Responding to Common Outbreaks in Alaskan Healthcare Settings

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Healthcare-Associated Infections Team
Alaska Section of Epidemiology

Contents

Introduction

This guide provides healthcare facilities and local public health jurisdictions information about selected communicable disease outbreaks in healthcare settings. These materials may assist with education and communication efforts during investigation and response. This guide is not comprehensive regarding all reportable diseases but contains information for the most commonly reported outbreaks of communicable diseases in healthcare settings. In Alaska, outbreaks of communicable disease, including those in congregate and institutional settings, are reportable to public health. Healthcare facilities should notify the Section of Epidemiology at 907-269-8000 immediately of all outbreaks. In most cases, the term "patient" is used in this guidance and includes residents of long-term care facilities.

Novel and targeted multidrug-resistant organisms (MDROs) such as *C. auris*, carbapenem-resistant enterobacterales, etc. are not addressed in this guide. MDROs are reportable; call the Section of Epidemiology to report these and submit isolates to the Alaska State Public Health Laboratory. See MDRO Prevention Strategies: https://www.cdc.gov/healthcare-associated-infections/php/preventing-mdros/mdro-prevention-strategies.html and contact the Section of Epidemiology at 907-269-8000 if an MDRO is suspected.

Healthcare-associated infections required to be reported to federal authorities are not specifically addressed here. Facilities are required to report certain healthcare-associated infections to NHSN rather than directly to the Alaska Section of Epidemiology. For more information, see Reportable Diseases guidelines at https://www.cdc.gov/nhsn/cms/index.html and click on the appropriate facility type for more information or call the Section of Epidemiology at 907-269-8000. For more information about statutes and regulations related to reporting, visit https://health.alaska.gov/dph/Epi/Pages/pubs/conditions/crregs.aspx

Public health emergencies are also not addressed here. To report a public health emergency, call 1-907-269-8000 during business hours or 1-800-478-0084 after hours.
See the Reportable Diseases guidelines for more information about public health emergencies: https://health.alaska.gov/dph/Epi/Documents/pubs/conditions/ConditionsReportable_HCP.pdf

This guide contains materials developed by the Alaska Section of Epidemiology (SOE); Healthcare Associated Infections (HAI) team. It was adapted from a guide developed by the Montana Department of Public Health and Human Services Infection Control and Prevention and Healthcare-Associated Infections and Communicable Disease Epidemiology Sections based on best practices and information from CDC.

Appendix A from the CDC's Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings is a quick reference that contains specific recommendations for infection prevention and control for common and uncommon pathogens: https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html

Clostridioides difficile (C. diff) Information

Background:

Clostridioides difficile (*C. diff*) is a spore-forming, Gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It causes diarrheal illness and is often associated with antibiotic use or shortly after antibiotic use. *C. diff* causes 15-25% of antibiotic-associated diarrhea.

Signs and Symptoms:

- Watery diarrhea
- Fever
- Loss of appetite
- Nausea
- Abdominal pain/tenderness

Individuals with increased infection risk include those with a history of:

- Antibiotic exposure (e.g., fluoroquinolones, third/fourth generation cephalosporins, clindamycin, carbapenems)
- Gastrointestinal surgery/manipulation
- Long length of stay in healthcare settings
- Serious underlying illness
- Immunocompromising conditions
- Advanced age

Route of Transmission:

Exposure to feces from an infected individual. Any surface, device, or material (such as toilets, bathtubs, and electronic rectal thermometers) contaminated with feces could serve as a reservoir for the *C. diff* spores.

Transmission-Based Precautions (TBP):

Contact: https://www.cdc.gov/infection-control/media/pdfs/contact-precautions-sign-p.pdf

Infectious Period/Duration of TBPs:

With confirmed *C. diff* infection, maintain contact precautions for at least 48 hours after diarrhea has resolved, or longer, up to the duration of the patient's hospitalization

Patient Placement:

Place symptomatic patients on contact precautions, in a single-patient room with a dedicated bathroom.

- If single-patient rooms are not available, room patients with confirmed *C. diff* infection together. Ensure the individuals are not infected with any another communicable disease.

Incubation Period (I.e., time from exposure to becoming symptomatic):

A few days to several weeks. The exact incubation period of *C. diff* is unknown.

Diagnosis:

Clinical personnel

- Assess for appropriateness of testing: Consider other infectious or non-infectious causes of diarrhea before testing for *C. diff.*
- Discontinue laxatives for the individual and wait for at least 48 hours before testing, if still symptomatic.
- Once a patient has a positive *C. diff* test, do not repeat testing to detect cure; tests may remain positive for ≥6 weeks.

Laboratory personnel

- Implement laboratory procedures to ensure testing of only appropriate specimens (e.g., unformed stool) for *C. diff* or its toxins.
- For sites where appropriateness of testing is an issue, consider implementing two-step testing (e.g., high sensitivity NAAT or GDH test followed by high-specificity toxin test, rather than NAAT alone) to improve diagnostic accuracy.

Reporting Requirements:

A single case of *C. diff* is not reportable to the Alaska Section of Epidemiology. However, an outbreak in a congregate or institutional setting is reportable to the Alaska Section of Epidemiology.

If you suspect or have confirmation that an outbreak of *C. diff* is occurring in your facility, notify the Alaska Section of Epidemiology as soon as possible at 907-269- 8000.

List of Reportable Conditions:
https://health.alaska.gov/media/h2yd3q4q/conditionsreportable_hcp.pdf

Outbreak Criteria in a Healthcare Setting:

Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of *C. diff*-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility); and 3) temporal relationship among cases. Report potential outbreaks to the Alaska Section of Epidemiology. Consult the Alaska Section of Epidemiology to determine outbreak status.

Criteria for Outbreak Closure:

30 days without any new cases or symptomatic individuals.

Personal Protective Equipment Recommendations:

Gown and Gloves

Hand Hygiene Recommendations:

Alcohol-based hand sanitizer is not effective at killing *C. diff*. Therefore, handwashing with soap and water is highly recommended before and after interacting with individuals diagnosed with *C. diff* as well as after leaving their room. Since no single method of hand hygiene will eliminate all *C. diff* spores, using gloves appropriately to prevent hand contamination and then washing hands with soap and water after taking gloves off remains the cornerstone for preventing *C. diff* transmission via the hands of healthcare personnel.

Cleaning and Disinfection Recommendations:

- Create daily and terminal cleaning protocols and checklists for patient-care areas and equipment.
- Perform daily cleaning of *C. diff* patient rooms using a *C. diff* sporicidal agent.
- Clean and disinfect the patient-care environment (including the immediate vicinity around a *C. diff* patient and high touch surfaces) at least once a day, including toilets.
- Clean and disinfect all shared equipment prior to use with another patient (e.g., wheelchairs, gurneys).
- Perform terminal cleaning after *C. diff* patient transfer/discharge with a *C. diff* sporicidal agent.
- Clean additional areas that are contaminated during transient visits by patients with suspected or confirmed *C. diff* (e.g., Radiology, Emergency Departments, Physical Therapy) with a *C. diff* sporicidal agent.
- Use of additional disinfection of *C. diff* patient rooms with no-touch technologies (e.g., UV light).
- Expand the use of environmental disinfection strategies (e.g., sporicidal agents) for daily and terminal cleaning in all rooms on affected units.
- Follow manufacturer's instructions for use, including the specific contact/wet time for the organism of concern.

CDC Resources: https://www.cdc.gov/c-diff/hcp/resources/

Other:

- Engage the facility antibiotic stewardship program.
- Implement the elements of antibiotic stewardship
  - https://www.cdc.gov/antibiotic-use/hcp/core-elements/
- Assess the appropriateness of prescribing antibiotics that pose the highest risk for *C. diff* infection (CDI), especially fluoroquinolones, carbapenems, and 3rd and 4th generation cephalosporins.
  - Develop facility-specific treatment recommendations for common infections that include first- and second-line antibiotics.

- Evaluate antibiotic treatment of conditions that commonly lead to high-risk antibiotic use, such as asymptomatic bacteriuria and common infections such as urinary tract infection and community-acquired pneumonia, to minimize the use of high-risk antibiotics.
- Ensure that patients receive the shortest effective duration of antibiotic therapy.
- Include inpatient antibiotic duration when determining post-discharge antibiotic duration.
- Develop infrastructure to support C. diff prevention.
- Incorporate reduction of CDI into the facility healthcare-associated infection prevention program, including but not limited to the design, implementation, evaluation, and feedback of intervention results.
- Include a multidisciplinary workgroup, including physicians, nursing, environmental services, and antibiotic stewardship to identify and implement the below strategies and to use data for action.
- Monitor facility CDI rates, and target units with highest incidence of CDI for evaluation and intervention.
- Review hospital-onset CDI cases to help identify potential gaps and opportunities for improvement.
- Review should focus on opportunities for improvement across each strategy (e.g., test indications, antibiotic appropriateness).
- Utilize findings to engage relevant care teams and staff in gap remediation and performance improvement as soon after the CDI case as possible.
- Educate and train healthcare personnel on prevention practices for CDI.
- Routinely audit
- Adherence to hand hygiene and contact precautions.
- Adequacy of room cleaning using methods described in https://www.cdc.gov/infection-control/php/evaluating-environmental-cleaning/ with a *C. diff* sporicidal agent (EPA List K agent).
- Provide CDI rates and other performance improvement measures to senior leadership, clinical providers, laboratory personnel, environmental services, and other stakeholders.
    - Notify appropriate individuals and facility departments about changes in the incidence (or frequency), complications (including recurrences), or severity of CDI.

All Healthcare Settings *Clostridioides difficile (C. diff)* Outbreak Response Guidance
This guidance is applicable to all settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants, schools, group homes) and not for persons outside of healthcare settings.** A facility must go 30 days without a new case to close the outbreak.

Outbreak Definition: Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of *C. diff*-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (i.e., confined or widespread in the facility); and 3) temporal relationship among cases.

Helpful Resources:
CDC C. Diff Healthcare Resources |

- The Section of Epidemiology Healthcare Associated Infections Team provides free, non-regulatory infection control assessments and outbreak consultations to all healthcare settings in Alaska. If interested, please contact the HAI/AR Program ICAR team at doh.dph.epi.ak.hai.access@alaska.gov or 907-269-8000.

1. **Recommended Routine IPC Practices for Healthcare (HC) settings**
   a. Establish a process to identify and manage individuals with suspected or confirmed *C. diff* infection (i.e., post signage).
   b. Alcohol-based hand sanitizer is not effective at killing *C. diff*. Therefore, handwashing with soap and water is highly recommended before and after interacting with individuals diagnosed with *C. diff* as well as after leaving their room. Since no single method of hand hygiene will eliminate all *C. diff* spores, using gloves appropriately to prevent hand contamination and then washing hands with soap and water after gloves are removed remains the cornerstone for preventing *C. diff* transmission via the hands of healthcare personnel.
2. **Visitation**
   a. Patients should be encouraged to limit in-person visitation while they are infectious.
   b. Counsel patients and their visitor(s) about the risks of in-person visitation.
   c. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
   d. Visitors should be instructed to only visit the patient room.
3. **Testing**
   a. Assess for appropriateness of testing: Consider other infectious or non-infectious causes of diarrhea before testing for *C. diff.*
   b. Discontinue laxatives and wait for at least 48 hours before initial testing, if still symptomatic.
   c. Once a patient has a positive *C. diff* test do not repeat testing to detect cure; tests may remain positive for ≥6 weeks.
   d. Laboratory testing for *C. diff* is not currently provided through State of Alaska laboratories. Please refer to the specimen collection requirements and shipping information specified by your facility's laboratory of choice.
4. **Patient Placement**
   a. Place a patient with suspected or confirmed *C. diff* in a single-person room (with a dedicated bathroom).
      i. If a positive individual has a roommate, that roommate should be moved to prevent further exposure to the positive case.
   b. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with *C. diff* when the number of patients with *C. diff* is high.
   c. Limit transport and movement of the patient outside of the room to medically essential purposes.
5. **Personal Protective Equipment**
   a. HCP who enter the room of a patient with suspected or confirmed *C. diff* should adhere to standard precautions and use gown and gloves.
   b. When entering an isolation room, don PPE prior to entering and doff prior to exiting in accordance with CDC guidance (https://www.cdc.gov/healthcare-associated-infections/media/pdfs/ppe-sequence-p.pdf)

6. **Duration of TBPs for patients with *C. diff***
    a. Contact Precautions should be implemented for at least 48 hours after diarrhea has resolved, or longer, up to the duration of hospitalization. Refer to facility policy.
7. **Environmental Infection Control**
    a. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed *C. diff.*
        i. All non-dedicated, non-disposable medical equipment used for the patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
    b. Create daily and terminal cleaning protocols and checklists for patient-care areas and equipment.
    c. Perform daily cleaning of *C. diff* patient rooms using a *C. diff* sporicidal agent (EPA List K agent).
        i. Clean and disinfect the patient-care environment (including the immediate vicinity around a *C. diff* patient and high touch surfaces) at least once a day, including toilets.
        ii. Clean and disinfect all shared equipment prior to use with another patient (e.g., wheelchairs, gurneys).
    d. Perform terminal cleaning after *C. diff* patient transfer/discharge with a *C. diff* sporicidal agent (EPA List K agent).
    e. Clean additional areas that are contaminated during transient visits by patients with suspected or confirmed *C. diff* (e.g., Radiology, Emergency Departments, Physical Therapy) with a *C. diff* sporicidal agent (EPA List K agent).
    f. Use of additional disinfection of *C. diff* patient rooms with no-touch technologies (e.g., UV light).
    g. Expand the use of environmental disinfection strategies (e.g., sporicidal agents [EPA List K agent]) for daily and terminal cleaning in all rooms on affected units.

