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To: Wisconsin Local Health Departments, Tribal Health Agencies, Infection Preventionists, Division of Quality Assurance, Wisconsin DON Council, Wisconsin LTC Medical Directors Association, Wisconsin Health Care Association, LeadingAge Wisconsin, Wisconsin Assisted Living Association

From: Ryan Westergaard, MD, PhD, MPH
Chief Medical Officer and State Epidemiologist

Thomas Haupt, MS
Respiratory Disease Epidemiologist

Prevention and Control of Acute Respiratory Illness Outbreaks in Long-Term Care Facilities

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Summary

This memo is intended as guidance to medical and administrative staff of long-term care facilities (LTCF) including skilled nursing facilities (SNFs), community based residential facilities (CBRFs), and residential care apartment complexes (RCACs) in Wisconsin. With regards to SARS-CoV-2/COVID-19, emerging information about the disease and changes in community spread may necessitate rapid changes to guidance. Refer to CDC or DHS websites for the most up-to-date information.

Requirements for the timing of reporting, once the disease or condition is recognized or suspected, vary by disease. In addition to the information listed below, general reporting requirements are described in [Wis. Stat. ch. 252\(link is external\)](#) Communicable Diseases. The specific reporting requirements are described in [Wis. Admin Code. ch. DHS 145\(link is external\)](#) Control of Communicable Diseases. Confirmed or suspected outbreaks are a Category 1 Disease meaning they shall be reported IMMEDIATELY by telephone to the patient's local health officer, or to the local health officer's designee, upon identification.

Definition of Terms Used

Acute respiratory illness (ARI) is defined as illness characterized by any two (2) of the following:

- Fever*
- Cough (new or worsening, productive or nonproductive)
- Rhinorrhea (runny nose) or nasal congestion
- Sore throat
- Myalgia (muscle aches) greater than the resident's norm
- Shortness of breath or difficulty breathing
- Low SpO2

- New loss of taste or smell

***Fever may be difficult to determine among elderly residents. Therefore, the definition of fever used for ARI is defined as temperature two degrees (2°F) above the established baseline for that resident.**

Pneumonia is defined as radiographic evidence of **new or increased** pulmonary infiltrates, usually accompanied by fever. It is strongly recommended that all clinically diagnosed pneumonia be followed with radiographic testing.

A suspect **Non-COVID-19 Respiratory Disease Outbreak** in a LTCF is defined by the Division of Public Health (DPH) as three or more residents and/or staff from the same unit with illness onsets within 72 hours of each other and who have:

- Pneumonia, or
- ARI, or
- Laboratory-confirmed viral or bacterial infection (including influenza)

A suspect **COVID-19 Respiratory Disease Outbreak** in a LTCF is defined by DPH as one or more residents and/or staff (who worked during their infectious period) within a facility who have a case of COVID-19.

Prevention and Control of Respiratory Outbreaks in LTCF

Laboratory Testing

When an outbreak of acute respiratory illness (COVID-19 or other viral respiratory disease) is suspected, consider collecting nasopharyngeal swabs (preferred) or oropharyngeal swabs from residents or staff and, **with DPH approval**, send specimens to the Wisconsin State Laboratory of Hygiene (WSLH). The WSLH will test any symptomatic resident or staff of SARS-CoV-2. A select amount may be tested for influenza and respiratory pathogens panel (RPP) testing. Testing will be done free of charge.

- Specimens should be collected within five days after the onset of illness and placed in viral transport media to assure optimal test results.
- If specimens will be submitted to the WSLH, include the WSLH lab requisition form.
- Facilities may choose to have clinical specimens tested at a laboratory other than the WSLH, however, fee-exempt testing cannot be offered for tests performed at these laboratories.
- Due to possible false positive results when using rapid influenza tests, especially when testing occurs during periods of low influenza activity, confirmatory testing of positive rapid test results using RT-PCR or viral culture should be performed.
- With DPH approval, the specimens may also be tested for other respiratory viruses.
- If test results confirm influenza or SARS-CoV-2 within a facility, no further testing will be performed unless the resident has an atypical presentation of illness or is not responding to treatment.
- A negative test result does not rule out viral infection or the existence of an outbreak.
- If SARS-CoV-2 is identified, consider point-prevalence screening of impacted units or the entire facility.

