type: none"> • Discuss influenza and COVID-19 prevention and management plans at time of resident admission • Prepare resident educational materials such as information sheets and signs in appropriate languages • Schedule educational sessions with opportunities for questions and discussion <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Schedule HCP educational sessions on the facility influenza prevention plan and relationship to the current COVID-19 and MDRO prevention (Enhanced Standard precautions) plans • Include high risk nature of the population and HCP responsibilities; provide opportunities for questions and discussion. <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Discuss influenza and COVID-19 prevention with family members at the time of resident admission • Include influenza and COVID-19 prevention information sheets in the admission packet provided to families • Prepare information sheets and signs for posting during influenza season and during outbreaks • Share information with SNF ombudsmen • Prepare to answer family/visitor questions <p><input type="checkbox"/> Complete _____(date)</p> |
| <p>2. Develop or update the influenza vaccination plan for residents and HCP according to ACIP recommendations for the current season (https://www.cdc.gov/mmwr/volumes/69/rr/rr6908a1.htm?s_cid=rr6908a1_w)</p> | <ul style="list-style-type: none"> • Obtain standing vaccination orders from providers for each resident before influenza season begins • Vaccinate residents; mild illness is not a contraindication to flu vaccination, and residents may receive influenza vaccination regardless of | <ul style="list-style-type: none"> • Discuss HCP influenza vaccine requirements at time of hire and during annual performance evaluations • Prepare information sheets for HCP describing HCP influenza vaccination requirements, roles and responsibilities, HCP staffing plan during influenza season, and signs for posting in HCP break rooms | <ul style="list-style-type: none"> • Notify families of facility influenza prevention plan at time of resident admission, including vaccination of residents and HCP before the beginning of influenza season. • Recommend influenza vaccination for families/visitors; SNF is not responsible for providing vaccine to this group |

| ACTIONS | RESIDENTS | HEALTH CARE PERSONNEL (HCP) | FAMILY MEMBERS/VISITORS |
|---|---|--|--|
| <p>Develop or update the influenza vaccination plan for residents and HCP according to ACIP recommendations for the current season (<i>continued</i>)</p> | <p>COVID-19 status as long as clinically stable</p> <ul style="list-style-type: none"> ◦ Designate an <i>Influenza Vaccination Week</i> in October or early November ◦ Continue to vaccinate throughout the influenza season <ul style="list-style-type: none"> • SNF should be aware that fever or myalgias resulting from influenza vaccination could complicate clinical evaluation for COVID-19 • Track each resident’s vaccination status and room location; calculate resident vaccination rates • If vaccine shortage, consult local health department and communicate revised plan to residents <p><input type="checkbox"/> Complete _____ (date)</p> | <ul style="list-style-type: none"> • Obtain standing vaccination orders from providers for SNF HCP before influenza season begins • Vaccinate HCP <ul style="list-style-type: none"> ◦ Designate an <i>Influenza Vaccination Week</i> in October or early November and vaccinate HCP at <u>no cost</u> (www.dir.ca.gov/title8/5199.html) and at a reasonable <u>time and place</u> (www.dir.ca.gov/title8/5199.html); designate different times to accommodate HCP work shifts ◦ Continue to vaccinate throughout the influenza season • Involve facility leadership and HCP thought-leaders to encourage HCP to accept vaccine • Consider using incentives or competitions to increase acceptance of flu vaccination • Discourage declination and exemptions, but develop policy for documentation and management of HCP who do not accept vaccination • Determine acceptable documentation required for HCP vaccination obtained off site <p><input type="checkbox"/> Complete _____ (date)</p> | <ul style="list-style-type: none"> • Prepare signs and information sheets for families/visitors that include vaccination recommendations, referral to primary care provider (PCP) for vaccine and how to find sites in <u>specific geographic areas</u> (www.cdc.gov/flu/freeresources/flu-finder-widget.html) to obtain vaccine • If vaccine shortage, consult local health jurisdiction and communicate revised vaccination plans to families/visitors <p><input type="checkbox"/> Complete _____ (date)</p> |

| ACTIONS | RESIDENTS | HEALTH CARE PERSONNEL (HCP) | FAMILY MEMBERS/VISITORS |
|---|--|--|--|
| <p>Develop or update the influenza vaccination plan for residents and HCP according to ACIP recommendations for the current season <i>(continued)</i></p> | | <ul style="list-style-type: none"> • Track vaccination status of each HCP, including location of assignment and role; calculate vaccination rates and provide feedback to SNF leaders and HCP throughout influenza season • Develop plan with local health department for possible vaccine shortage; communicate to HCP <p><input type="checkbox"/> Complete _____(date)</p> | |
| <p>3. Review pneumococcal vaccination status of residents</p> | <ul style="list-style-type: none"> • Obtain standing orders for pneumococcal vaccines for residents from their PCPs • Ensure that all residents have received pneumococcal vaccines according to current ACIP recommendations (www.cdc.gov/vaccines/schedules/hcp/adult.html); usually done at the time of admission, but if not done then, complete before influenza season begins • Schedule additional doses of pneumococcal vaccine as needed <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • SNF are not responsible for providing pneumococcal vaccines to HCP; refer to PCP or clinic if questions | <ul style="list-style-type: none"> • SNF are not responsible for providing pneumococcal vaccines to families/visitors; refer to PCP or clinic if question |