COVID-19 Information

Background:
Coronavirus disease 2019 (COVID-19) is a highly contagious respiratory disease caused by the SARS-CoV-2 virus. The virus infects the nose, throat, and lungs, causing mild to severe illness, and can lead to death. The best way to prevent COVID-19 is by making sure that you (and everyone in your facility) are up-to-date on COVID-19 vaccinations. https://www.cdc.gov/covid/vaccines/stay-up-to-date.html

Signs and Symptoms:

- Fever/feeling feverish or chills
- Cough
- Sore throat
- Runny or stuffy nose
- Muscle or body aches
- Headaches

- Fatigue (tiredness)
- Loss of Taste or Smell
- Nausea or Vomiting
- Diarrhea
- Shortness of Breath

Route of Transmission:

- Droplets made when people with COVID-19 cough, sneeze, or talk (within 6 ft distance) are breathed in by people or land on/in their eyes, nose, or mouth
- Touching a surface or object that has COVID-19 virus on it and subsequently touching your nose, eyes or mouth

Transmission-Based Precautions (TBP):

Healthcare workers and other facility staff who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should use a NIOSH approved particulate respirator with N95 filters or higher of a type they have been fit tested for and trained on; gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). See https://www.cdc.gov/covid/hcp/infection-control/ (updated June 2024).

Procedures that could generate infectious aerosols should be performed cautiously and avoided if appropriate alternatives exist. Aerosol-generating procedures should take place in an airborne infection isolation room, if possible.
Staff present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.

Infectious Period:

48 hours prior to symptom onset until the individual meets CDC criteria for release from isolation

Duration of TBPs:

- Patients with mild to moderate illness who are *not* moderately to severely immunocompromised:
- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- Patients who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:
- At least 10 days have passed since the date of their first positive viral test
- Patients with severe to critical illness (in general, this includes patients who are hospitalized for SARS-CoV-2 infection) who are *not* moderately to severely immunocompromised:
- At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- The test-based strategy as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation
- Patients who are moderately to severely immunocompromised may continue to produce virus for longer than other patients. Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients. The criteria for the test-based strategy are:
- Patients who are symptomatic:
- Resolution of fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved, and
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT
- Patients who are not symptomatic:
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

Patient Placement:

Place ill patients in a private room with their own bathroom. If a private room is not available, place (cohort) patients suspected/confirmed of having COVID-19 with one another. Ensure that the individuals are not infected with another communicable disease before cohorting.

Incubation Period (i.e., time from exposure to becoming symptomatic):

2 to 14 days, average of 3 to 5 days

Diagnosis (include laboratory testing and other criteria):

Determine if COVID-19 is the causative agent by performing COVID-19 testing on upper respiratory tract specimens (i.e., nasopharyngeal swab, nasal swabs, nasopharyngeal or nasal aspirates, or combined nasal and throat swabs) of ill patients with recent onset of signs and symptoms suggestive of COVID-19 or acute respiratory illness. The following COVID-19 tests are recommended: nucleic acid amplification tests (NAATs) and antigen tests. Antibody testing is not recommended for diagnosis.

Reporting Requirements:

All COVID-19 cases with laboratory evidence (molecular, antigen, or over-the-counter antigen) of infection must be reported to the Alaska Section of Epidemiology as soon as possible. Notify the Alaska Section of Epidemiology of any hospitalizations and/or deaths due to COVID-19.

If you suspect or have confirmation that an outbreak of COVID-19 is occurring in your facility, notify the Alaska Section of Epidemiology as soon as possible. All COVID-19 cases associated with an outbreak must be reported to the Alaska Section of Epidemiology even if there is no laboratory testing supporting a diagnosis. To reach the Section, call 907-269-8000.

List of Reportable Conditions:
https://health.alaska.gov/dph/Epi/Documents/pubs/conditions/ConditionsReportable_HCP.pdf

Outbreak Criteria in a Healthcare Setting:

LTCF: A single new case of COVID-19 infection in any HCP or resident should be evaluated and determine if others in the facility could have been exposed. Report potential outbreaks to the Alaska Section of Epidemiology at 907-269-8000 or by using the Influenza and SARS-CoV-2 Outbreak Report Form.

All other healthcare settings: Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of COVID-19-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility); and 3) temporal relationship among cases. Report potential outbreaks to the Alaska Section of Epidemiology. Consult with the Alaska Section of Epidemiology to determine if cases meet the outbreak criteria.

Criteria for Outbreak Closure:

14 days without any new cases or symptomatic individuals. **Prior to closing your outbreak, you should verify the closure with the Alaska Section of Epidemiology.**

Personal Protective Equipment Recommendations:

Gown, gloves, fit-tested NIOSH-approved respirator with N95 filter, eye protection

Hand Hygiene Recommendations:

Alcohol-based hand sanitizer is the preferred hand hygiene method in most cases.

Cleaning and Disinfection Recommendations:

- Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.
  - All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures (AGPs) are performed.
  - Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a *difficile* sporicidal agent is recommended to disinfect the rooms of patients with *C. difficile* infection).
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room without all recommended PPE until sufficient time has elapsed for enough air changes to remove potentially infectious particles [more information (to include important footnotes on its application) on clearance rates under differing ventilation conditions is available]. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before returning to routine use.

CDC Resources:

- Last Updated 6/24/2024: Infection Control Guidance: SARS-CoV-2 CDC https://www.cdc.gov/covid/hcp/infection-control/
- Last Updated 3/18/2024: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
- Last Updated 9/23/2022: Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC https://www.cdc.gov/covid/hcp/infection-control/mitigating-staff-shortages.html

Other:

Source Control:

1. Source control is recommended for individuals (e.g., staff, visitors, patients) in healthcare settings who:

a. Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
b. Had close contact (patients and visitors) or a higher-risk exposure (healthcare personnel [HCP]) with someone with SARS-CoV-2 infection, for 10 days after their exposure.

2. Recommended during an outbreak response (can be discontinued as a mitigation measure once no new cases have been identified for 14 days).
3. Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances:

a. By those residing or working on a unit or area of the facility experiencing a COVID-19 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or
b. Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission.
c. Have otherwise had source control recommended by public health authorities

Outbreak Testing:

The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.

- Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
- Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period. If performing outbreak testing, facilities should determine if contact-tracing testing or broad-based testing is appropriate.

Vaccinations:

COVID-19 vaccines available in the United States are effective at protecting people from getting seriously ill, being hospitalized, and dying. As with other vaccine-preventable diseases, you are protected best from COVID-19 when you stay up to date with the recommended vaccinations, including recommended boosters.

Three COVID-19 vaccines are approved or authorized in the United States: Pfizer-BioNTech, Moderna, and Novavax.

All Healthcare Settings COVID-19 Outbreak Response Guidance

This guidance is applicable to all U.S. settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants) and not for persons outside of healthcare settings.** A facility must go 14 days without a new positive case or exposure to close the outbreak.

Healthcare settings refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, nursing homes, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, dental offices, and others.

Helpful Resources:
See also CDC Resources on page 13

- The Section of Epidemiology Healthcare Associated Infections Team provides free, non-regulatory infection control assessments and outbreak consultations to all healthcare settings in Alaska. If interested, please contact the HAI/AR Program ICAR team at doh.dph.epi.ak.hai.access@alaska.gov or 907-269-8000.

1. **Recommended Routine IPC Practices for Healthcare (HC) settings**
   a. Encourage remaining up to date with all recommended COVID-19 vaccine doses.
   b. Facilities should post visual alerts at the entrance and in strategic places (waiting areas, elevators, cafeterias). Alerts should include instructions about current IPC recommendations. Dating the alerts can help ensure people know that they reflect current recommendations.
   c. Establish a process to make everyone aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
      i. A positive viral test for COVID-19,
      ii. Symptoms of COVID-19, OR
      iii. Close contact to someone with COVID-19.

2. **Source Control**
   a. **Source Control:** Refers to the use of respirators or well-fitting facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when breathing, talking, sneezing or coughing. See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html
   b. Source control is recommended for individuals (e.g., staff, visitors, patients) in healthcare settings who:
      i. Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
      ii. Had close contact (patients and visitors) or a higher-risk exposure (healthcare personnel [HCP]) with someone with SARS-CoV-2 infection, for 10 days after their exposure. https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html
   c. Source control options for HCP include:
      i. NIOSH-approved respirator.

ii. Respirator approved under standards used in other countries that are similar to NIOSH-approved N95s (these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated).
iii. A barrier face covering that meets ASTM F3502-21 requirements.
iv. A well-fitting facemask.

d. Recommended during an outbreak response (can be discontinued as a mitigation measure once no new cases have been identified for 14 days).
e. Source control is recommended more broadly in the following circumstances:
   i. By those residing or working on a unit or area of the facility experiencing a COVID-19 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or
   ii. Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission.
   iii. Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high).

Considerations for Implementing Broader Use of Masking in Healthcare Settings:

a. As COVID-19 transmission increases in a community, the potential for encountering asymptomatic or pre-symptomatic patients with COVID-19 also increases. Healthcare facilities could consider implementing broader use of respirators and eye protection by HCP during patient care encounters.
b. Use of well-fitting masks in healthcare settings are an important strategy to prevent the spread of respiratory viruses.
c. Facilities should consider several factors when determining how and when to implement broader mask use. These factors include the types of patients cared for in their facility, input from stakeholders, plans from other facilities in the jurisdiction, and what data are available to make decisions.

3. **Personal Protective Equipment**
   a. HCP entering the room of a patient with suspected or confirmed COVID-19 should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection.
   b. When entering an isolation room, don PPE prior to entering and doff prior to exiting in accordance with CDC guidance (PPE-Sequence.pdf (cdc.gov)(CDC PPE Sequence flyer)).
   c. Additional information about using PPE is available atin https://www.cdc.gov/healthcare-associated-infections/. Protecting Healthcare Personnel | HAI | CDC.
4. **Visitation**
   a. Visitors with confirmed COVID-19 or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation.
   b. For visitors with close contact that would put them at higher risk, it is safest to defer non-urgent in-person visitation until 10 days after their close contact.
   c. Patients should be encouraged to limit in-person visitation while they are infectious.

i. Counsel patients and their visitor(s) about the risks of in-person visitation.
ii. Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets.

d. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
e. Visitors should be instructed to only visit the patient room.
f. Long-term care facilities please refer to this guidance: QSO-20-39-NH Visitation REVISED (cms.gov).

Testing

a. Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible.
b. Asymptomatic patients with close contact
   i. Series of 3 viral tests (day 1, 3, and 5 with the day of exposure = 0).
c. Testing is not generally recommended for asymptomatic people who have recovered from COVID-19 in the prior 30 days. Testing should be considered for those who have recovered from COVID-19 in the prior 31-90 days (recommended that an antigen test is used).
d. If performing outbreak testing, facilities should determine if contact-tracing testing or broad-based testing is appropriate.
   ii. Contact Tracing Testing: Testing individuals identified as a close contact (series of 3 viral tests on day 1, 3, and 5 with the day of exposure = 0).
   iii. Broad-Based Testing: Preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. This includes testing all staff and residents/patients regardless of vaccination status as part of outbreak response. Test every 3-7 days.

Iv. If antigen testing is used, more frequent testing (every 3 days), should be considered.

