Respiratory Outbreak Checklist For Behavioral Health Residential Treatment Programs and Other Similar Congregate Living Facilities such as Group Homes, Crisis Residential, Substance Use Treatment/Detox

Managing Flu/RSV/COVID-19 in a high-risk congregate living facilities benefit 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 client 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
Reporting Requirements	☐ 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 daily by 10:00am newly identified cases using Sharepoint	☐ 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), emailing a complete Confidential Morbidity Report (CMR), Subject: COVID-19 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 daily by 10:00am newly identified cases using Sharepoint
Outbreak Monitoring	☐ 7 Days	☐ 14 Days

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Outbreak Definition	• One case of laboratory-confirmed respiratory pathogen, OR • A cluster of respiratory illness (≥ 2 cases) within a 72-hour (3 day) period **Influenza-like Illness (ILI)** New onset of fever (100.0 °F [37.8 °C] or greater) in addition to one or more of the following: cough and/or sore throat. Individuals can also present with some of the following symptoms: chest discomfort, chills, fatigue, general weakness, headache, muscle aches (myalgia), runny nose, and/or confusion.	**Confirmed Outbreak:** ≥3 cases (staff and/or clients) in a 7-day period.
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 clients 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 clients for COVID-19 symptoms ☐ Passive surveillance for all visitors
Testing	☐ (November-April) Regardless of vaccination status, test symptomatic clients 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/clients for COVID-19. ☐ Test exposed staff/clients between days 5 and 6 after exposure. Then continue to monitor for symptomatic staff and residents until no new cases are identified over the 7-day period. ☐ Additionally, due to the potential for rapid and wide transmission within congregate settings, facility-wide or broader testing beyond immediate close contacts may be appropriate in response to an identified case of COVID-19 infection in the facility, please review with Public Health. ☐ Employee testing is recommended by CalOSHA for 14 days https://www.dir.ca.gov/title8/3205_1.html

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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 with transmission-based precautions signs placed on door. - Implement **Airborne and Contact Precautions** for residents who have COVID-19 like symptoms with testing pending.
Isolation and Quarantine	- **Isolate** client 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 client 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.	- Clients who test positive (symptomatic or asymptomatic) should be isolated, regardless of their vaccination status until the following conditions are met: • At least **5 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 10 days for individuals who are unable to wear a mask when around others for a total of 10 days • Clients who are close contacts and asymptomatic do not need to be quarantined, restricted to their room, or cared for by facility staff using the PPE required for the care of a person in care with COVID-19. Facilities can follow CDC Homeless and Detention Guidance
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).	- Isolate for 5 days. - Isolation can end after day 5 if: - At least 24 hours have passed since resolution of fever without the use of fever-reducing medications; AND - Able to wear a well-fitting mask for a total of 10 days. - Quarantine: No work restriction with **negative** diagnostic test between days 3 and 5. - Employees who are not tested within 3-5 days after a close contact must be excluded from the workplace starting

		from the date of the last known contact until the return-to-work requirements for COVID-19 cases are met.
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Visitation	Visitation is allowed during an outbreak. Visitors are required to wear the PPE that is required for the client 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:*** ○ Clients who are not in isolation may eat in the same room without physical distancing, regardless of vaccination status. ○ Clients who are not in isolation may participate in group/social activities together without face masks or physical distancing, regardless of vaccination status. ○ Clients who have been exposed should not participate in communal dining since masks must be removed during eating and drinking. ➢ Clients who have been exposed, must wear a mask for a total of 10 days following the most recent exposure, even during group activities.

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Admissions and Readmissions	Facility can stay open for new admissions unless testing determines ongoing transmission. If an outbreak is confirmed, new admissions may still be allowed but should first be reviewed with Public Health (PH) to ensure appropriate infection control is in place. 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.	Facility can stay open for new admissions unless testing determines ongoing transmission. If an outbreak is confirmed, new admissions may still be allowed but should first be reviewed with Public Health (PH) to ensure appropriate infection control is in place. 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 clients who are transported out of facility for severe illness and/or death. Complete the transfer form: **Interfacility Transfer Communication Form – Abbreviated (PDF)**	

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PPE *Any person with ILI symptoms and lab results are pending, place	**Place symptomatic clients 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**	**Place symptomatic clients 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**

the client on Standard, Airborne, and Contact precautions	Droplet- **Sample Isolation Sign**	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	Masking continues to be important in settings where vulnerable people are residing or being cared for and is increasingly important when the risk for transmission increases in the community. High-risk settings should develop and implement their own facility-specific plans based on their community, client population, and other facility considerations incorporating CDPH and CDC recommendations. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Respiratory-Viruses/When-and-Why-to-Wear-a-Mask.aspx	
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
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.