| ACTIONS | RESIDENTS | HEALTH CARE PERSONNEL (HCP) | FAMILY MEMBERS/VISITORS |
|--|--|--|---|
| <p>4. Develop or update plan for conducting daily active surveillance for influenza-like illness (ILI) during influenza season and until at least 1 week after last confirmed influenza case, in addition to continuing surveillance for COVID-19</p> | <ul style="list-style-type: none"> • Develop process to conduct daily active surveillance for ILI during influenza season and until at least 1 week after last confirmed influenza case in the facility, using resident log (Appendix A); note, this ILI log is different from the linelist used to track COVID-19 test results (contact HAIProgram@cdph.ca.gov for COVID-19 tracking linelist template) • Assign responsibility for daily review and implementation of actions when needed • Develop plan for influenza and COVID-19 diagnostic testing of symptomatic residents (Table 3) • Develop surveillance plan to identify residents who develop influenza after receiving antiviral chemoprophylaxis for 72 hours or more and report to local health jurisdiction to assess for antiviral resistance <p><input type="checkbox"/> Complete _____ (date)</p> | <ul style="list-style-type: none"> • Continue symptom screening of HCP for COVID-19 and ILI during influenza season • Develop a process for tracking HCP absenteeism during influenza season, using HCP log (Appendix B); note, this log is different from the linelist used to track COVID-19 test results. • Evaluate causes of absence during influenza season and until at least 1 week after last confirmed influenza case in the facility <p><input type="checkbox"/> Complete _____ (date)</p> | <ul style="list-style-type: none"> • Develop a process for identifying and recording possible introductions of influenza into the facility by ill family members or visitors <p><input type="checkbox"/> Complete _____ (date)</p> |

| ACTIONS | RESIDENTS | HEALTH CARE PERSONNEL (HCP) | FAMILY MEMBERS/VISITORS |
|---|--|--|--|
| <p>5. Develop a plan for monitoring influenza activity in the surrounding community and for testing residents and HCP who develop signs of respiratory tract infection during influenza season</p> | <ul style="list-style-type: none"> • Know which testing methods for influenza and COVID-19, such as multiplex point-of-care (POC) antigen and PCR tests for both influenza and COVID-19, will be available to the facility, when they will be available, and their turnaround time • Plan for a surge supply of testing materials • Develop a plan for testing symptomatic residents for both COVID-19 and influenza throughout the influenza season, even when an outbreak of either pathogen has been confirmed; symptomatic residents who test negative for influenza using a POC antigen test will need confirmatory influenza PCR testing • Conduct influenza testing of symptomatic residents regardless of influenza vaccination status <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Develop a plan for testing symptomatic HCP for both influenza and COVID-19; symptomatic HCP who test negative for influenza using a POC antigen test will need confirmatory influenza PCR testing. • Conduct influenza testing independent of influenza vaccination status • Consider providing a single referral site or performing rapid testing for influenza on site in order to facilitate prompt testing and reporting of results <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Prepare and provide information about the importance of testing for both influenza and COVID-19 when an individual develops respiratory symptoms during the influenza season • Prepare message to refer symptomatic family members to their PCP or clinic for evaluation <p><input type="checkbox"/> Complete _____(date)</p> |

| ACTIONS | RESIDENTS | HEALTH CARE PERSONNEL (HCP) | FAMILY MEMBERS/VISITORS |
|--|---|---|--|
| <p>6. Develop or update influenza infection control precautions and outbreak management plan (see Table 3)</p> | <ul style="list-style-type: none"> • Continue universal masking for source control • Prepare to implement Transmission-based precautions and other infection control measures when needed for single cases and during outbreaks of influenza (see Table 3 for specific recommendations). • Develop a plan for room placement of residents with influenza during the COVID-19 pandemic (see Table 3 for specific recommendations) • Define decision-making process for accepting and transferring residents during influenza season (Table 3) <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Prepare extra supplies that will be needed by HCP throughout the facility during influenza season and throughout the COVID-19 pandemic such as gowns, gloves, masks, N95 respirators, tissues, waterless hand gel for hand hygiene, soap, paper towels • Prepare to conserve PPE if needed during critical supply shortages • Train and remind all HCP of infection control measures that reduce the risk of influenza and COVID-19 spread • Prepare for increased environmental services needs during influenza season • Share outbreak plan with HCP before the beginning of influenza season • Update and review policy for sick HCP and communicate policy to HCP • Identify contacts in the local health jurisdiction and CDPH Licensing & Certification (L&C) district office for outbreak reporting, assistance with vaccine, antiviral, or PPE shortages, and assistance with diagnostic testing <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Provide respiratory hygiene/ cough etiquette information and materials (tissues, supplies for hand hygiene, waste receptacles) at facility entrances year-round; provide signage indicating that masks are required or must be requested • Prepare outbreak communication letter for distribution to families/visitors when outbreak occurs • Prepare outbreak signage for facility entrances. • If visitation is permitted, prepare to use COVID-19 symptom screening forms for family members/visitors for signs/symptoms of ILI • Restrict sick visitors • Prepare outbreak communication for EMS and outside hospitals when transferring residents with influenza and/or COVID-19 for a higher level of care <p><input type="checkbox"/> Complete _____(date)</p> |