Point-Prevalence Screening for COVID-19

Nursing Homes should follow any testing mandates issued by the Centers for Medicare and Medicaid Services. Other facilities with confirmed COVID-19 should test residents and/or staff for COVID-19 based on the current recommendations on the [DHS website](#). Testing and supplies are provided for fee-exempt testing through WSLH or participating private or clinical labs. More information about requesting testing supplies can be found on the [DHS COVID testing website](#).

Antiviral Treatment and Prophylaxis during Influenza Outbreaks

Influenza antiviral prophylaxis may prevent further spread of infection during outbreaks of influenza in a LTCF. Ideally, within 48 hours of the **onset of illness**, treat residents with confirmed or suspect cases of influenza with oseltamivir (Tamiflu®), zanamivir (Relenza®), or baloxovir (Xofluza®) to reduce the severity and shorten the duration of illness. At the discretion of a clinician, treatment with oseltamivir (Tamiflu®) or zanamivir (Relenza®) can be initiated more than 48 hours after the onset of illness.

Because of identified resistance, adamantanes should not be used to treat or prevent cases of influenza A. Both pd2009/H1N1 and seasonal H3N2 viruses are resistant to adamantanes (amantadine, rimantadine, Symadine®, Symmetrel®, Flumadine®). Adamantanes are not effective against influenza B. CDC influenza antiviral recommendations can be found at: [cdc.gov/flu/professionals/antivirals/summary-clinicians.htm](https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm).

When cases of influenza have been confirmed in a facility, antiviral prophylaxis should be offered to:

- All residents regardless of vaccination status,
- All unvaccinated employees, and
- Those employees vaccinated less than two weeks before the cases were identified.

If exposure is limited to a specific wing or residential area, antiviral prophylaxis use can be limited to residents and unvaccinated staff in those areas.

Only oseltamivir (Tamiflu®) and zanamivir (Relenza®) can be used for antiviral prophylaxis to prevent influenza A and B infection. Once initiated, antiviral prophylaxis should continue for a minimum of two weeks, and continue up to seven days after the last known case was identified.

NOTE: For a resident with a known creatinine clearance of 10-30 mL per minute, a reduction of the treatment dosage of oseltamivir and in the prophylaxis dosage is recommended. Refer to CDC recommendations. It is **not necessary** for residents to have their creatinine clearance checked prior to receiving oseltamivir treatment or prophylaxis.

Infection Control

Caregivers and visitors should adhere to the appropriate precautions when in the presence of a resident with suspected or confirmed respiratory illness. Until the cause(s) of an ARI outbreak is determined facilities should use both droplet and contact precautions, in addition to standard precautions. This includes eye protection (goggles and face shield).

Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. In contrast to contact transmission, respiratory droplets carry and transmit infectious pathogens when they travel directly from the respiratory tract of the infectious individual to susceptible mucosal surfaces of the recipient, generally over short distances (within 6 feet).

- Health care personnel should wear a surgical mask for close contact with an ill resident. A respirator is not necessary unless engaging in aerosolizing generating such as nebulizer treatment procedures. The mask is generally donned immediately prior to room entry.
- Health care personnel should wear surgical masks for all patient care activities or when around other staff members.
- Residents on droplet precautions who must be transported outside of their room should wear a surgical or cloth mask if tolerated and practice respiratory hygiene/cough etiquette.

Contact Precautions apply when the presence of discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission.

- Health care staff should wear a gown and gloves for all interactions that may involve direct contact with the resident or potentially contaminated areas in the environment.
- Don PPE immediately prior to room entry and discard before exiting the room to contain pathogens implicated in direct transmission or indirect transmission through environmental contamination.