COVID-19 (SARS-CoV-2, coronavirus disease 2019)

Testing site SARS-CoV-2 Requisition Form	Please send testing to Alaska State Virology Laboratory (ASVL) – Fairbanks 907-371-1000, 1051 Sheenjek Dr, Fairbanks, AK 99706 All Covid testing is currently being sent to the ASVL in Fairbanks; any testing received at ASPHL will be forwarded to the ASVL. Form: https://health.alaska.gov/media/5owfcxo3/resppathrequestform.pdf
Disease	COVID-19
Organism	SARS-CoV-2
Test Method	Real-time polymerase chain reaction, transcription mediated amplification, sequencing
Required Specimens	Collect one specimen per patient
Specimen Collection	Nasopharyngeal swab* (NP): insert a swab into one nostril parallel to the palate. Leave the swab in place for a few seconds to absorb secretions. Oropharyngeal swab* (OP, i.e. throat swab): Swab the posterior pharynx, avoiding the tongue. Nasal swab* (NS): Self- or healthcare worker-collected nasal swabs are acceptable if an NP swab is not possible. **Swabs: use synthetic material swabs only (i.e. Dacron, polypropylene, rayon, polyester). Cotton or calcium-alginate tips and wooden shafts are not acceptable.* All swabs must be stored in 2-3 mL of acceptable viral transport media, including sterile RNase-free phosphate buffered saline (PBS).
Storage/Transport	Store all specimens in your refrigerator (2-8 degrees C) up to 72 hours or freeze for longer storage. Pack refrigerated specimens on ice packs to preserve viral integrity. Pack frozen specimens with plenty of ice packs or dry ice. Ship as a Biological Substance Category B UN3373. If using dry ice, indicate UN1845 as well.
Results	**Positive:** this is a final result **Not detected:** this is a final result, unless other testing is requested **Inconclusive:** this result indicates intermittent reactivity **Invalid:** this result indicates that the specimen was inhibitory or insufficiently collected. A normal result is **Not detected.**
Turnaround time	1-3 days

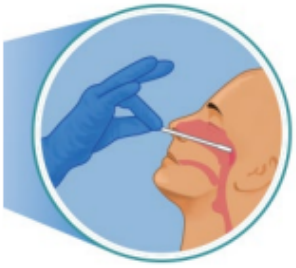
Respiratory Pathogen Panel (RPP)	
Testing site Fairbanks Requisition Form	Please send testing to Alaska State Virology Laboratory (ASVL) – Fairbanks 907-371-1000, address 1051 Sheenjek Dr, Fairbanks, AK 99706 Respiratory pathogen lab request form: https://health.alaska.gov/media/5owfcxo3/resppathrequestform.pdf General virology lab request form: https://health.alaska.gov/media/jo5loh2f/virologytestreq.pdf
Test Method	Multiplex PCR (CPT code 87633)
CPT code and fee	87633, *To receive RPP results, a memorandum of agreement (MOA) must be on file with the Alaska State Public Health Labs.*
Targets – Luminex NxTag RPP Assay	Respiratory Syncytial Virus (Groups A & B), rhinovirus/enterovirus (cannot differentiate), parainfluenza (Types 1, 2, 3, and 4), human metapneumovirus, adenovirus, seasonal coronavirus (HKU1, NL63, 229E, OC43), human bocavirus, *Chlamydophila pneumoniae, and Mycoplasma pneumoniae*
Specimen	**Preferred specimen: Nasopharyngeal swab*, in 3mL Universal Transport Media (UTM) or other acceptable liquid viral transport media.** Other acceptable specimens: Nasal swab*, nasal wash, tracheal aspirate, nasal aspirate, broncheoalveolar lavage, lung tissue, bronchial wash. **Swabs: use synthetic material swabs only – cotton or calcium-alginate tips and wooden or metal shafts are not acceptable*
Collection	Swab: place swab into 3mL UTM and break swab **below** lid line Wash or lavage: aseptically transfer no more than 3 mL of wash to 3mL UTM Lung tissue: transfer a pea sized piece (about 1 gram) into 3mL UTM
Storage/Transport	Store the specimens in your refrigerator until ready to ship, pack samples on cool packs to preserve viral integrity. Ship as a Biological Substance Category B UN3373. If you are in an outlying area, use the pre-addressed **Priority Mail** Labels provided. Mail Monday or Tuesday to avoid weekends at the Post Office.
Result (for each target)	**Positive:** nucleic acid detected **Not detected:** nucleic acid not detected. A normal result is **Not detected.**
Turnaround time	Due to limited staff, testing is performed on Mondays only.

Collecting Nasopharyngeal Swabs for Respiratory Virus Testing

Supplies Needed: UTM Kit = Universal Transport Media (UTM) with collection swab:
Swabs are made of synthetic or plastic materials only. Metal, wood, calcium alginate or cotton material will NOT be accepted. Fairbanks Lab Request Form

Collection Instructions:
Please Note: *The following instructions are for nasopharyngeal collection only. While nasopharyngeal swabs are preferred, other specimen types are acceptable. Please see the* Respiratory Pathogen Panel test section *in this directory for further information. These instructions were adapted from https://www.cdc.gov/coronavirus/2019-ncov/downloads/lab/NP-Specimen-Collection-Infographic.pdf.*

1. One NP swab is collected for PCR as described below.
2. Remove mucus from the patient's nose.
3. Carefully open package containing the NP swab and remove swab for specimen collection.
4. Tilt patient's head back 70 degrees. Gently and slowly insert a minitip swab with a flexible shaft through the nostril parallel to the palate until resistance is encountered. The distance is equivalent to that from the nostril to the ear of the patient, indicating contact with the nasopharynx.
5. Gently rub and roll the swab, leaving it in place for several seconds to absorb secretions. If a deviated septum or blockage creates difficulty in obtaining the specimen from one nostril, use the same swab to obtain the specimen from the other nostril.
6. Slowly remove swab while rotating it. Specimens can be collected from both nostril, but it is not necessary if the minitip swab is saturated with fluid from the first nostril.
7. Place swab, tip first, into the transport tube provided. Once the tip is near the bottom, break the swab handle at the swab breakpoint by bending back and forth or cut it off with sterile scissors. The swab should fit in the tube comfortably so that the cap can be screwed on tightly to prevent leakage and contamination.



8. Clearly label the UTM containing the swab with patient's name (or alternate unique identifier), date of birth and collection date. Two patient identifiers are required for specimen acceptance at ASVL.
9. Complete the Fairbanks Lab Request Form.
10. Immediately transport specimen to the laboratory. If transport is delayed, place specimen on ice or refrigerate.

Transport:
1. Place the collected specimen in the Ziploc portion of a specimen transport bag and seal. Place the completed Fairbanks Lab Request form in outside pouch.
2. Package as a Biological Substance Category B specimen according to all current shipping regulations and send to the State Public Health Laboratory-Fairbanks as soon as possible.
   - It is preferable to hold UTM specimen at 4°C until transport. Transport specimen on cold packs.

5. **Patients Being Evaluated for COVID-19 due to signs/symptoms**
    a. Consult the Alaska Section of Epidemiology when ruling out a positive case (i.e., determining if someone was a false positive).
    b. The decision to discontinue empiric transmission-based precautions (TBP) by excluding the diagnosis of COVID-19 can be made based upon having negative results from at least one viral test.
        i. If using NAAT (PCR), a single negative is sufficient in most circumstances (if suspicion is high, repeat testing).
        ii. If using an antigen test, a negative result should be confirmed by a NAAT (PCR), or second negative antigen taken 48 hours after the first negative.

If an individual was infected in the prior 90 days, rapid antigen testing is preferred over a PCR test.

6. **Close Contact**
    a. Determining the time period when the patient, visitor, or HCP with confirmed SARS-CoV-2 infection could have been infectious: https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html
        i. Confirmed COVID-19 positive patients who developed symptoms should consider their exposure window to be **2 days before symptom onset** through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions. https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html
        ii. For individuals with confirmed SARS-CoV-2 infection without symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic confirmed positive individual may have been exposed may help define their potentially infectious period.
        iii. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions.
    b. In general, asymptomatic individuals do not require empiric use of TBPs following close contact (within 6 feet for 15 minutes or more over a 24-hour period).
        i. Examples when empiric TBP following close contact may be considered:
            1. Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure.
            2. Patient is moderately to severely immunocompromised.
            3. Patient is residing on a unit with others who are moderately to severely immunocompromised.
        ii. Patients placed on empiric TBP based on close contact with someone with COVID-19 should be maintained in TBPs for the following time periods:
            1. Patients can be removed from TBP after day 7 following the exposure (exposure=day 0) if they do not develop symptoms and all viral testing as described in in the testing section (see #6) is negative.

2. If viral testing is not performed, patients can be removed from TBPs after day 10 following the exposure (count the day of the exposure as day 0) if they do not develop symptoms.

c. Individuals who had close contact should wear source control and those who have not had COVID in the prior 30 days should be tested as described in the testing section (see #5).

7. **Patient Placement**
   a. Place a patient with suspected or confirmed COVID-19 in a single-person room (with a dedicated bathroom).
      i. If cohorting, only patients with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable disease should be taken into consideration.
   b. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with COVID-19 when the number of patients with COVID-19 is high.
   c. Limit transport and movement of the patient outside of the room to medically essential purposes.
8. **Duration of TBPs for patients with COVID-19**
   a. In general, patients who are hospitalized for COVID-19 should be maintained in TBPs for the time frame described for patients with severe to critical illness.
      - **Patients with mild to moderate illness who are *not* moderately to severely immunocompromised:**
        - At least 10 days have passed *since symptoms first appeared* **and**
        - At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
        - Symptoms (e.g., cough, shortness of breath) have improved.
      - **Patients who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:**
        - At least 10 days have passed since the date of their first positive viral test.
      - **Patients with severe to critical illness and who are *not* moderately to severely immunocompromised:**
        - At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
        - At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
        - Symptoms (e.g., cough, shortness of breath) have improved.
        - The test-based strategy as described for moderately to severely immunocompromised patients can be used to inform the duration of isolation.
9. **Environmental Infection Control**
   a. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed COVID-19.
      i. All non-dedicated, non-disposable medical equipment used for the patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
      ii. Routine cleaning and disinfection procedures are appropriate for COVID-19 (Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a *C.*

difficile sporicidal agent is recommended to disinfect the rooms of patients with *C. difficile* infection)).

iii. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.

10. **Nursing Home Specific Guidance**
    a. **Outbreak Definition:** A single new case of COVID-19 infection in any HCP or resident should be evaluated and a determination made if others in the facility could have been exposed.
    b. Admission testing is at the discretion of the facility.
    c. Residents who leave the facility for 24 hours or longer should generally be managed as an admission. Empiric use of TBPs is generally not necessary for admissions or for residents who leave the facility for less than 24 hours.
    d.
11. **Assisted Living, Group Homes, and Other Residential Care Settings (excluding nursing homes) Guidance**
    a. In general, long-term care settings whose staff provide non-skilled personal care (i.e., non-medical care that can reasonably and safely be provided by non-licensed caregivers, such as help with daily activities like bathing and dressing) should follow community prevention strategies similar to independent living, retirement communities or other non-healthcare congregate settings.
    b. Visiting or shared HCP who enter the setting to provide healthcare to one or more residents should follow the HC IPC recommendations: https://www.cdc.gov/covid/hcp/infection-control/

Healthcare Personnel Guidance

CDC guidance: https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html

1. **Exposure:** In most circumstances, HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for COVID-19.
    a. Higher-risk exposures are classified as HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19 and:
        i. HCP was not wearing a respirator.
        ii. HCP was not wearing eye protection.
        iii. HCP was not wearing all recommended PPE during an aerosol-generating procedure.
    b. Following a high-risk exposure, HCP should:
        i. Have a series of 3 viral tests for COVID-19 (day 1, 3 and 5 with date of exposure= day 0).
        ii. Testing is not recommended for asymptomatic people who have recovered from COVID-19 in the prior 30 days. Testing (rapid antigen) should be considered for those who have recovered in the prior 31-90 days.
    c. Examples of when work restriction may apply for exposed, asymptomatic HCP:
        i. HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure.
        ii. HCP is moderately to severely immunocompromised.
        iii. HCP cares for or works on a unit with patients who are moderately to severely immunocompromised.

iv. HCP works in a unit experiencing ongoing COVID-19 transmission that is not controlled with initial interventions.

d. If work restriction is recommended, HCP can return to work:

i. HCP can return to work after day 7 following the exposure (exposure= day 0) if they do not develop symptoms and viral testing is negative.

ii. If viral testing is not performed, HCP can return to work after day 10 (exposure= day 0) if they are asymptomatic.

2. **Return to Work Criteria for HCP**

- **HCP with mild to moderate illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:**
  - At least 7 days have passed *since symptoms first appeared* if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7)*,* **and**
  - At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
  - Symptoms (e.g., cough, shortness of breath) have improved.

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

- **HCP who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:**
  - At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

- **HCP with severe to critical illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:**
  - At least 10 days and up to 20 days have passed *since symptoms first appeared,* **and**
  - At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
  - Symptoms (e.g., cough, shortness of breath) have improved.
  - The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

3. **Strategies to Mitigate HCP Staffing Shortages** (Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC)

a. Contingency Staffing

i. HCP with mild to moderate illness who are not moderately to severely immunocompromised:

1. At least 5 days have passed (return day 6) since symptoms first started (day 0), **and**
2. At least 24 hours have passed since last fever without the use of fever-reducing medications, **and**
3. Symptoms have improved.

b. Crisis Staffing

i. If HCP are requested to return to work before meeting all return-to-work criteria, they should adhere to the following:
    1. Self-monitor for symptoms and seek re-evaluation if symptoms recur or worsen.
    2. Until they meet the conventional return to work criteria:
        a. Wear a respirator or well-fitting facemask at all times, even when they are in non-patient areas.
        b. Practice physical distancing, to the extent possible.
        c. Patients should wear well-fitting source control when interacting with HCP.
        d. Staff that are deemed still infectious should only work with residents/patients who are currently on transmission-based precautions due to active COVID-19 infection.

Influenza Information

Background:

Influenza (flu) is a common respiratory illness that is highly contagious. Caused by influenza viruses infecting the nose, throat, and sometimes the lungs, it can cause mild to severe illness and can lead to death. The best way for an individual to prevent flu infection is by getting a flu vaccine each year, washing your hands, and avoiding contact with people who are sick.

Signs and Symptoms:

- Fever/feeling feverish or chills
- Cough
- Sore throat
- Runny or stuffy nose
- Muscle or body aches
- Headaches
- Fatigue (tiredness)
- Some people may have vomiting and diarrhea (more common in children than adults)
- Behavioral changes

Influenza may have a more rapid onset of symptoms compared to other respiratory infections.