| ACTIONS | RESIDENTS | HEALTH CARE PERSONNEL (HCP) | FAMILY MEMBERS/VISITORS |
|---|--|--|---|
| <p>Develop or update influenza infection control precautions and outbreak management plan (see Table 3) (continued)</p> | | <ul style="list-style-type: none"> • Provide weekly updates to HCP on status of influenza activity in facility and in community during influenza season; refer to the CDPH influenza reports (www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Flu-Reports.aspx) during influenza season <p><input type="checkbox"/> Complete _____(date)</p> | |
| <p>7. Develop or update plan for obtaining and using antiviral agents for influenza treatment and chemoprophylaxis</p> | <ul style="list-style-type: none"> • Know which antiviral agents for influenza treatment and chemoprophylaxis will be available • Define indications and mechanism for obtaining antiviral agents for prompt initiation of treatment or chemoprophylaxis • Identify residents with renal impairment that will require dose adjustment of antiviral agents • Together with PCP and/or medical director plan to flag resident charts for dose adjustments of antivirals needed for underlying | <ul style="list-style-type: none"> • Define indications and mechanism for obtaining antiviral agents for HCP chemoprophylaxis and dose adjustments as needed for underlying conditions <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • SNF are not responsible for providing antiviral agents to family members or visitors; refer to PCP or clinic <p><input type="checkbox"/> Complete _____(date)</p> |

| ACTIONS | RESIDENTS | HEALTH CARE PERSONNEL (HCP) | FAMILY MEMBERS/VISITORS |
|--|---|---|--|
| Develop or update plan for obtaining and using antiviral agents for influenza treatment and chemoprophylaxis (<i>continued</i>) | conditions, (for example, renal impairment) <input type="checkbox"/> Complete _____(date) | | |
| 8. Develop process to evaluate experiences after influenza season complete: Illnesses in residents and HCP Successful strategies Barriers Lessons learned Needs for the following season Impact of COVID-19 | <ul style="list-style-type: none"> • Develop process for tracking and evaluating: <ul style="list-style-type: none"> ◦ Number (%) of residents <ul style="list-style-type: none"> ▪ Vaccinated ▪ Ill ▪ Received antiviral treatment or chemoprophylaxis ▪ With influenza and COVID-19 co-infection ▪ Transferred to acute care hospital ▪ Deceased ◦ Number and duration of influenza outbreaks • Successes, challenges • Obtain feedback from residents <input type="checkbox"/> Complete _____(date) | <ul style="list-style-type: none"> • Develop process for tracking and evaluating: <ul style="list-style-type: none"> ◦ Number (%) of HCP <ul style="list-style-type: none"> ▪ Vaccinated ▪ Absent due to ILI ▪ Received antiviral chemoprophylaxis or treatment ▪ With influenza and COVID-19 co-infection • Lessons learned, challenges • Obtain feedback from HCP <input type="checkbox"/> Complete _____(date) | <ul style="list-style-type: none"> • Develop process for tracking and evaluating: <ul style="list-style-type: none"> ◦ Number of suspected introductions of influenza by visitors ◦ Family/visitor understanding, and acceptance of messaging related to influenza in SNF • Lessons learned, challenges • Obtain feedback from families/visitors <input type="checkbox"/> Complete _____(date) |

Table 3. Identifying and Managing Influenza Outbreaks in SNF

| ACTIONS | RECOMMENDATIONS |
|--|--|
| <p>1. Perform daily active surveillance for respiratory illness in residents and HCP (Appendix A, B)</p> <p><input type="checkbox"/> Initiated _____(date)</p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • During influenza season, usually October-March, conduct daily active surveillance for acute upper respiratory illness and pneumonia among residents and HCP until at least 1 week after the last confirmed case of influenza using a line list (contact HAIProgram@cdph.ca.gov for Appendices A and B for examples of line lists) <ul style="list-style-type: none"> ◦ The respiratory illness line lists are different from the line lists used to track serial testing results for COVID-19 (contact HAIProgram@cdph.ca.gov for COVID-19 line list template); continue to use COVID-19 linelist for tracking serial test results ◦ Include individuals with current or recovered COVID-19 who have new onset of respiratory symptoms ◦ Record specific locations of ill residents and HCP assignments and include information about sick HCP and sick visitors, as available • Review line list daily and take actions needed if suspect influenza cases are identified. |
| <p>2. Use diagnostic testing (www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm) for influenza and SARS-CoV-2:</p> <ul style="list-style-type: none"> • Multiplex molecular assays <ul style="list-style-type: none"> ◦ Influenza A, B, and SARS-CoV-2 • Rapid molecular assays • Rapid antigen detection assays | <ul style="list-style-type: none"> • Test residents with onset of respiratory symptoms for both influenza and SARS-CoV-2 at the same time to confirm the diagnosis; contact the local health department for assistance obtaining real-time RT-PCR testing for influenza with rapid turn-around time. • Wherever available, use multiplex influenza A and B and SARS-CoV-2 (Flu SC2) (www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html) tests; multiplex point-of-care (POC) testing for both influenza and SARS-CoV-2 should be considered for rapid evaluation of symptomatic individuals, followed by confirmatory real-time RT-PCR testing for negative results. • The lower sensitivity of antigen detection rapid influenza diagnostic tests (RIDTs) increases the risk of not identifying an influenza case; a negative RIDT in a symptomatic individual should be confirmed with real-time RT-PCR testing for influenza, even when the SARS-CoV-2 test is positive. • The lower sensitivity of POC antigen tests for SARS-CoV-2 increases the risk of not identifying a COVID-19 case; a negative POC antigen test for SARS-CoV-2 in a symptomatic individual should be confirmed with real-time RT-PCR testing for SARS-CoV-2, even when the influenza test (RIDT or otherwise) is positive. • Collect specimens (www.cdc.gov/flu/professionals/diagnosis/index.htm) for influenza testing as follows as directed in the kits used for testing <ul style="list-style-type: none"> ◦ When: 24-72 hours after symptom onset is optimal for influenza |