CDC Recommended Precautions for Common Respiratory Viruses

	Droplet Precautions	Contact Precautions	Airborne Precautions*
Influenza	√		
COVID-19/SARS-CoV-2	√	√	√
RSV	√	√	
Parainfluenza		√	
Rhino/Enterovirus	√		
Coronavirus		√	
Human Metapneumovirus		√	
Adenovirus	√	√	

*Airborne precautions (e.g. N95 respirator and negative airflow rooms) should be used for patients with confirmed or suspected COVID-19 during aerosol generating procedures.

When test results fail to identify an etiologic agent, ill residents should continue to be placed on contact and droplet precautions.

Duration of Contact and Droplet Precautions

When a resident has confirmed or suspected influenza, the resident should remain on droplet precautions for seven days after onset of illness or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.

When a resident has confirmed or suspected COVID-19, the resident should remain on droplet and contact precautions until conditions for discontinuation* are met:

- At least 24 hours since recovery, defined as resolution of fever without the use of fever-reducing medications AND improvement in respiratory symptoms; AND

- At least 10 days have passed since onset of symptoms.

Some people with severe illness OR who are severely immunocompromised should be maintained on droplet and contact precautions until at least 24 hours since recovery AND at least **20 days have passed since symptom onset.*

For other respiratory illnesses, the resident should remain on appropriate precautions for the duration of illness, defined as 24 hours after resolution of fever without the use of fever-reducing medications and without respiratory symptoms (see ARI symptoms above). Criteria for determining ARI among staff or residents should focus on whether cough is a new or worsening symptom. For discontinuation of droplet or contact precautions, exclude cough as a criterion unless the cough produces purulent sputum. In many cases, a non-infectious post-viral cough may continue for several weeks following resolution of other respiratory symptoms.

Resident Room Assignments during an Outbreak

If possible, any resident who is ill with symptoms of ARI should stay in a private room. Decisions by medical and administrative staff regarding resident placement should be made on a case-by-case basis. In determining resident placement, consider:

- Balancing the risk of infection to other residents in the room.
- The presence of risk factors that increase the likelihood of transmission within the facility.
- The potential adverse psychological impact on the infected resident.

When a single-resident room is not available, ill residents can be placed in a multi-bed room following consultation with infection control personnel to assess risks associated with resident placement options (e.g., cohorting, keeping the resident with an existing roommate). Spatial separation of six feet or more and drawing the curtain between resident beds is especially important for residents in multi-bed rooms.

The LTCF may consider allowing a resident with a cough to leave their room while wearing a surgical mask if the resident's understanding and compliance with mask use will minimize the risk of infection to other residents. Non-ill residents should not be confined or restricted to their rooms during a non-COVID-19 outbreak.

Outbreaks of COVID-19 may necessitate the cohorting of patients with COVID-19 to a dedicated floor, unit, or wing, with dedicated staff.

Visitors – During respiratory outbreaks including COVID-19

A facility with a confirmed or suspected respiratory outbreak, including COVID-19, should immediately restrict all visitation except for certain compassionate care reasons, and essential visitors.

- Post signs at the entrances to the facility advising that only limited essential visitors may enter the facility.
- Send letters or emails to families advising that no visitors will be allowed.
- Use of alternative methods for visitation (e.g., video conferencing) should be facilitated by the facility.

Decisions about compassionate care situations should be made on a case-by-case basis, which should include careful screening of the visitor for fever or symptoms consistent with COVID-19. Those with symptoms should not be permitted to enter the facility. Any visitors who are permitted must wear a cloth face covering while in the building and restrict their visit to the resident's room or other location

designated by the facility. They should also be reminded to frequently perform hand hygiene. Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.

Temporary Halting of New Admissions to an LTCF – Non-COVID Outbreaks

Upon recognition of a confirmed or suspected outbreak of respiratory illness, the facility may consider restricting new admissions to the facility. If the outbreak is confined to a specific unit, wing, or floor, the facility may consider allowing new admissions to other units, wings, or floors not affected by the outbreak. Restriction of new admissions to the facility or the affected unit, wing, or floor may be considered until one week after the illness onset of the last confirmed or suspected case for non-COVID outbreaks.