Route of Transmission:

- Droplets made when people with flu cough, sneeze, or talk (within 6 ft distance).
- Touching a surface or object that has flu virus on it and then touching your eyes, nose or mouth.

Transmission-Based Precautions (TBP):

Droplet: https://www.cdc.gov/infection-control/media/pdfs/droplet-precautions-sign-p.pdf
See https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html for more information.

Infectious Period/Duration of TBPs:

5-7 days (Individuals are typically most infectious days 3-4)

Droplet Precautions should be implemented for patients with suspected or confirmed influenza for 7 days after illness onset **or** until 24 hours after the resolution of fever and respiratory symptoms, **whichever is longer**, while a patient is in a healthcare facility.

Patient Placement:

Place ill patients in a private room with their own bathroom. If a private room is not available, place (cohort) patients suspected/confirmed of having influenza with one another. Ensure that the individuals are not infected with any other communicable disease.

Incubation Period (i.e., time from exposure to becoming symptomatic):

1-4 days (average is 2 days)

Diagnosis (include laboratory testing and other criteria):

To determine influenza virus as a causative agent, perform influenza testing on upper respiratory tract specimens (i.e., nasopharyngeal swab, nasal swabs, nasopharyngeal or nasal aspirates, or combined nasal and throat swabs) from ill patients with recent onset of signs and symptoms suggestive of influenza or acute respiratory illness. PCR testing is the preferred method of testing, but antigen testing can be used if needed. Antigen testing sensitivity varies with circulation. A provider may need to order testing depending on facility policy.

Reporting Requirements:

A single case of influenza is not reportable to the Alaska Section of Epidemiology. An outbreak in a congregate or institutional setting is reportable. Influenza hospitalizations and/or deaths are also reportable to the Alaska Section of Epidemiology.

If you suspect or have confirmation that an outbreak of influenza or influenza-like illness is occurring in your facility, notify the Alaska Section of Epidemiology as soon as possible at 907-269-8000.

List of Reportable Conditions:
https://health.alaska.gov/media/h2yd3q4q/conditionsreportable_hcp.pdf

Clusters of respiratory illnesses with unknown etiology should still be reported to the Alaska Section of Epidemiology and testing should be conducted based on signs and symptoms.

Outbreak Criteria in a Healthcare Setting:

Two cases of laboratory-confirmed influenza identified within 72 hours of each other in residents/patients on the same unit. Report potential outbreaks to the Alaska Section of Epidemiology at 907-269-8000 or using the Influenza and SARS-CoV-2 Outbreak Report Form. Consult with the Alaska Section of Epidemiology to determine if cases meet the outbreak criteria.

Criteria for Outbreak Closure:

8 days without any new cases or symptomatic individuals.

Personal Protective Equipment Recommendations:

Facemask and eye protection; adhere to standard precautions and wear appropriate PPE

Hand Hygiene Recommendations:

Standard hand hygiene practices

Cleaning and Disinfection Recommendations:

- Standard cleaning and disinfection procedures (e.g., using cleaners and water to preclean surfaces prior to applying disinfectants to frequently touched surfaces or objects for indicated contact times) are adequate for influenza virus environmental control in all settings within the healthcare facility, including those patient-care areas in which aerosol-generating procedures are performed.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with standard procedures.
- Laundry and food service utensils should first be cleaned, then sanitized as appropriate.
- Some medical waste may be designated as regulated or biohazardous waste and require special handling and disposal methods approved by the State authorities.

CDC Resources:

Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities | CDC
Prevention Strategies for Seasonal Influenza in Healthcare Settings | CDC
https://www.cdc.gov/flu/hcp/infection-control/healthcare-settings.html
https://www.cdc.gov/flu/vaccines/keyfacts.html

Other:

If possible, all residents/patients should receive inactivated influenza vaccine (IIV) annually before influenza season. For persons aged ≥65 years, the following quadrivalent influenza vaccines are recommended: high-dose IIV, adjuvanted IIV, or recombinant influenza vaccine. If not available, standard-dose IIV may be given. In the majority of seasons, influenza vaccines will become available to long-term care facilities beginning in September and influenza vaccination should be offered by the end of October.

When at least 2 patients are ill within 72 hours of each other and at least one patient has laboratory-confirmed influenza (i.e. an outbreak may be occurring), the facility should promptly initiate antiviral chemoprophylaxis with oral oseltamivir to all non-ill patients living on the same unit as the patient with laboratory-confirmed influenza (outbreak affected units), regardless of whether they received influenza vaccination during the current season.

Antiviral treatment is recommended **as soon as possible** for any patient with suspected or confirmed influenza who:

- is hospitalized
- has severe, complicated, or progressive illness, or
- is at higher risk for influenza complications.

Decisions about starting antiviral treatment for patients with suspected influenza should not wait for laboratory confirmation of influenza virus infection. Empiric antiviral treatment using oral oseltamivir, inhaled zanamivir, intravenous peramivir, or oral baloxavir (i.e., Tamiflu) should be started as soon as possible in the above priority groups.

Clinicians can consider early empiric antiviral treatment of non-high-risk outpatients with suspected influenza [e.g., influenza-like illness (fever with either cough or sore throat)] based upon clinical judgement, if treatment can be initiated within 48 hours of illness onset.

All Healthcare Settings Influenza Outbreak Response Guidance

This guidance is applicable to all U.S. settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants, schools, group homes) and not for persons outside of healthcare settings.** A facility must go 8 days without a new positive case or exposure to close the outbreak.

Outbreak Definition: Two cases of laboratory-confirmed influenza identified within 72 hours of each other in residents/patients on the same unit.

Helpful Resources:

- Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities | CDC
- Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings | CDC
- Interim Guidance for the Use of Masks to Control Seasonal Influenza Virus Transmission | CDC
- The Section of Epidemiology Healthcare Associated Infections Team provides free, non-regulatory infection control assessments and outbreak consultations to all healthcare settings in Alaska. If interested, please contact the HAI/AR Program ICAR team at doh.dph.epi.ak.hai.access@alaska.gov or 907-269-8000.

1. **Recommended Routine IPC Practices for Healthcare (HC) settings**
   a. Encourage everyone to get their yearly flu vaccine.
   b. Establish a process to identify and manage individuals with suspected or confirmed influenza infection (i.e., post signage).
   c. Determine the time frame when the patient, visitor, or HCP with confirmed influenza infection could have been infectious.
      i. For individuals with confirmed or suspected influenza, consider the exposure window to be 5 to 7 days from symptom onset. Droplet precautions should be implemented for patients with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility.

2. **Visitation**
   a. Visitors with confirmed influenza or compatible symptoms should defer non-urgent in-person visitation until meeting the healthcare criteria to end isolation.
   b. Patients should be encouraged to limit in-person visitation while they are infectious.
   c. Counsel patients and their visitor(s) about the risks of in-person visitation.
   d. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
   e. Visitors should be instructed to only visit the patient room.

3. **Testing**
   a. Anyone with even mild symptoms of influenza, regardless of vaccination status, should receive a viral test as soon as possible.

b. If one laboratory-confirmed influenza positive case is identified along with other cases of acute respiratory illness in a unit of a long-term care facility, an influenza outbreak might be occurring. Active surveillance for additional cases should be implemented as soon as possible. Prioritize testing for individuals who are newly symptomatic within the last 3 days.
c. In widespread outbreaks, use discretion for testing compared to epi-linking of symptomatic individuals.

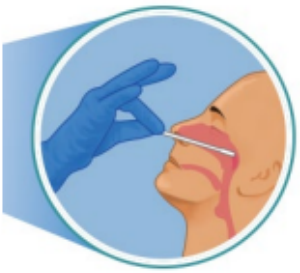
Influenza virus	
Testing site Fairbanks Requisition Form	Please send testing to Alaska State Virology Laboratory (ASVL) – Fairbanks 907-371-1000, address 1051 Sheenjek Dr, Fairbanks, AK 99706 Form: https://health.alaska.gov/dph/Labs/Documents/RespPathRequestForm.pdf
Diseases	Influenza A, Influenza B – positive specimens will be subtyped **Note: testing for novel strains of influenza (Flu A/H5N1, Flu A/H7N9) must be approved by the Section of Epidemiology** **Business hours: 907-269-8000; after hours 1-800-478-0084**
Test Method	Real-time reverse-transcriptase polymerase chain reaction
Specimen	Preferred specimen: Nasopharyngeal swab* Other acceptable specimens: Nasal swab*, nasal aspirate, tracheal aspirate, nasal wash, bronchial wash, dual NP/throat swabs* **Swabs: use synthetic material swabs only (i.e. Dacron, polypropylene, rayon, polyester). Cotton or calcium-alginate tips and wooden shafts are not acceptable.*
Collection	**Collection materials are available upon request.** Swab: place swab into 3mL UTM and break swab **below** lid line Wash or lavage: aseptically transfer no more than 3mL of wash into 3mL UTM Lung tissue: transfer a pea sized piece (about 1 gram) into 3mL UTM Be sure the cap is twisted down completely Place UTM inside the biohazard bag; place Lab Request in outer pocket
Storage/Transport	Store all specimens in your refrigerator until ready to ship. Pack specimens on ice packs to preserve viral integrity. Ship as a Biological Substance Category B UN3373 If you are in an outlying area: • Use pre-addressed **Priority Mail** labels provided • Mail Monday or Tuesday to avoid weekends at the Post Office
Results	**Positive:** viral nucleic acid was detected **Target not detected:** viral nucleic acid was not detected. A normal result is **not detected.**
Turnaround time	1-3 days after receipt at ASVL

Collecting Nasopharyngeal Swabs for Respiratory Virus Testing

Supplies Needed: UTM Kit = Universal Transport Media (UTM) with collection swab:
Swabs are made of synthetic or plastic materials only. Metal, wood, calcium alginate or cotton material will NOT be accepted. Fairbanks Lab Request Form

Collection Instructions:
Please Note: *The following instructions are for nasopharyngeal collection only. While nasopharyngeal swabs are preferred, other specimen types are acceptable. Please see the* Respiratory Pathogen Panel test section *in this directory for further information. These instructions were adapted from https://www.cdc.gov/coronavirus/2019-ncov/downloads/lab/NP-Specimen-Collection-Infographic.pdf.*

1. One NP swab is collected for PCR as described below.
2. Remove mucus from the patient's nose.
3. Carefully open package containing the NP swab and remove swab for specimen collection.
4. Tilt patient's head back 70 degrees. Gently and slowly insert a minitip swab with a flexible shaft through the nostril parallel to the palate until resistance is encountered. The distance is equivalent to that from the nostril to the ear of the patient, indicating contact with the nasopharynx.
5. Gently rub and roll the swab, leaving it in place for several seconds to absorb secretions. If a deviated septum or blockage creates difficulty in obtaining the specimen from one nostril, use the same swab to obtain the specimen from the other nostril.



6. Slowly remove swab while rotating it. Specimens can be collected from both nostril, but it is not necessary if the minitip swab is saturated with fluid from the first nostril.
7. Place swab, tip first, into the transport tube provided. Once the tip is near the bottom, break the swab handle at the swab breakpoint by bending back and forth or cut it off with sterile scissors. The swab should fit in the tube comfortably so that the cap can be screwed on tightly to prevent leakage and contamination.
8. Clearly label the UTM containing the swab with patient's name (or alternate unique identifier), date of birth and collection date. Two patient identifiers are required for specimen acceptance at ASVL.
9. Complete the Fairbanks Lab Request Form.
10. Immediately transport specimen to the laboratory. If transport is delayed, place specimen on ice or refrigerate.

Transport:
1. Place the collected specimen in the Ziploc portion of a specimen transport bag and seal. Place the completed Fairbanks Lab Request form in outside pouch.
2. Package as a Biological Substance Category B specimen according to all current shipping regulations and send to the State Public Health Laboratory-Fairbanks as soon as possible.
   - It is preferable to hold UTM specimen at 4°C until transport. Transport specimen on cold packs.

4. **Active Surveillance**
   a. Conduct daily active surveillance until at least 1 week after the last laboratory-confirmed influenza case was identified.
   b. Test for influenza with a molecular assay in the following:
      i. Ill persons who are in the affected unit(s) as well as previously unaffected units in the facility.
      ii. Persons who develop acute respiratory illness symptoms after beginning antiviral chemoprophylaxis.
      *Note that older adults and other long-term care residents, including those who are medically fragile and those with neurological or neurocognitive conditions, may manifest atypical signs and symptoms of influenza virus infection (e.g., behavior change), and may not have fever.
   c. Ensure that the laboratory performing influenza testing notifies the facility of tests results promptly.
   d. The Alaska Section of Epidemiology and the state health department should be notified of every suspected or confirmed influenza outbreak in a long-term care facility, especially if a resident develops influenza while on or after receiving antiviral chemoprophylaxis.