| ACTIONS | RECOMMENDATIONS |
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| <p>Use diagnostic testing for influenza and SARS-CoV (continued)</p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> ◦ What: For diagnosis of influenza, a nasopharyngeal or combined throat and midturbinate nasal specimens provide the most accurate results ◦ How: Follow directions that accompany the rapid influenza testing kit; use a swab with a synthetic tip (e.g., polyester or Dacron®) and an aluminum or plastic shaft. Specimens collected with swabs made of calcium alginate are NOT acceptable. • Follow the recommended protocol for testing for SARS-CoV-2 or when using a multiplex influenza/SARS-CoV-2 test. Whenever a multiplex Flu SC2 test is used, all residents must receive the <u>patient information sheet</u>. • Add influenza and SARS-CoV-2 test results to the respiratory illness tracking spreadsheets. • If influenza and SARS-CoV-2 (COVID-19) tests on residents with symptoms of a respiratory tract infection are both negative, send specimens for a complete viral respiratory panel that will include other viruses such as adenovirus, respiratory syncytial virus, human metapneumovirus. Coronaviruses detected on those broad respiratory virus panels are not SARS-CoV-2 unless the report says specifically SARS-CoV-2. • The presence or absence of influenza will not change the recommended frequency of routine screening or response testing for SARS-CoV-2. |
| <p>3. Establish presence of an influenza outbreak</p> <p><input type="checkbox"/> Suspected _____(date)</p> <p><input type="checkbox"/> Confirmed _____(date)</p> | <ul style="list-style-type: none"> • An influenza outbreak is defined as at least 2 residents with onset of influenza-like illness within 72 hours of each other AND at least 1 resident with laboratory confirmed influenza, preferably by a molecular assay (RT-PCR preferred). <p><i>Influenza outbreaks might occur separately or concurrently with COVID-19 outbreaks; the presence of a confirmed influenza outbreak does not preclude the possibility of a COVID-19 outbreak, nor does a COVID-19 outbreak preclude the possibility of an influenza outbreak.</i></p> |

| ACTIONS | RECOMMENDATIONS |
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| <p>4. Communicate</p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • As soon as presence of an influenza outbreak is established, notify: <ul style="list-style-type: none"> ◦ Facility Infection Preventionist ◦ Facility administration ◦ Medical director ◦ HCP of facility ◦ Local health department ◦ CDPH L&C district office ◦ Residents, family members, visitors • Distribute influenza outbreak communication letter to residents and their families • Post signs at facility entrances • Remind HCP of their specific tasks according to the influenza outbreak plan. <ul style="list-style-type: none"> ◦ Document assignments and dates initiated and completed |
| <p>5. Implement appropriate Transmission- based precautions (www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm) and other infection control measures for influenza</p> | <ul style="list-style-type: none"> • Emphasize and strictly enforce universal source control with facemask or face covering per COVID-19 guidance and respiratory hygiene/cough etiquette for residents, HCP, family members, and visitors <ul style="list-style-type: none"> ◦ Distribute signs and related materials throughout the facility • Use COVID-19 Transmission-based precautions (www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html): <ul style="list-style-type: none"> ◦ For residents with suspected influenza while test results are pending in a facility without COVID-19 cases, in green (COVID-19 negative, unexposed) areas, and ◦ For residents with suspected or confirmed influenza who are located in red (COVID-19 confirmed) or yellow areas (COVID-19 exposed or observation) • Prioritize single-bed rooms, where available, for residents with suspected influenza pending test results; if single rooms are unavailable, ill residents may remain in their room with spatial separation of at least 6 feet and privacy curtain between residents. |

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| <p>Implement appropriate <u>Transmission- based precautions</u> and other infection control measures for influenza, <i>(continued)</i></p> | <p>When influenza <i>only</i> is confirmed, and the resident is not on COVID-19 transmission-based precautions (not in red or yellow areas):</p> <ul style="list-style-type: none"> ◦ <i>PPE</i> <ul style="list-style-type: none"> ▪ Use Droplet precautions (surgical mask) plus face shield; HCP may continue to wear N95 respirators plus face shield per extended use when caring for residents with influenza ▪ Use an N95 or higher respirator plus face shield for aerosol generating procedures ▪ Add gloves and gown per Standard precautions when contact with blood or body fluids is anticipated ▪ Add Enhanced Standard precautions for high contact activities with residents at risk for MDRO ▪ Perform hand hygiene and ensure facemask and face shield are in place upon entry into the room ▪ Don gowns and gloves upon entry into the room or at any time in the room when exposure to resident secretions or close contact with resident likely ▪ Remove PPE, discard, and perform hand hygiene upon completion of contact with a resident or when leaving the room ▪ Place facemask on resident and have resident perform hand hygiene and don clean clothes if he/she needs to leave room for medical reasons ▪ Continue Droplet Precautions for 7 days after the resident’s illness onset or 24 hours after the resolution of fever or respiratory signs, whichever is longer ◦ <i>Room placement</i> <ul style="list-style-type: none"> ▪ Where single-bed rooms are available, these can be used for residents with confirmed influenza. If single rooms are unavailable, residents with laboratory-confirmed influenza may remain in their room with spatial separation of at least 6 feet and privacy curtain between residents; HCP must change PPE and perform hand hygiene between contact with each resident in multi-bedrooms. ▪ Prioritize cohorting of residents and HCP by COVID-19 status over influenza status, and avoid moving residents with suspected or confirmed influenza between COVID-19 cohorts; for example, do not move a resident with suspected or confirmed influenza from a yellow |