Temporary Halting of New Admissions to an LTCF – COVID-19 Outbreaks

When a suspected or confirmed case of COVID-19 is identified in a facility, the [CDC recommends](#) temporary restriction of admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented. If it is determined, after the identification of potential close contacts and the evaluation of infection control practices, that the outbreak is confined to a specific unit, wing, or floor, the facility may consider allowing new admissions to other units, wings, or floors not affected by the outbreak. This should only be considered if the facility has the adequate staff, PPE, and available accommodations on units/wings/floors not affected by the outbreak, to care for a new admission based on current recommendations. A situation where this may be appropriate is when a single positive staff member only worked on one wing during their infectious period.

To limit the spread of disease during an outbreak within the facility, restrict new admissions for potentially affected wings/units/floors for:

- **28 days** after the last confirmed or suspected case worked or was placed in isolation AND the facility has the adequate staff, PPE, and available accommodations on units/wings/floors not affected by the outbreak, to care for new admissions based on current recommendations; OR
- **14 days** after the last confirmed or suspected case worked or was placed in isolation AND the facility completed a round of testing of those potentially exposed in the facility (including staff and residents) after the 14 days and did not identify any additional cases AND the facility has the adequate staff, PPE, and available accommodations on units/wings/floors not affected by the outbreak, to care for new admissions based on current recommendations.

There may also be extenuating circumstances where admissions to an impacted area of the facility are needed. Examples include situations where all area facilities with the necessary level of care have an outbreak or the impacted part of the facility is the only area that can provide the needed level of care, such as a ventilator unit. If a facility has a circumstance that requires admissions to the affected unit, they should reach out to their local health department to discuss this option as part of their ongoing outbreak management.

Management of New Admissions or Readmissions

When the facility is able to accept new admissions or is readmitting a resident, they should be placed in a single-person room or in a separate observation area so the resident can be monitored for symptoms of COVID-19.

- A negative test prior to admission does not replace the need for a 14 day quarantine.

- Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission.
- All recommended PPE used for a COVID-19 positive resident (face shield, facemask or N95, gloves, and gown) should be worn by staff entering a room of patient under quarantine.

Readmission of Current Residents

The facility should consider the readmission of ill residents (e.g., those returning from a hospital stay), provided that upon return to the facility, the appropriate infection control measures are implemented to protect the health of other residents. Laboratory testing of residents for ARI (including influenza and COVID-19) prior to readmission is not recommended and should not be used as criterion for readmission to the facility.

Screening of Staff – COVID-19

Screen all staff at the beginning of their shift for fever and symptoms of COVID-19.

- Actively take their temperature and document absence of shortness of breath, new or change in cough, sore throat, new loss of taste or smell, and muscle aches.
- Fever is defined as either measured temperature $\geq 100^{\circ}\text{F}$ or subjective fever.
- Prioritize testing of staff with symptoms.

Exclusion of Staff with Non-COVID-19 ARI

Staff with ARI who are tested and do not have COVID-19 should be excluded from work until at least 24 hours after they no longer have a fever (without the use of fever-reducing medicines such as acetaminophen or ibuprofen). If symptoms such as cough and sneezing are still present, staff should wear a surgical mask during resident care activities. Support and flexibility should be given to staff to encourage them to stay home from work – try to reduce logistical barriers and financial hardship to the extent possible.

Exclusion of Staff with COVID-19

Staff with confirmed COVID-19 and staff with ARI who are not tested for COVID-19 should be excluded from work until they meet criteria for discontinuation of isolation established by [CDC](#) and [DHS](#). Support should be given to staff being excluded from work to stay home– try to reduce logistical barriers and financial hardship to the extent possible.

Symptomatic staff should be excluded until:

- At least 1 day (24 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications AND improvement in respiratory symptoms; AND
- At least 10 days have passed since symptom onset.

Staff who have **not** had any symptoms should be excluded until:

- 10 days have passed since the date of their first positive COVID-19 test, assuming they have not subsequently developed symptoms.