5. **Close Contact**
   a. When at least 2 patients are ill within 72 hours of each other and at least one patient has laboratory-confirmed influenza, the facility should promptly initiate antiviral chemoprophylaxis with oral oseltamivir to all non-ill patients living on the same unit as the patient with laboratory-confirmed influenza (outbreak affected units), regardless of whether they received influenza vaccination during the current season.
   b. Antiviral chemoprophylaxis is meant for patients who are not exhibiting influenza-like illness but who may be exposed or who may have been exposed to an ill person with influenza, to prevent transmission.
   c. Consideration may be given for extending antiviral chemoprophylaxis to patients on other unaffected units or wards in the long-term care facility based upon other factors (e.g., unavoidable mixing of patients or healthcare personnel from affected units and unaffected units).
   d. CDC recommends antiviral chemoprophylaxis with oseltamivir for a minimum of 2 weeks and continuing for at least 7 days after the last known laboratory-confirmed influenza case was identified on affected units.

6. **Patient Placement**
   a. Place a patient with suspected or confirmed influenza in a single-person room (with a dedicated bathroom). If a positive individual has a roommate, that roommate should be moved to prevent further exposure to the positive case.
   b. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with influenza when the number of patients with influenza is high.
   c. Limit transport and movement of the patient outside of the room to medically essential purposes. If transport must occur, place source control on the patient if possible.

7. **Personal Protective Equipment**

a. HCP who enter the room of a patient with suspected or confirmed influenza should adhere to standard precautions and use a facemask and eye protection.
b. When entering an isolation room, don PPE prior to entering and doff prior to exiting in accordance with CDC guidance (PPE-Sequence.pdf (cdc.gov)).

8. **Duration of TBPs for patients with Influenza**
   a. Droplet Precautions should be implemented for patients with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility.
9. **Environmental Infection Control**
   a. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed influenza.
      i. All non-dedicated, non-disposable medical equipment used for the patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
      ii. Routine cleaning and disinfection procedures are appropriate for influenza.
      iii. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
10. **Healthcare Personnel Guidance**
    a. HCP guidance can be found here: Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings | CDC
    b. HCP developing fever and respiratory symptoms should be:
       i. Instructed not to report to work, or if at work, to stop patient-care activities, don a facemask, and promptly notify their supervisor and infection control personnel/occupational health before leaving work.
       ii. Reminded that adherence to respiratory hygiene and cough etiquette after returning to work is always important. If symptoms such as cough and sneezing are still present, HCP should wear a facemask during patient-care activities. The importance of performing frequent hand hygiene (especially before and after each patient contact and contact with respiratory secretions) should be reinforced.
       iii. 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). Those with ongoing respiratory symptoms should be considered for evaluation by occupational health to determine appropriateness of contact with patients.
       iv. Considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer, if returning to care for patients in a Protective Environment (PE) such as hematopoietic stem cell transplant patients (HSCT).
          1. Patients in these environments are severely immunocompromised, and infection with influenza virus can lead to severe disease. Furthermore, once infected, these patients can have prolonged viral shedding despite antiviral treatment and expose other patients to influenza virus infection. Prolonged shedding also increases the chance of developing and spreading antiviral-resistant influenza strains; clusters of influenza antiviral resistance cases have been found among severely immunocompromised persons exposed to a common source or healthcare setting.

c. HCP with influenza or many other infections may not have fever or may have fever alone as an initial symptom or sign. Thus, it can be very difficult to distinguish influenza from many other causes, especially early in a person's illness. HCP with fever alone should follow workplace policy for HCP with fever until a more specific cause of fever is identified or until fever resolves.

HCP developing acute respiratory symptoms without fever may still have influenza infection and should be:

i. Considered for evaluation by occupational health to determine appropriateness of patient contact. HCP suspected of having influenza may benefit from influenza antiviral treatment.
ii. Reminded adherence to respiratory hygiene and cough etiquette after returning to work is always important. If symptoms such as cough and sneezing are still present, HCP should wear a facemask during patient care activities. The importance of performing frequent hand hygiene (especially before and after each patient contact) should be reinforced.
iii. Allowed to continue or return to work unless assigned to care for patients requiring a protective environment such as hematopoietic stem cell transplant patients. These HCP should be considered for temporary reassignment or considered for exclusion from work for 7 days from symptom onset or until the resolution of all non-cough symptoms, whichever is longer.

Lice Information

Background:

Lice are parasitic insects that can be found on people's heads and bodies, including the pubic area. Human lice survive by feeding on human blood. Lice found on each area of the body are different from each other. The three types of lice that live on humans are head, body/clothes, pubic louse. Only the body louse is known to spread disease. Dogs, cats, and other pets do not play a role in the transmission of human lice. Lice move by crawling; they cannot hop or fly.

Signs and Symptoms:

- Itching
- Irritability and sleeplessness
- Sores on the body caused by scratching, which can sometimes become infected with bacteria normally found on a person's skin.
- Head Lice- Tickling feeling or sensation of something moving in the hair

Route of Transmission:

- Skin to skin contact
- Contact with contaminated materials such as hats, scarfs, bedding, towels

Transmission-Based Precautions (TBP):

Contact: https://www.cdc.gov/infection-control/media/pdfs/contact-precautions-sign-p.pdf

Infectious Period/Duration of TBPs and Patient Placement:

Head lice: Contact precautions should be implemented for patients with suspected or confirmed head lice until 24 hours after the initiation of effective therapy followed by standard precautions. Place a patient with suspected or confirmed head lice in a single-person room (with a dedicated bathroom). Limit transport and movement of the patient outside of the room to medically essential purposes.
If a positive individual has a roommate, that roommate should be moved to prevent further exposure to the positive case. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with head lice when the number of patients with head lice is high.

Body and Pubic: Standard precautions should be used. No isolation is necessary.
Adult louse can live up to 30 days on a person. Louse will die within 1 to 2 days off the host without blood meals.

Incubation Period (i.e., time from exposure to becoming symptomatic):

Once exposed to infectious material, lice eggs typically hatch in 7-10 days.

Diagnosis (include laboratory testing and other criteria):

- **Head:** finding a live nymph or adult louse on the scalp or hair of a person or finding nits attached firmly within ¼ in of the base of the hair shafts.
- **Body:** finding eggs and crawling lice in the seams of clothing or crawling/feeding on the skin.
- **Pubic:** short and crab-like appearance differentiates from head or body lice; finding a "crab" louse or eggs on hair in the pubic region or, less commonly, elsewhere on the body (eyebrows, eyelashes, beard, mustache, armpit, perianal area, groin, trunk, scalp).

Reporting Requirements:

A single case of lice is not reportable. However, an outbreak in a congregate or institutional setting is reportable.

If you suspect or have confirmation that an outbreak of lice is occurring in your facility, notify the Alaska Section of Epidemiology as soon as possible at 907-269-8000.

List of Reportable Conditions:
https://health.alaska.gov/media/h2yd3q4q/conditionsreportable_hcp.pdf

Outbreak Criteria in a Healthcare Setting:

Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of lice-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility); and 3) temporal relationship among cases. Report potential outbreaks to the Alaska Section of Epidemiology. Consult the Alaska Section of Epidemiology to determine outbreak status.

Criteria for Outbreak Closure:

30 days without any new cases or symptomatic individuals.

Personal Protective Equipment Recommendations:

Gown and Gloves

Hand Hygiene Recommendations:

Standard hand hygiene practices

Cleaning and Disinfection Recommendations:

- Machine wash and dry clothing worn and bedding used by the person with lice in the hot water (at least 130°F) laundry cycle and the high heat drying cycle. Clothing and items that are not washable can be dry-cleaned OR sealed in a plastic bag and stored for 2 weeks.

- Disinfect combs and brushes used by a person with lice by soaking them in hot water (at least 130°F) for 5–10 minutes.
- Vacuum the floor and furniture, particularly where the person with lice sat or lay. However, spending much time and money on housecleaning activities is not necessary to avoid reinfestation by lice or nits that may have fallen off the head or crawled onto furniture or clothing.
- **Head or Pubic:** There is no need to use fumigant sprays or fogs.
- **Body:** Fumigation or dusting with chemical insecticides is sometimes necessary to control and prevent the spread of body lice for certain diseases (epidemic typhus).

CDC Resources:

Head: CDC - Lice - Head Lice - Prevention & Control
Body: CDC - Lice - Body Lice - Prevention & Control
Pubic "Crab": CDC - Lice - Pubic "Crab" Lice - Prevention & Control

Other:

- All roommates and other close contacts should be evaluated by a physician; those persons with evidence of an active infestation should be treated.
- If a bed is shared, the bedmate should be treated at the same time as the individual with lice.

All Healthcare Settings Lice Outbreak Response Guidance

This guidance is applicable to all U.S. settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants, schools, group homes) and not for persons outside of healthcare settings.** A facility must go 30 days without a new case or exposure to close the outbreak.

Outbreak Definition: Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of lice-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility); and 3) temporal relationship among cases. Please work with the Alaska Section of Epidemiology to determine if cases meet outbreak status.

Helpful Resources:

- Head: CDC - Lice - Head Lice - Prevention & Control
- Body: CDC - Lice - Body Lice - Prevention & Control
- Pubic "Crab": CDC - Lice - Pubic "Crab" Lice - Prevention & Control
- The Section of Epidemiology Healthcare Associated Infections Team provides free, non-regulatory infection control assessments and outbreak consultations to all healthcare settings in Alaska. If interested, please contact the HAI/AR Program ICAR team at doh.dph.epi.ak.hai.access@alaska.gov or 907-269-8000.

1. **Recommended Routine IPC Practices for Healthcare (HC) settings**
   a. Establish a process to identify and manage individuals with suspected or confirmed lice infection (i.e. post signage).
   b. Determining dates when the patient, visitor, or HCP with confirmed lice could have spread lice.

2. **Testing**
   a. Anyone with symptoms of lice should be assessed by a physician or healthcare provider.
      i. Head: finding a live nymph or adult louse on the scalp or hair of a person or finding nits attached firmly within ¼ in of the base of the hair shafts.
      ii. Body: finding eggs and crawling lice in the seams of clothing or crawling/feeding on the skin.
      iii. Pubic: short and crab-like appearance differentiates from head or body lice; finding a "crab" louse or eggs on hair in the pubic region or, less commonly, elsewhere on the body (eyebrows, eyelashes, beard, mustache, armpit, perianal area, groin, trunk, scalp).

Close Contacts

   a. All roommates and other close contacts should be checked by their physician or primary care provider; those persons with evidence of an active infestation should be treated.
   b. If a bed is shared, the bedmate should be treated at the same time as the individual with lice.

Ectoparasites

Testing site Anchorage Requisition Form	Please send testing to Alaska State Public Health Laboratory – Anchorage (907-334-2100) 5455 Dr Martin Luther King Jr Ave, Anchorage, AK 99507 Form: https://health.alaska.gov/dph/Labs/Documents/publications/;AncTestReq.pdf
Diseases	Ectoparasites, arthropods, lice, crabs, mites, bedbugs
Organisms	*Cimex lectularis, Pediculus capitis, Pediculus humanus, Phthirus pubis, Pulex irritans*
Test Method	Morphological identification
Specimen	Suspect arthropod
Collection	Comb for nits or use forceps to pluck hair; place into clean, dry tube with secure lid.
Storage/Transport	Ambient temperature
Results	**No Ectoparasites observed** *Cimex lectularis* (bed bug) *Pediculus capitis* (head louse) *Pediculus humanus* (body louse) *Phthirus pubis* (crab louse) *Pulex irritans* (human flea) A normal result is **no ectoparasites observed.**
Turnaround time	1 day after receipt at ASVL

Methicillin-Resistant *Staphylococcus aureus* (MRSA) Information

Background:

Methicillin-resistant *Staphylococcus aureus* (MRSA) is an antimicrobial-resistant type of *S. aureus* resistant to currently available beta-lactam antibiotics including penicillins (e.g., penicillin, amoxicillin), "anti-staphylococcal" penicillins (e.g., methicillin, oxacillin), and cephalosporins (e.g., cephalexin).

Signs and Symptoms:

Most *S. aureus* skin infections, including MRSA, appear as a bump or infected area on the skin that might be:

- Red
- Swollen
- Painful
- Warm to the touch
- Full of pus or other drainage
- Accompanied by a fever

Many people perceive these infections to be a spider bite or to look like a spider bite, even if they have a history of MRSA infection.

Route of Transmission:

Skin to skin contact or contact with contaminated surfaces including equipment, supplies, and bandages, and/or the sharing of personal items such as razors and towels.

Transmission-Based Precautions (TBP):

Contact Precautions sign: https://www.cdc.gov/infection-control/media/pdfs/contact-precautions-sign-p.pdf.

Infectious Period/Duration of TBPs:

Until the wound is healed or the wound can be covered in specific setting types. See below for more information.

Acute Care: CDC recommends the use of Contact Precautions in inpatient acute care settings for patients known to be colonized or infected with epidemiologically important multidrug-resistant organisms (MDROs) including MRSA. Please refer to your facility policy as well.

LTCF: Enhanced Barrier precautions can be used if the wound can be contained and covered. Please refer to your facility policy as well.

Patient Placement:

Acute Care: CDC recommends the use of Contact Precautions in inpatient acute care settings for patients known to be colonized or infected.

LTCF: Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device placing them at higher risk. Enhanced Barrier Precautions can be used for residents with wounds able to be contained by a bandage.