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| <p>Implement appropriate <u>Transmission- based precautions</u> and other infection control measures for influenza, <i>(continued)</i></p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> ▪ (exposed or observation) to a green (unexposed or recovered) area. Residents with suspected or confirmed influenza may be cohorted together within the same COVID-19 zone. ◦ Other <ul style="list-style-type: none"> ▪ Increase frequency of environmental cleaning with focus on high touch surfaces and common areas ▪ Maintain residents on Droplet Precautions in their rooms and restrict from activities in common areas including meals ▪ Plan workflow from asymptomatic to symptomatic residents, always observing hand hygiene and other infection control precautions (such as using gowns and gloves) between resident contacts ▪ Restrict HCP movement from areas of sick residents to well residents, as feasible ▪ Perform repeated audits of HCP adherence to masking for source control, hand hygiene and other infection control precautions and provide immediate feedback to HCP if deficiencies are observed ▪ Report trends in audit results to SNF administrators and leaders ▪ Post de-identified adherence monitoring data in HCP break or charting areas |
| <p>6. <u>Treat with antiviral agents</u> (www.cdc.gov/flu/professionals/antivirals/links.htm) as recommended</p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Treat all residents with confirmed or suspected influenza with the currently recommended antiviral medication (www.cdc.gov/flu/professionals/antivirals/links.htm) as soon after symptom onset as possible, but ideally within 48 hours of onset, for maximum benefit; consider empiric treatment for roommates of residents with confirmed influenza • Do NOT wait for confirmatory test results to initiate treatment unless there is ongoing transmission of SARS-CoV-2 in the facility • Consult resident’s PCP for any necessary dose adjustments in residents with underlying conditions, such as renal impairment • Be aware of the possibility of resistance to the antiviral agent used if resident has continued progressive illness after 72 hours of treatment, if positive for influenza. Consult local health department for information on antiviral resistance and for alternative treatment recommendations. |

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| <p>7. Administer antiviral chemoprophylaxis (www.cdc.gov/flu/professionals/antivirals/links.htm) as recommended</p> <p><input type="checkbox"/> Initiated _____(date)</p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Obtain orders from primary care providers for influenza chemoprophylaxis when it is indicated • As soon as the presence of an influenza outbreak is established, provide influenza antiviral chemoprophylaxis (www.cdc.gov/flu/professionals/antivirals/links.htm) with the currently recommended antiviral agent at the recommended dosage regimen to all non-ill residents in the in the entire facility or in the building affected, regardless of vaccination status. If there is a limited supply of antiviral agents: <ul style="list-style-type: none"> ◦ Give top priority for chemoprophylaxis to roommates and residents on the same floor or unit as residents with active influenza ◦ Prioritize residents in the same building with shared HCP ◦ Consult with medical director and local health department for further guidance • CDC recommends antiviral chemoprophylaxis for at least 2 weeks, and continuing for at least 7 days after the last known case was identified • Obtain influenza testing (in addition to SARS-CoV-2 testing) for any resident who develops signs or symptoms of ILI after receiving an antiviral agent for at least 72 hours and report positive result to the local health department due to possibility of antiviral resistance. Consult local health department for current information on resistance and recommendations for alternative chemoprophylaxis agents • Consider referring HCP for antiviral chemoprophylaxis in any of the following circumstances: <ul style="list-style-type: none"> ◦ If vaccinated and the circulating influenza strain is not well matched with vaccine strains ◦ If recently vaccinated and exposure to influenza occurred within 2 weeks of receiving injectable vaccine; do NOT give antiviral chemoprophylaxis until at least 14 days after the intranasal live- attenuated (LAIV) vaccine was received ◦ HCP who were not vaccinated due to a medical contraindication or are at high risk for complications of influenza due to age or medical conditions ◦ At high risk for complications of influenza due to age or medical conditions |
| <p>8. Define process for accepting and transferring residents</p> | <ul style="list-style-type: none"> • During the times when SARS-CoV-2 is co-circulating, acceptance and transfer policies will be determined primarily by the processes established for COVID-19 |

| ACTIONS | RECOMMENDATIONS |
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| <p>Define process for accepting and transferring residents (<i>continued</i>)</p> <p><input type="checkbox"/> Initiated _____(date)</p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • When planning to accept or transfer of residents who still require isolation for influenza, evaluate the resident’s COVID-19 exposure status and test for SARS-CoV-2 as appropriate before movement of resident • Before transferring residents with suspected, probable or confirmed influenza to other departments or facilities, communicate all relevant information to transport personnel and other HCP accepting the resident in another department or facility. <ul style="list-style-type: none"> ◦ Information should include test results, date of illness onset, antiviral treatment, and needed infection control precautions • SNF must develop plans for managing new admissions and providing care for residents with influenza who require Droplet Precautions, while still maintaining capacity to provide care safely for other residents • Do not place new admissions on units with symptomatic residents • Do not transfer asymptomatic residents to units with residents who have active influenza • Consult with the medical director and local health department to determine if the facility should be closed to new admissions due to an influenza outbreak <ul style="list-style-type: none"> ◦ Determine the duration of closures or limiting admissions for each situation individually. Consider the effectiveness of the influenza control measures implemented within the facility. Facility-wide and prolonged closures are not necessary if transmission is controlled and there is an unaffected location available where new admissions can be placed • Hospitalized patients with influenza should be discharged when they no longer require the level of care provided in an acute care setting. Discharge from hospital and admission or re-admission to SNF should not be determined by the period of potential virus shedding or recommended duration of Droplet Precautions • Ensure that new or returning residents with acute respiratory illness are evaluated medically by the SNF to determine room placement and needed infection control precautions • Develop plan to implement Droplet Precautions for returning residents who were hospitalized with influenza and are ready clinically for discharge from the acute care setting, but are still within the 7 day or longer period of required Droplet Precautions |