CDC and DHS **do not recommend** the use of a test-based strategy for return to work. Any facility considering implementing a test-based strategy should be aware that there have been reports of prolonged detection of RNA without direct correlation to viral culture.

Participation in Activities, Therapy, and Communal Dining during a Non-COVID-19 Outbreak

An outbreak of ARI does not require the cancellation of facility-wide resident activities, therapy, or communal dining. Residents with active ARI should not participate in facility-wide resident activities, therapy, or communal dining.

Participation in Activities, Therapy, and Communal Dining during a COVID-19 Outbreak

During an outbreak of COVID-19 residents should be encouraged to remain in their room. Restrict residents (to the extent possible) to their rooms, except for medically necessary purposes. If residents leave their room, they should be encouraged to wear a cloth face covering or facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing.

References

Infection Control Guidelines (CDC): [cdc.gov/flu/professionals/infectioncontrol/index.htm](https://www.cdc.gov/flu/professionals/infectioncontrol/index.htm)

Outbreak Case Definition (CSTE): <https://preparedness.cste.org/wp-content/uploads/2020/08/LCTF-Outbreak-Definition.pdf>

DHS

- Immunization: dhs.wisconsin.gov/immunization/index.htm
- Surveillance: dhs.wisconsin.gov/influenza/reporting.htm
- Influenza: dhs.wisconsin.gov/influenza/index.htm
- COVID-19 Long-Term Care Facilities: dhs.wisconsin.gov/covid-19/ltc.htm

If you have any questions or concerns, please contact Thomas Haupt, Influenza Surveillance Coordinator, at 608-266-5326, or by email at thomas.haupt@wisconsin.gov, or call the Bureau of Communicable Diseases at 608-267-9003.



ENHANCED SURVEILLANCE rev.1/2020

Patient Information		Submitter Information	
Name (Last, First):		(Your Institution's Agency Number If Known)	
Address:		(Your Institution's Name)	
City:	State: Zip:	(Your Institution's Address)	
Date of Birth:	Gender: M F	(City, State, Zip Code)	
Occupation:		(Telephone Number)	
Your Patient ID Number (optional):		Health Care Provider Full Name:	
Your Specimen ID Number (optional):		WSLH Use Only Study: VI SURV-ENHANCED	WSLH Use Only: Bill To: (WSLH Account # 74200)
Reason for submission: <input type="checkbox"/> 2019 Novel Coronavirus Suspect <input type="checkbox"/> Outbreak Investigation (name & location) _____ <input type="checkbox"/> Avian Influenza Suspect <input type="checkbox"/> MERS-Coronavirus Suspect <input type="checkbox"/> Swine Contact <input type="checkbox"/> Other _____			
Date Collected:	Specimen Type: <input type="checkbox"/> Other _____ <input type="checkbox"/> Combined Throat/Nasopharynx Swab <input type="checkbox"/> Nasopharynx Swab (in VTM) <input type="checkbox"/> Throat Swab (in VTM)		
Date of Onset:			
General Symptoms		Respiratory Symptoms	
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Nausea / Vomiting	
<input type="checkbox"/> Fever	<input type="checkbox"/> Nasal Congestion	CNS	
<input type="checkbox"/> Headache	<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Encephalopathy	
<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Pharyngitis	<input type="checkbox"/> Delirium	
<input type="checkbox"/> Malaise	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Meningismus	
<input type="checkbox"/> Myalgia	<input type="checkbox"/> Cough (circle one) productive / nonproductive / barking		
<input type="checkbox"/> Photophobia	<input type="checkbox"/> Crackles		
<input type="checkbox"/> Rash	<input type="checkbox"/> Dyspnea		
<input type="checkbox"/> Mouth Lesions	<input type="checkbox"/> Wheeze		
	<input type="checkbox"/> Pneumonia		
Vaccination History (Influenza): Was patient vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Date Vaccinated: / /			
Travel History (Places and dates):			
Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, where: _____			
WISCONSIN STATE LABORATORY OF HYGIENE USE ONLY			
WSLH Test Code: To Be Determined On Receipt			