Incubation Period (i.e., time from exposure to becoming symptomatic):

The exact incubation period for MRSA is unknown.

Diagnosis (include laboratory testing and other criteria):

Wound drainage is sent for culture and susceptibility testing.

- Culture should identify *Staphylococcus aureus.*
- Broth-based, agar-based, or cefoxitin disk diffusion methods can be used for susceptibility testing.
- Resistance to oxacillin/methicillin: all beta-lactams.

Reporting Requirements:

A single case of MRSA is not reportable. However, an outbreak in a congregate or institutional setting is reportable.
If you suspect or have confirmation that an outbreak of MRSA is occurring in your facility, notify the Alaska Section of Epidemiology as soon as possible at 907-269-8000.
List of Reportable Conditions:
https://health.alaska.gov/media/h2yd3q4q/conditionsreportable_hcp.pdf

Outbreak Criteria in a Healthcare Setting:

Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of MRSA-like condition to determine:
1) levels of risk for patients, staff, and visitors
2) extent of the outbreak (e.g. confined or widespread in the facility)
3) temporal relationship among cases
Report potential outbreaks to the Alaska Section of Epidemiology. Report potential outbreaks to the Alaska Section of Epidemiology. Consult the Alaska Section of Epidemiology to determine outbreak status.

Criteria for Outbreak Closure:

30 days without any new cases or symptomatic individuals.

Personal Protective Equipment Recommendations:

- Gown and gloves.
- Masks, eye protection, and face shields should be used when care activities will likely generate splashes, or sprays of blood, body fluids, secretions, and excretions such as wound care, in accordance with standard precautions.

Hand Hygiene Recommendations:

Use soap and water to clean your hands if available. If you cannot access soap and water, use an alcohol-based hand sanitizer containing at least 60% alcohol to clean hands.

Cleaning and Disinfection Recommendations:

The EPA provides a list of EPA-registered products effective against MRSA (List H).

CDC Resources:

Healthcare Settings | MRSA | CDC
All Healthcare Settings Methicillin-Resistant *Staphylococcus aureus* (MRSA) Outbreak Response Guidance

This guidance is applicable to all U.S. settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants, schools, group homes) and not for persons outside of healthcare settings.** A facility must go 30 days without a new case to close the outbreak.

Helpful Resources:

- Healthcare Settings | MRSA | CDC
- The Section of Epidemiology Healthcare Associated Infections Team provides free, non-regulatory infection control assessments and outbreak consultations to all healthcare settings in Alaska. If interested, please contact the HAI/AR Program ICAR team at doh.dph.epi.ak.hai.access@alaska.gov or 907-269-8000.

1. **Recommended Routine IPC Practices for Healthcare (HC) settings**
   a. Establish a process to identify and manage individuals with suspected or confirmed MRSA infection (i.e. skin checks, proper wound care).
2. **Visitation**

a. Patients should be encouraged to limit in-person visitation if the wound cannot be covered.
b. Counsel patients and their visitor(s) about the risks of in-person visitation.
c. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
d. Visitors should be instructed to only visit the patient room.

3. **Testing**
   a. Anyone with symptoms of a wound infection should be evaluated by a provider. A wound culture may be collected and sent for testing.
   b. The Alaska State Public Health Laboratories do not provide testing for MRSA at this time. Consult with the bacteriology department or commercial laboratory providing your facility with microbiological testing for specimen collection requirements and shipping/transport requirements.
4. **Personal Protective Equipment**
   a. HCP entering the room of a patient with suspected or confirmed MRSA should adhere to standard and contact precautions and use a gown and gloves.
   b. If care activities are likely to generate splashes, or sprays of blood, body fluids, secretions, and excretions such as wound care are to be performed, HCP should also use masks, eye protection, and face shields, in accordance with standard precautions.
   c. When entering an isolation room, don PPE prior to entering and doff prior to exiting in accordance with CDC guidance (PPE-Sequence.pdf (cdc.gov)).
5. **Duration of TBPs for patients with MRSA**
   a. Contact Precautions should be implemented for patients with suspected or confirmed MRSA until the wound is healed.
   b. In LTCF, if the wound can be contained and covered, the resident may be transferred to enhanced barrier precautions.
6. **Environmental Infection Control**
   a. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed MRSA.
      i. All non-dedicated, non-disposable medical equipment used for the patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
   b. Routine cleaning and disinfection procedures are appropriate for MRSA using products on the list of EPA-registered products effective against MRSA (List H).
   c. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
7. **Nursing Home/Assisted Living Specific Guidance**
   a. Patient Placement
      i. Patients with confirmed or suspected MRSA should be placed in a single room until the wound has healed or is contained and covered.
      ii. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device, placing them at higher risk.
   b. Duration of TBP

i. In LTCF, if the wound can be contained and covered, the resident may be placed on enhanced barrier precautions.

8. **Hospital Specific Guidance**
   a. Patient placement
      i. CDC recommends the use of Contact Precautions for inpatient acute care settings with patients known to be colonized or infected.
   b. Duration of TBP
      i. CDC recommends the use of Contact Precautions for inpatient acute care settings with patients known to be colonized or infected with epidemiologically important multidrug-resistant organisms (MDROs) including MRSA.

Norovirus Information

Background:

Norovirus is a highly contagious virus that causes vomiting and diarrhea. Individuals will often refer to noroviral illness as “food poisoning” or “stomach flu”. A hardy virus, it spreads easily through direct contact with an infected individual, eating food or drinking liquids contaminated with norovirus, or touching contaminated surfaces or objects and then touching your mouth.

Signs and Symptoms:

- Diarrhea
- Vomiting
- Nausea
- Stomach pain
- Fever
- Headache
- Body aches

Route of Transmission:

- Direct contact with an individual infected with norovirus.
- Eating food or drinking liquids contaminated with norovirus.
- Touching surfaces or objects contaminated with norovirus, then putting unwashed hands in your mouth.

Transmission-Based Precautions (TBP):

Contact Precautions signage: https://www.cdc.gov/infection-control/media/pdfs/contact-precautions-sign-p.pdf.

Infectious Period/Duration of TBPs:

Contact Precautions should be used for a minimum of **48 hours** after the resolution of symptoms to prevent further exposure of susceptible patients.

Healthcare staff and food handlers should be excluded from work for at least 72 hours after the resolution of symptoms to prevent further exposure to susceptible patients as best practice. However, if your facility is short-staffed, please consult with the Alaska Section of Epidemiology as this may be reduced to 48 hours.

Norovirus can still be shed for several weeks after symptoms have resolved

Patient Placement:

Place patient in single occupancy room with their own bathroom if they have symptoms consistent with norovirus. If single occupancy is not feasible, cohorting symptomatic patients is recommended. Ensure that the individuals are not also infected with another communicable disease. During large outbreaks, designating patient care areas or contiguous sections within a facility for patient cohorts may be useful.

Incubation Period (i.e., time from exposure to becoming symptomatic):

12-48 hours

Diagnosis (include laboratory testing and other criteria):

Detection of norovirus in stool specimen

Epi-linkage: symptomatic cases that meet the outbreak definition may be counted without confirmatory lab results.

Reporting Requirements:

A single case of norovirus is not reportable. However, an outbreak in a congregate and institutional setting is reportable.

If you suspect or have confirmation that an outbreak of norovirus or norovirus-like illness is occurring in your facility, notify the Alaska Section of Epidemiology as soon as possible at 907-269-8000.

List of Reportable Conditions:
https://health.alaska.gov/media/h2yd3q4q/conditionsreportable_hcp.pdf

Outbreak Criteria in a Healthcare Setting:

Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of norovirus-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility); and 3) temporal relationship among cases. Report potential outbreaks to the Alaska Section of Epidemiology. Consult the Alaska Section of Epidemiology to determine outbreak status.

Criteria for Outbreak Closure:

4 days without any new cases or symptomatic individuals.

Personal Protective Equipment Recommendations:

- Gown and gloves.
- Use a surgical or procedure mask and eye protection or a face shield if there is an anticipated risk of splashes to the face during the care of patients, particularly among those vomiting, in accordance with standard precautions.

Hand Hygiene Recommendations:

During outbreaks, use soap and water for hand hygiene after providing care or having contact with patients suspected or confirmed with norovirus. **Alcohol-based hand sanitizer does not work well against norovirus.** Be sure to wash hands well with soap and water after removing gloves.

Cleaning and Disinfection Recommendations:

- Disinfect all high-touch surfaces (faucets, door handles, commodes, and toilet or bath rails) multiple times per day during a norovirus outbreak.
- Use EPA-registered disinfectants or detergents/disinfectants approved for use against norovirus for routine cleaning and disinfection.
- CDC recommends cleaning with a bleach solution; combine 3/4 cup of household bleach per 1 gallon of water.
- Bleach needs to be remade every 24 hrs and should be labeled with date and time of dilution, as well as product name.
- EPA List G: https://www.epa.gov/pesticide-registration/epas-registered-antimicrobial-products-effective-against-norovirus-feline
- Clean soiled carpets and soft furnishings with hot water and detergent or steam clean as appropriate.
- Handle soiled linens carefully using appropriate infection control precautions.
- Conduct thorough cleaning of affected personal and communal areas 48 hours after resolution of the last case.
- Immediately remove and wash clothes or linens that may be contaminated with vomit or poop.
- Handle soiled items carefully without agitating them.
- Wear rubber or disposable gloves while handling soiled items and wash your hands with soap afterward.
    - Wash the items with detergent and hot water at the maximum available cycle length then machine dry them at the highest heat setting.

*Norovirus can live on surfaces for days to weeks depending on whether or not the surface is porous *

CDC Resources:

Norovirus | Guidelines Library | Infection Control | CDC

All Healthcare Settings Norovirus Outbreak Response Guidance

This guidance is applicable to all U.S. settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants, schools, group homes) and not for persons outside of healthcare settings.** A facility must go 4 days without a new positive case or exposure to close the outbreak.

Outbreak Definition: Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of norovirus-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g., confined or widespread in the facility); and 3) temporal relationship among cases. Please consult with the Alaska Section of Epidemiology to determine if cases meet outbreak criteria.

Helpful Resources:

- Norovirus | Guidelines Library | Infection Control | CDC
- The Section of Epidemiology Healthcare Associated Infections Team provides free, non-regulatory infection control assessments and outbreak consultations to all healthcare settings in Alaska. If interested, please contact the HAI/AR Program ICAR team at doh.dph.epi.ak.hai.access@alaska.gov or 907-269-8000.

1. **Recommended Routine IPC Practices for Healthcare (HC) settings**
   a. Establish a process to identify and manage individuals with suspected or confirmed norovirus infection (i.e., post signage).
   b. Determining the time frame when the patient, visitor, or HCP with confirmed norovirus infection could have been infectious:
      i. For patients with confirmed or suspected norovirus, consider the infectious window to be at least 48 hours after symptom resolution. Contact Precautions should be implemented for patients with suspected or confirmed norovirus from symptom onset through at least 48 hours after symptom resolution.
      ii. For healthcare staff and food handlers with confirmed or suspected norovirus, consider the infectious window to be at least 72 hours after symptom resolution. These staff should be work excluded from symptom onset through at least 72 hours after symptom resolution to prevent further exposure to susceptible patients as best practice. However, if your facility is short-staffed, please consult with the Alaska Section of Epidemiology as this may be reduced to 48 hours.
2. **Visitation**
   a. Visitors with confirmed norovirus or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation.
   b. Patients should be encouraged to limit in-person visitation while they are infectious.
   c. Counsel patients and their visitor(s) about the risks of in-person visitation.
   d. Facilities should provide instruction (before visitors enter the patient's room) on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
   e. Visitors should be instructed to only visit the patient room.
3. **Testing**

a. At least 2 norovirus stool specimens must be positive for the outbreak to be confirmed. After that, individuals with norovirus-like symptoms can be epi-linked to the outbreak without confirmatory testing. Please work with the Alaska Section of Epidemiology to coordinate testing.
b. If stool specimens were collected and tested at a local laboratory, please work with the Alaska Section of Epidemiology to have them forward the specimen to the AK Public Health Laboratory (ASPHL) for further testing. If not, please collect 2 stool specimens and work with the Alaska Section of Epidemiology to coordinate testing at ASPHL. Please work with the Alaska Section of Epidemiology to coordinate sending specimens to ASPHL. Do not send to ASPHL directly without coordination with the Alaska Section of Epidemiology.

Testing request forms for ASVL are available here:
https://health.alaska.gov/dph/Labs/Documents/publications/Virologytestreq.pdf

Norovirus	
Testing site Fairbanks Requisition Form	Please send testing to Alaska State Virology Laboratory (ASVL) – Fairbanks 907-371-1000, address 1051 Sheenjek Dr, Fairbanks, AK 99706 Form: https://health.alaska.gov/dph/Labs/Documents/publications/Virologytestreq.pdf
Diseases	Noro, Norovirus, Norwalk-like disease, epidemic viral gastroenteropathy
Organism	Norovirus, Norwalk-like viruses
Test Method	PCR
Availability	**Testing will only be completed for outbreak situations.** **Contact Section of Epidemiology at 907-269-8000 during business hours or 1-800-478-0084 during non-business hours.**
Specimen	Collect at least 5 mL of raw stool or vomit in sterile container. Specimens must not be submitted in UTM. .
Collection	Requests for collection supplies may be made by contacting ASPHL.
Storage/Transport	Store refrigerated. Ship with cool packs.
Results	Norovirus Positive (Genogroup I or II) **Target Not Detected** A normal result is **not detected.**
Turnaround time	2-7 days after receipt at ASVL

Collecting Specimens for Norovirus Testing

Norovirus outbreak testing should be pre-approved by the Section of Epidemiology. Please call the Section of Epidemiology at 907-269-8000 during business hours or 1-800-478-0084 after business hours.