| ACTIONS | RECOMMENDATIONS |
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| <p>9. Manage healthcare personnel (HCP)</p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Encourage well HCP who have not received annual influenza vaccine to accept vaccine. <ul style="list-style-type: none"> ◦ Provide at no cost (www.dir.ca.gov/title8/5199.html) and at a reasonable time and place (www.dir.ca.gov/title8/5199.html) for employees during working hours. • Instruct HCP who develop respiratory symptoms when away from facility to contact supervisor, not to come to work, and to obtain testing for both COVID-19 and for influenza. <ul style="list-style-type: none"> ◦ If influenza is the only respiratory tract infection (SARS-CoV-2 test negative), HCP should follow the facility policy for return to work for influenza – at minimum do not return to work until afebrile >24 hours without antipyretic treatment and with improvement in respiratory symptoms or no earlier than 5 days after illness onset • Instruct HCP who develop respiratory symptoms during the work shift to <ul style="list-style-type: none"> ◦ Ensure that facemask is in place, inform supervisor and promptly leave the facility ◦ Obtain COVID-19 and influenza diagnostic tests • Offer or refer ill HCP for influenza testing and empiric antiviral treatment as described above in #7. |
| <p>10. Manage visitors</p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Follow the policy for visitors during the flu season that has been implemented by the facility for prevention of transmission of COVID-19. If there are no COVID-19 restrictions, then implement visitor restrictions for influenza as follows: <ul style="list-style-type: none"> ◦ Implement screening of visitors for signs of acute respiratory illness and exclude symptomatic visitors • Educate and encourage influenza vaccination for visitors • Encourage universal masking or wearing facial coverings for source control/respiratory hygiene/cough etiquette • Instruct visitors to use a facemask for source control and for their own protection when in the room of a resident on Droplet precautions • Consider implementing visitor restrictions, such as limiting the number of visitors and excluding young children, if not already in place for COVID-19. |

| ACTIONS | RECOMMENDATIONS |
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| <p>11. Review vaccine records</p> <p>a. Influenza vaccine (residents, HCP)</p> <p>b. Pneumococcal vaccines (residents)</p> <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Verify that the influenza vaccination plan from Table 1 has been implemented • Encourage and vaccinate residents and HCP who declined previously. Focus on areas with groups of unimmunized individuals and the highest risk residents, (for example, those who require ventilator therapy or have complex underlying medical conditions) • Ensure that residents admitted during an outbreak have received pneumococcal vaccines as per current ACIP recommendations (www.cdc.gov/mmwr/preview/mmwrhtml/mm6434a4.htm) and schedule reminders for providing any additional indicated doses |
| <p>12. Determine end of influenza outbreak</p> <p><input type="checkbox"/> Completed _____(date)</p> | <ul style="list-style-type: none"> • If no new cases of influenza have been identified for at least 1 week after the last confirmed case of influenza, it is reasonable to consider the influenza outbreak over and resume new admissions to previously affected units, or as determined by COVID-19 status. • Consult the local health department to assist in determining the outbreak endpoint • As soon as end of outbreak is confirmed, notify: <ul style="list-style-type: none"> ◦ Facility Infection Preventionist, administration, medical director ◦ HCP of facility ◦ Local health department ◦ L&C district office ◦ Residents, family members, visitors |
| <p>13. Perform assessment of outbreak control measures:</p> <ul style="list-style-type: none"> • Successful strategies • Barriers • Lessons learned • Needs for the following season • Impact of COVID 19 <p><input type="checkbox"/> Complete _____(date)</p> | <ul style="list-style-type: none"> • Upon completion of the influenza season, evaluate outbreak control processes and experiences: <ul style="list-style-type: none"> ◦ Number (%) of residents vaccinated; ill; received anti-viral treatment or chemoprophylaxis; transferred to acute care hospitals; and deceased ◦ Number and duration of outbreaks ◦ Number (%) vaccinated and ill HCP ◦ Number (%) of residents, no. (%) of HCP with co-infection with influenza and COVID 19 ◦ Successes ◦ Challenges • Obtain feedback from residents, HCP, families/visitors |

GLOSSARY

Aerosol-generating procedures (AGPs): (www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control) Procedures that generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking, or breathing. Examples of AGPs include: nebulizer treatments, sputum induction, open suctioning of the airway, endotracheal intubation, cardiopulmonary resuscitation.

Cloth face covering (www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html): Textile (cloth) covers that are intended for source control. They are not personal protective equipment (PPE); however, cloth face coverings may provide minimal protection to the wearer against respiratory viral particles when in the community.

Cohorting: The practice of grouping patients infected, colonized with or exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. Individuals who are suspected to have the same infection (for example, influenza) may be cohorted during an outbreak without confirmatory testing; therefore, it is important to treat each bed space in a cohort separately, performing hand hygiene and changing PPE between contacts with individuals in the cohort. However, during the COVID-19 pandemic, all individuals with symptoms of respiratory tract infection should be tested for both influenza and SARS-CoV-2 and individuals with influenza should remain in their designated COVID-19 category. Cohorting also refers to assigning the same staff members to care for individuals in one cohort of residents and not other resident cohorts within a work shift.

COVID-19: Coronavirus infectious disease caused by the SARS-CoV-2 that first emerged in December 2019 and caused a worldwide pandemic. The case definition (ndc.services.cdc.gov/) of COVID-19 as of August 5, 2020 is:

1) *no other etiology* identified;

2) ***clinical criteria***: a) at least **two** of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, nausea or vomiting, diarrhea, fatigue, congestion or runny nose or b) any **one** of the following symptoms: cough, shortness of breath, difficulty breathing, new olfactory disorder, new taste disorder or c) severe respiratory illness with at least **one** of the following: clinical or radiographic evidence of pneumonia or acute respiratory distress syndrome (ARDS);

3) ***laboratory criteria: confirmatory***: positive RT-PCR test in clinical or post-mortem specimen; ***presumptive***: positive antigen in a respiratory specimen; ***supportive***: detection of specific antibody in serum, plasma, or whole blood or detection of specific antigen by immunocytochemistry in an autopsy specimen;

4) ***epidemiologic linkage***: one or more of the following exposures in the prior 14 days: **close contact** with a confirmed or probable case of COVID-19 disease or member of a **risk cohort** as defined by public health authorities during an outbreak.

[Diagnostic tests for influenza](http://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm) (www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm): There are three types of laboratory tests used for diagnosis of influenza on respiratory tract specimens from a nasopharyngeal (NP) swab or combined midturbinate nasal and throat swabs:

- 1) Rapid diagnostic influenza test (RIDT)
 - a. Widely available, detects influenza antigens with results within 15 minutes
 - b. Sensitivity 50-70%, specificity 90-95%; therefore, 30-50% of influenza cases will not be detected
 - c. Some RIDT will not distinguish influenza subtypes A and B
- 2) Molecular assays including real-time reverse transcription polymerase chain reaction (real-time RT-PCR); real-time RT-PCR is the preferred test.
 - a. Results available in 1-8 hours; rapid molecular assays produce results in 15-30 minutes
 - b. Very high sensitivity
 - c. Single or multiplex; detects influenza subtypes (A and B)
 - d. Preferred test to confirm the presence of an outbreak
- 3) Viral culture
 - a. Not readily available and rarely performed
 - b. Results available in 1-10 days

CDC has summarized the **[Multiplex Assays Authorized for Simultaneous Detection of Influenza Viruses and SARS-CoV-2 by FDA](http://www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html)** (www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html) available at the time of posting of this document.

[Droplet Precautions](http://www.cdc.gov/flu/professionals/infectioncontrol/lfc-facility-guidance.htm) (www.cdc.gov/flu/professionals/infectioncontrol/lfc-facility-guidance.htm): A set of practices to prevent transmission of pathogens through close respiratory or mucous membrane contact with respiratory secretions. A single patient room is preferred for patients who require Droplet Precautions. When a single patient room is not available, assess the risks associated with other patient placement options such as cohorting or keeping the patient with an existing roommate. For patients in multi-bedrooms, maintain spatial separation of at least 6 feet and draw the privacy curtain between patient beds. Health care personnel don a surgical mask upon room entry (a respirator is not necessary). Facemasks should be changed when wet and between patient contacts. Residents on Droplet Precautions who must be transported outside of the room should wear a mask if tolerated and follow respiratory hygiene/cough etiquette.

[Enhanced Standard Precautions](#) (PDF) (www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/Enhanced-Standard-Precautions.pdf): The use of gowns, gloves and frequent hand hygiene, based on resident characteristics that increase the risk of colonization and transmission of multi-drug resistant organisms (MDRO); for example, total dependence on others for assistances with activities of

daily living (ADLs), presence of indwelling devices, ventilator dependence, presence of wounds, habitual incontinence and frequent soiling with urine/stool. If there is suspected or confirmed ongoing transmission of an MDRO within a facility, Contact Precautions is recommended for individuals known to be colonized or infected with the MDRO.

Eye protection: A properly fitting device to shield the eyes and conjunctivae from respiratory viral particles. Eyeglasses do NOT provide sufficient protection. Appropriately fitted, indirectly-vented **goggles** or a **face shield** with crown and chin protection that wraps around the face to the point of the ear to reduce the likelihood that a splash could go around the edge of the shield and reach the eyes can be used for eye protection. Face shields are preferred for the increased facial coverage. A face shield without a mask does not provide adequate source control.

Facemask

(www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/PersonalProtectiveEquipment/ucm055977.htm): A loose-fitting, disposable device that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. Facemasks are not to be shared and may be labeled as surgical, isolation, dental or medical procedure masks.

Facemasks may come with or without a face shield. If worn properly, a facemask is meant to help block large-particle droplets, splashes, sprays or splatter that may contain germs (viruses and bacteria), keeping it from reaching the mouth and nose of the person wearing it. Facemasks also help contain and reduce exposure of an individual's saliva and respiratory secretions to others. Facemasks are not intended to be used more than once. If the mask is damaged, soiled, or wet, or if breathing through the mask becomes difficult, remove it, discard it safely, and replace it with a new one.