Collection of Specimens

1. Section of Epidemiology will determine the number of specimens that need to be collected (usually 4-6).
2. Raw, loose, stool and vomitus are appropriate specimens to collect.
3. Collect at least 5 mL, preferably 10-50 mL of specimen.
4. Collect specimen in a clean, leak-proof container. Supplies can be obtained from Epidemiology, the Alaska State Virology Laboratory – Fairbanks or Anchorage State Public Health Laboratory.
5. Collection should begin as soon as symptoms appear, ideally within 48-72 hours of onset.
6. DO NOT submit samples in universal transport media (UTM).

Storage and Transport

1. Store specimens at 4°C.
2. Complete all information on the norovirus request slip. Paperwork may be obtained from Section of Epidemiology, Alaska State Virology Laboratory – Fairbanks or Anchorage.
3. Specimen containers should be individually sealed and bagged with the appropriate amount of absorbent material. (Roughly two paper towels per 50 mL.)
4. Paperwork should be separated from the specimen.
5. Specimens should be packaged and labeled as Biological Substance, Category B, and shipped in an insulated, waterproof shipping container with cool packs.
6. Arrange with Section of Epidemiology for transportation to:

If shipping with third party vendors (FedEx, UPS, Goldstreak, etc.)	*If using USPS:*
Alaska State Virology Laboratory - Fairbanks 1051 Sheenjek Drive Fairbanks, AK 99775 (907) 371-1000	**Alaska State Virology Laboratory - Fairbanks** PO Box 60260 Fairbanks, AK 99706 (907) 371-1000

Note: Food, water or environmental samples are not tested. Please refer any further questions to the Alaska State Virology Laboratory – Fairbanks at 907-371-1000.

4. **Patient Placement**
   a. Place a patient with suspected or confirmed norovirus in a single-person room (with a dedicated bathroom). If a positive individual has a roommate, that roommate should be moved to prevent further exposure to the positive case.
   b. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with norovirus when the number of norovirus patients is high.
   c. Limit patient transport and movement outside of the room to medically essential purposes.
5. **Personal Protective Equipment**
   a. HCP entering the room of a patient with suspected or confirmed norovirus should adhere to contact and standard precautions.
   b. When entering an isolation room, don PPE prior to entering and doff prior to exiting in accordance with CDC guidance.
6. **Duration of TBPs for patients with Norovirus**
   a. Contact Precautions should be implemented for patients with suspected or confirmed norovirus until at least 48 hours have passed since symptom resolution.
7. **Environmental Infection Control**
   a. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed norovirus.
      i. All non-dedicated, non-disposable medical equipment used for the patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
   b. Use EPA-registered disinfectants or detergents/disinfectants approved for use against norovirus for routine cleaning and disinfection.
      i. CDC recommends cleaning with a bleach solution; combine 3/4 cup of household bleach per 1 gallon of water. Bleach needs to be remade every 24 hours and should be labeled with date, time, and product name.
      ii. EPA List G: https://www.epa.gov/pesticide-registration/epas-registered-antimicrobial-products-effective-against-norovirus-feline
   c. Clean soiled carpets and soft furnishings with hot water and detergent or steam clean as appropriate.
   d. Handle soiled linens carefully using appropriate infection control precautions.
   e. Conduct thorough cleaning of affected personal and communal areas 48 hours after resolution of the last case.
   f. Immediately remove and wash clothes or linens that may be contaminated with vomit or poop.
      i. Handle soiled items carefully without agitating them.
      ii. Wear rubber or disposable gloves while handling soiled items and wash hands with soap afterward
      iii. Wash the items with detergent and hot water at the maximum available cycle length then machine dry them at the highest heat setting.

Norovirus can live on surfaces for days to weeks depending on whether the surface is porous or not

Respiratory Syncytial Virus (RSV) Information

Background:

Respiratory syncytial virus (RSV) is a common respiratory virus that causes cold-like symptoms. In the United States, RSV circulation starts in the fall and peaks in the winter but can vary from year to year depending on the given community. Older adults are among those prone to developing pneumonia following or concurrent with RSV infections.

Signs and Symptoms:

- Runny nose
- Decrease in appetite
- Coughing
- Sneezing
- Fever
- Wheezing

Route of Transmission:

- Coughing or sneezing.
- Direct contact with the virus like kissing the face of child with RSV.
- Touching contaminated surfaces and then touching eyes, nose, or mouth.

Transmission-Based Precautions (TBP):

Contact: https://www.cdc.gov/infection-control/media/pdfs/contact-precautions-sign-P.pdf
Staff and others should wear masks when entering the room or caring for the patient.

Infectious Period/Duration of TBPs:

3-8 days

Immunocompromised individuals may spread the virus for as long as 4 weeks after symptoms have stopped

Patient Placement:

Place ill patients in a private room. If a private room is not available, place (cohort) patients suspected/confirmed of having RSV with one another.

Incubation Period (i.e., time from exposure to becoming symptomatic):

4 – 6 days

Diagnosis (include laboratory testing and other criteria):

Positive RSV rRT-PCR test

Reporting Requirements:

A single case of RSV is not reportable. However, an outbreak in a congregate and institutional setting is reportable. If you suspect or have confirmation that an RSV outbreak is occurring in your facility, notify the Alaska Section of Epidemiology as soon as possible at 907-269-8000.

List of Reportable Conditions:
https://health.alaska.gov/media/h2yd3q4q/conditionsreportable_hcp.pdf

Outbreak Criteria in a Healthcare Setting:

Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of RSV-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility); and 3) temporal relationship among cases. This may include 2 cases with respiratory symptoms within 72 hrs. Report potential outbreaks to the Alaska Section of Epidemiology. Consult the Alaska Section of Epidemiology to determine outbreak status.

Criteria for Outbreak Closure:

12 days without any new cases or symptomatic individuals.

Personal Protective Equipment Recommendations:

- Gown and gloves.
- Use eye protection or a face shield if the individual is coughing or if aerosol-generating procedures are being performed.
- Wear a mask according to standard precautions.

Hand Hygiene Recommendations:

Standard hand hygiene practices

Cleaning and Disinfection Recommendations:

- Standard cleaning and disinfection procedures (e.g., using cleaners and water to preclean surfaces prior to applying disinfectants to frequently touched surfaces or objects for indicated contact times) are adequate for RSV environmental control in all settings within the healthcare facility, including those patient-care areas in which aerosol-generating procedures are performed.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with standard procedures.
- Laundry and food service utensils should first be cleaned, then sanitized as appropriate.
- Some medical waste may be designated as regulated or biohazardous waste and require special handling and disposal methods approved by the State authorities.

CDC Resources https://www.cdc.gov/rsv/hcp/clinical-overview/
All Healthcare Settings Respiratory Syncytial Virus (RSV) Outbreak Response Guidance

This guidance is applicable to all U.S. settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants, schools, group homes) and not for persons outside of healthcare settings.** A facility must go 12 days without a new positive case or exposure to close the outbreak.

Outbreak Definition: Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of RSV-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility); and 3) temporal relationship among cases. This may include 2 cases with respiratory symptoms within 72 hrs. Consult the Alaska Section of Epidemiology to determine outbreak status.

Helpful Resources:

- For Healthcare Professionals: RSV (Respiratory Syncytial Virus) | CDC
- The Section of Epidemiology Healthcare Associated Infections Team provides free, non-regulatory infection control assessments and outbreak consultations to all healthcare settings in Alaska. If interested, please contact the HAI/AR Program ICAR team at doh.dph.epi.ak.hai.access@alaska.gov or 907-269-8000.

1. **Recommended Routine IPC Practices for Healthcare (HC) settings**
   a. Establish a process to identify and manage individuals with suspected or confirmed RSV infection (i.e., post signage).
   b. Determining the time frame when the patient, visitor, or HCP with confirmed RSV infection could have been infectious. For individuals with confirmed or suspected RSV, consider the exposure window for others to be for3 to 8 days after symptom onset. Contact Precautions should be implemented for patients with suspected or confirmed RSV for 8 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility.
2. **Visitation**
   a. Visitors with confirmed RSV or compatible symptoms should defer non-urgent in-person visitation until healthcare criteria to end isolation have been met.
   b. Patients should be encouraged to limit in-person visitation while infectious.
   c. Counsel patients and their visitor(s) about the risks of in-person visitation.
   d. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
   e. Visitors should be instructed to only visit the patient room.
3. **Testing**
   a. Anyone with even mild symptoms of RSV should receive a viral test as soon as possible.
   b. If one laboratory-confirmed RSV positive case is identified along with other cases of acute respiratory illness in a unit of a long-term care facility, an RSV outbreak might be occurring. Active surveillance for additional cases should be implemented as soon as possible once one case of laboratory-confirmed RSV is identified in a facility.
   c. Specimen requirements for submission to the Alaska State Virology Laboratory (ASVL)

Respiratory Syncytial Virus (RSV)	
Testing site Fairbanks Requisition Form	Please send testing to Alaska State Virology Laboratory (ASVL) – Fairbanks 907-371-1000, address 1051 Sheenjek Dr, Fairbanks, AK 99706 Respiratory pathogen lab request form: https://health.alaska.gov/dph/Labs/Documents/RespPathRequestForm.pdf General virology lab request form: https://health.alaska.gov/dph/Labs/Documents/publications/Virologytestreq.pdf
Diseases	Respiratory Syncytial Virus (RSV)
Test Method	PCR (see also Respiratory Pathogen Panel)
Specimen	**Preferred specimen: Nasopharyngeal swab*, in 3mL Universal Transport Media (UTM) or other acceptable liquid viral transport media.** Other acceptable specimens: Nasal swab*, nasal wash, tracheal aspirate, nasal aspirate, broncheoalveolar lavage, lung tissue, bronchial wash. **Swabs: use synthetic material swabs only – cotton or calcium-alginate tips and wooden or metal shafts are not acceptable*
Collection	Swab: place swab into 3mL UTM and break swab **below** lid line Wash or lavage: aseptically transfer no more than 3 mL of wash to 3mL UTM Lung tissue: transfer a pea sized piece (about 1 gram) into 3mL UTM
Storage/Transport	Store the specimens in your refrigerator until ready to ship, pack sample on cool packs to preserve viral integrity. Ship as a Biological Substance Category B UN3373. If you are in an outlying area, use the pre-addresse **Priority Mail** Labels provided. Mail Monday or Tuesday to avoid weekends at the Post Office.
Result (for each target)	**Positive:** nucleic acid detected **Not detected:** nucleic acid not detected. A normal result is **Not detected.**
Turnaround time	1-7 days after receipt at ASVL.

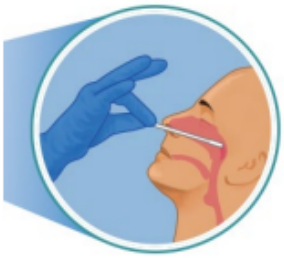
Respiratory Pathogen Panel (RPP)	
Testing site Fairbanks Requisition Form	Please send testing to Alaska State Virology Laboratory (ASVL) – Fairbanks 907-371-1000, address 1051 Sheenjek Dr, Fairbanks, AK 99706 Respiratory pathogen lab request form: https://health.alaska.gov/dph/Labs/Documents/RespPathRequestForm.pdf General virology lab request form: https://health.alaska.gov/dph/Labs/Documents/publications/Virologytestreq.pdf
Test Method	Multiplex PCR (CPT code 87633)
CPT code and fee	87633, *To receive RPP results, a memorandum of agreement (MOA) must be on file with the Alaska State Public Health Labs.*
Targets – Luminex NxTag RPP Assay	Respiratory Syncytial Virus (Groups A & B), rhinovirus/enterovirus (cannot differentiate), parainfluenza (Types 1, 2, 3, and 4), human metapneumovirus, adenovirus, seasonal coronavirus (HKU1, NL63, 229E, OC43), human bocavirus, *Chlamydophila pneumoniae, and Mycoplasma pneumoniae*
Specimen	**Preferred specimen: Nasopharyngeal swab*, in 3mL Universal Transport Media (UTM) or other acceptable liquid viral transport media.** Other acceptable specimens: Nasal swab*, nasal wash, tracheal aspirate, nasal aspirate, broncheoalveolar lavage, lung tissue, bronchial wash. **Swabs: use synthetic material swabs only – cotton or calcium-alginate tips and wooden or metal shafts are not acceptable*
Collection	Swab: place swab into 3mL UTM and break swab **below** lid line Wash or lavage: aseptically transfer no more than 3 mL of wash to 3mL UTM Lung tissue: transfer a pea sized piece (about 1 gram) into 3mL UTM
Storage/Transport	Store the specimens in your refrigerator until ready to ship, pack sample on cool packs to preserve viral integrity. Ship as a Biological Substance Category B UN3373. If you are in an outlying area, use the pre-addresse **Priority Mail** Labels provided. Mail Monday or Tuesday to avoid weekends at the Post Office.
Result (for each target)	**Positive:** nucleic acid detected **Not detected:** nucleic acid not detected. A normal result is **Not detected.**
Turnaround time	Due to limited staff, testing is performed on Mondays only.