Hand hygiene (www.cdc.gov/handhygiene/): A general term that applies to any one of the following:

- Handwashing with plain (non-antimicrobial) soap and water);
- Antiseptic hand wash (soap containing antiseptic agents and water);
- Antiseptic hand rub (waterless antiseptic product, most often alcohol-based, rubbed on all surfaces of hands); or
- Surgical hand antisepsis (antiseptic hand wash or antiseptic hand rub performed preoperatively by surgical personnel to eliminate transient hand flora and reduce common hand flora).

Healthcare personnel (HCP) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>) also referred to as healthcare workers (HCWs): All paid and unpaid persons who work in a healthcare setting; for example, any person who has professional

or technical training in a healthcare-related field and provides patient care in a health care setting or any person who provides services that support the delivery of health care such as dietary, housekeeping, engineering, maintenance personnel.

Influenza-like illness (ILI): Fever (oral or equivalent temperature of 100 °F or greater) and cough and/or sore throat in the absence of a known cause other than influenza. This definition is used for influenza surveillance worldwide.

Influenza Outbreak within a residential facility: At least two residents with onset of influenza-like illness (ILI) within 72 hours of each other AND at least one resident has laboratory confirmed influenza by a molecular test (RT-PCR preferred).

Isolation (www.cdc.gov/quarantine/): Separation of infected individual from others; applies to infection with both influenza viruses and SARS-CoV-2 in this document. Recommendations for use of Transmission-based precautions and other infection control practices are determined by the route(s) of transmission of the specific suspected or proven infectious agents.

Long-term care facilities: Institutions, such as skilled nursing facilities (SNF), nursing homes and facilities that provide health care to people including children, who are unable to manage independently in the community. This care may represent custodial or chronic care management or short-term rehabilitative services. In California, long term care facilities are licensed by CDPH Licensing and Certification (L&C), including skilled nursing facilities (SNF), congregate living health facilities, intermediate care facilities (ICF), ICF/developmentally disabled (DD), ICF/DD Continuous Nursing, and ICF/DD – Habilitative, and ICF/DD – Nursing

Personal protective equipment (PPE) (PDF) (www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf): A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, goggles, face shields, and gowns. See [recommended COVID-19 PPE](#) (PDF) (www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-74-Attachment-01.pdf) and [recommendations for influenza PPE](#) (www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm) for details.

Quarantine (www.cdc.gov/quarantine/): People who have been exposed to an infectious disease are separated from others and restricted from movement until it is known that they did not acquire the infection (usually for the incubation period); applies to individuals exposed to COVID-19 in this document. In SNF, COVID-19-exposed individuals are often placed in [“yellow” zones](#)” (PDF) (www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-74-Attachment-01.pdf) and there are specific recommendations for PPE use when in contact with for COVID-19 exposed individuals.

Respirators (www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html): A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents, including those in aerosols), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare. Some examples include N95 respirators, elastomeric respirators, and powered air-purifying respirators (PAPR). Consult **CalOSHA** (PDF) (www.dir.ca.gov/dosh/Cal-OSHA_influenza_guidance_11-5-10.pdf) standards for specific regulations pertaining to respirators for seasonal influenza.

Respiratory hygiene/ cough etiquette

(www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm): A combination of measures to minimize the transmission of respiratory pathogens via droplet or airborne routes in healthcare settings. Respiratory hygiene/cough etiquette includes:

- Covering the mouth and nose during coughing and sneezing.
- Using tissues to contain respiratory secretions with prompt disposal into a no-touch receptacle.
- Turning the head away from others and maintaining spatial separation, ideally ≥ 6 feet, when coughing.
- Performing hand hygiene after contact with respiratory secretions or items contaminated with respiratory secretions.
- Offering a facemask to persons who are coughing to decrease contamination of the surrounding environment.

SARS-CoV-2: Severe acute respiratory syndrome-coronavirus-2, the virus that causes coronavirus infectious disease-19 (COVID-19).

Source Control (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html):

Use of cloth face coverings or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

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Additional Resources

- [Preparing for the 2020-2021 Flu Season](http://www.cdc.gov/flu/) (www.cdc.gov/flu/)
- [Coronavirus \(COVID-19\)](http://www.cdc.gov/coronavirus/2019-nCoV/index.html) (www.cdc.gov/coronavirus/2019-nCoV/index.html)
- [CDPH Guidance for COVID-19](http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx) (www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx)
- [Influenza Antiviral Medications](http://www.cdc.gov/flu/professionals/antivirals/index.htm) (www.cdc.gov/flu/professionals/antivirals/index.htm)
- [Overview of Influenza Testing Methods](http://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm) (www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm)
- [Similarities and Differences between Flu and COVID-19](http://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm) (www.cdc.gov/flu/symptoms/flu-vs-covid19.htm)
- [Influenza Vaccination Coverage among Health Care Personnel — United States, 2018–19 Influenza Season](http://www.cdc.gov/flu/fluview/hcp-coverage_1819estimates.htm) (www.cdc.gov/flu/fluview/hcp-coverage_1819estimates.htm)
- [Multiplex Assays Authorized for Simultaneous Detection of Influenza Viruses and SARS-CoV-2 by FDA](http://www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html) (www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html)