Collecting Nasopharyngeal Swabs for Respiratory Virus Testing

Supplies Needed: UTM Kit = Universal Transport Media (UTM) with collection swab:
Swabs are made of synthetic or plastic materials only. Metal, wood, calcium alginate or cotton material will NOT be accepted. Fairbanks Lab Request Form

Collection Instructions:
Please Note: *The following instructions are for nasopharyngeal collection only. While nasopharyngeal swabs are preferred, other specimen types are acceptable. Please see the* Respiratory Pathogen Panel test section *in this directory for further information. These instructions were adapted from https://www.cdc.gov/coronavirus/2019-ncov/downloads/lab/NP-Specimen-Collection-Infographic.pdf.*

1. One NP swab is collected for PCR as described below.
2. Remove mucus from the patient's nose.
3. Carefully open package containing the NP swab and remove swab for specimen collection.
4. Tilt patient's head back 70 degrees. Gently and slowly insert a minitip swab with a flexible shaft through the nostril parallel to the palate until resistance is encountered. The distance is equivalent to that from the nostril to the ear of the patient, indicating contact with the nasopharynx.
5. Gently rub and roll the swab, leaving it in place for several seconds to absorb secretions. If a deviated septum or blockage creates difficulty in obtaining the specimen from one nostril, use the same swab to obtain the specimen from the other nostril.
6. Slowly remove swab while rotating it. Specimens can be collected from both nostril, but it is not necessary if the minitip swab is saturated with fluid from the first nostril.
7. Place swab, tip first, into the transport tube provided. Once the tip is near the bottom, break the swab handle at the swab breakpoint by bending back and forth or cut it off with sterile scissors. The swab should fit in the tube comfortably so that the cap can be screwed on tightly to prevent leakage and contamination.



8. Clearly label the UTM containing the swab with patient's name (or alternate unique identifier), date of birth and collection date. Two patient identifiers are required for specimen acceptance at ASVL.
9. Complete the Fairbanks Lab Request Form.
10. Immediately transport specimen to the laboratory. If transport is delayed, place specimen on ice or refrigerate.

Transport:
1. Place the collected specimen in the Ziploc portion of a specimen transport bag and seal. Place the completed Fairbanks Lab Request form in outside pouch.
2. Package as a Biological Substance Category B specimen according to all current shipping regulations and send to the State Public Health Laboratory-Fairbanks as soon as possible.
   - It is preferable to hold UTM specimen at 4°C until transport. Transport specimen on cold packs.

4. **Active Surveillance**
   a. Conduct daily active surveillance for the duration of the outbreak period.
   b. Test for RSV with a molecular assay in ill persons in the affected unit(s) as well as previously unaffected units in the facility.
   c. Ensure that the laboratory performing RSV testing notifies the facility of tests results promptly.
   d. The Alaska Section of Epidemiology and the state health department should be notified of every suspected or confirmed RSV outbreak in a long-term care facility.
5. **Patient Placement**
   a. Place a patient with suspected or confirmed RSV in a single-person room (with a dedicated bathroom). If a positive individual has a roommate, that roommate should be moved to prevent further exposure to the positive case.
   b. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with RSV when the number of RSV patients is high.
   c. Limit patient transport and movement outside of the room to medically essential purposes.
6. **Personal Protective Equipment**
   a. HCP entering the room of a patient with suspected or confirmed RSV should adhere to standard precautions and use gown and gloves, wear a mask.
   b. Eye protection may be warranted if the patient is coughing or undergoing aerosol-generating procedures.
   c. When entering an isolation room, don PPE prior to entering and doff prior to exiting in accordance with CDC guidance.
7. **Duration of TBPs for patients with RSV**
   a. Contact Precautions should be implemented for patients with suspected or confirmed RSV for 8 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility.
8. **Environmental Infection Control**
   a. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed RSV.
      i. All non-dedicated, non-disposable medical equipment used for the patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
      ii. Routine cleaning and disinfection procedures are appropriate for RSV.
      iii. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
9. **Prevention**
   a. RSV is a vaccine-preventable infection. A one-time (once per lifetime) RSV vaccination is available for all adults 75 years and older, and for adults aged 60 – 74 years who have medical condition(s) making them higher risk for severe illness from RSV. Facilities should offer eligible residents and patients RSV vaccination at the time of intake (or for current residents/patients as soon as possible) if they have not already been vaccinated.

Scabies Information

Background:

Scabies is an infestation of the skin by the human itch mite (*Sarcoptes scabiei* var. *hominis*). The microscopic scabies mite burrows into the upper layer of skin where it lives and lays eggs. Scabies can spread rapidly in overcrowded conditions where close body and skin contact is frequent, such as nursing homes. Crusted (Norwegian) scabies is a severe form of scabies and can occur in some immunocompromised, elderly, disabled, or debilitated individuals. Persons with crusted scabies have thick crusts of skin containing large numbers of scabies mites and eggs. People with crusted scabies are very contagious.

Signs and Symptoms:

- Burrows (most often in the webbing between the fingers, skin folds on the wrist, elbow or knee, and on the penis, breast or shoulder blade)
- Pimple-like rash lesions (most common between fingers, wrist, elbow, armpit, penis, nipple, waist, buttocks, shoulder blades)
- Itching (severe, especially at night)

Route of Transmission:

- Direct, prolonged, skin to skin contact.
- Contact with mites or eggs from contaminated items in the environment such as bedding, towels, clothing, furniture.

Scabies can still be spread from a person without symptoms.

Transmission-Based Precautions (TBP):

Contact: https://www.cdc.gov/infectioncontrol/pdf/contact-precautions-sign-P.pdf.

Infectious Period/Duration of TBPs:

Typically 30 days.

Norwegian crusted scabies must have negative skin scrapings to be released from isolation, per CDC guidance.

Patient Placement:

Uncrusted: Isolate patients for 24 hours after start of effective treatment.

Norwegian Crusted: Isolate patients with crusted scabies from other patients who do not have crusted scabies; consider assigning a cohort of caretakers to care only for patients with crusted scabies. Isolate the patient until meeting criteria to discontinue contact precautions which includes a negative skin

scraping result.

Incubation Period (time from exposure to becoming symptomatic):

Up to 2 months

Diagnosis (include laboratory testing and other criteria):

Diagnosis of a scabies infestation is usually made based upon the customary appearance and distribution of the rash and presence of burrows.
Whenever possible, the diagnosis of scabies should be confirmed by identifying the mite or mite eggs or fecal matter (scybala). This can be done by carefully removing the mite from the end of its burrow using the tip of a needle or by obtaining a skin scraping to examine under a microscope for mites, eggs, or mite fecal matter. However, a person can still have lice even if mites, eggs, or fecal matter cannot be found; fewer than 10-15 mites may be present on a person with lice who is otherwise healthy.

Reporting Requirements:

A single case of scabies is not reportable. However, an outbreak in a congregate and institutional setting is reportable.

If you suspect or have confirmation that an outbreak of scabies is occurring in your facility, notify the Alaska Section of Epidemiology as soon as possible at 907-269-8000.

List of Reportable
Conditions: https://health.alaska.gov/media/h2yd3q4q/conditionsreportable_hcp.pdf

Outbreak Criteria in a Healthcare Setting:

Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of scabies-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility); and 3) temporal relationship among cases. Report potential outbreaks to the Alaska Section of Epidemiology. Consult the Alaska Section of Epidemiology to determine outbreak status.

Criteria for Outbreak Closure:

30 days without any new cases or symptomatic individuals.

Personal Protective Equipment Recommendations:

Uncrusted: Gown and gloves.
Norwegian crusted: Use contact precautions with protective garments (e.g. gowns, disposable gloves, shoe covers, etc.) when providing care to any patient with crusted scabies until successfully treated; wash hands thoroughly after providing care.

Hand Hygiene Recommendations:

Thoroughly wash hands with soap and water before and after treating or contact with patients who have scabies.

Cleaning and Disinfection Recommendations:

Uncrusted:

- Machine wash and dry bedding, clothing, and towels of scabies patients using the hot water and hot dryer cycles (temperatures in excess of 50°C or 122°F for 10 minutes will kill mites and eggs); or seal in plastic bag for at least 72 hours.
- Environmental disinfection is neither necessary nor warranted. Routine cleaning and vacuuming of the room should be done. Scabies mites do not survive for more than 2-3 days away from human skin.

Norwegian Crusted:

- Ensure bedding, clothing, and towels used by a person with crusted scabies is collected and transported in a plastic bag and emptied directly into washer to avoid contaminating other surfaces and items; machine wash and dry all items using the hot water and high heat cycles (temperatures in excess of 50°C or 122°F for 10 minutes will kill mites and eggs); ensure laundry personnel use protective garments and gloves when handling contaminated items.
- Attempt to ensure that all persons receiving treatment have their clothing and bedding used anytime during the 3 days before treatment machine-washed and dried using the hot water and high heat cycles.
- Clean the room of patients with crusted scabies regularly to remove contaminating skin crusts and scales that can contain many mites.
- Thoroughly clean and vacuum the room when a patient with crusted scabies leaves the facility or moves to a new room.

CDC Resources:

https://www.cdc.gov/scabies/php/public-health-strategy/
https://www.cdc.gov/scabies/hcp/clinical-care/index.html

Other:

Control measures for a single or multiple cases of non-crusted scabies should consist of heightened surveillance for early detection of new cases. Identify and treat all persons (i.e. staff, relatives, residents, etc.) having prolonged, direct skin to skin contact with a person with scabies before their scabicide treatment (permethrin).

Control measures for an outbreak involving one or more cases of Norwegian crusted scabies should involve rapid and aggressive detection, diagnosis, infection control, and treatment measures because this form of scabies is so highly transmissible. All staff, volunteers, and visitors potentially exposed to a patient with crusted scabies, or their clothing, bedding, or furniture, should be identified and treated.

All Healthcare Settings Scabies Outbreak Response Guidance

This guidance is applicable to all U.S. settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants, schools, group homes) and not for persons outside of healthcare settings.** A facility must go 30 days without a new case or exposure to close the outbreak.

Outbreak Definition: Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of scabies-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility); and 3) temporal relationship among cases. Consult the Alaska Section of Epidemiology to determine outbreak status.

Helpful Resources:

- CDC - Scabies - Resources for Health Professionals - Institutional Settings
- The Section of Epidemiology Healthcare Associated Infections Team provides free, non-regulatory infection control assessments and outbreak consultations to all healthcare settings in Alaska. If interested, please contact the HAI/AR Program ICAR team at doh.dph.epi.ak.hai.access@alaska.gov or 907-269-8000.

1. **Recommended Routine IPC Practices for Healthcare (HC) settings**
   a. Establish a process to identify and manage individuals with suspected or confirmed scabies infection (i.e. post signage).
   b. Determine the time frame when the patient, visitor, or HCP with confirmed scabies could have been infectious.
      i. For individuals with confirmed or suspected scabies, consider the exposure window to be around 30 days. Contact Precautions should be implemented for residents/patients with suspected or confirmed uncrusted scabies for 24 hours after the start of effective treatment. For patients with Norwegian crusted scabies, Contact Precautions should be implemented until the individual has negative skin scrapings.
2. **Visitation**
   a. Visitors with confirmed scabies or compatible symptoms should defer non-urgent in-person visitation until the healthcare criteria to end isolation have been met.
   b. Residents/patients should be encouraged to limit in-person visitation while infectious.
   c. Counsel residents/patients and their visitor(s) about the risks of in-person visitation.
   d. Facilities should provide instruction, before visitors enter the resident/patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
   e. Visitors should be instructed to only visit the resident/patient room.
3. **Testing**
   a. Anyone with even mild symptoms of scabies should see their primary care provider.
   b. Diagnosis of a scabies infestation usually is made based upon the customary appearance and distribution of the rash and presence of burrows.
   c. Whenever possible, the diagnosis of scabies should be confirmed by identifying the mite or mite eggs or fecal matter (scybala). This can be done by carefully removing the mite from the end of

its burrow using the tip of a needle or by obtaining a skin scraping to examine under a microscope for mites, eggs, or mite fecal matter. However, a person can still have lice even if mites, eggs, or fecal matter cannot be found; fewer than 10-15 mites may be present on a person with scabies who is otherwise healthy.

d. The State Public Health Laboratories do not currently provide testing for scabies; any specimens received will be forwarded to CDC for identification.

4. **Close Contact**
   a. Uncrusted scabies: Identify and treat all persons (i.e., staff, relatives, residents, etc.) having prolonged, direct skin to skin contact with a person with scabies before scabicide treatment (permethrin).
   b. Norwegian crusted scabies: This form is highly transmissible. All staff, volunteers, and visitors potentially exposed to a patient with crusted scabies, or to clothing, bedding, or furniture used by such a patient, should be identified and treated.
5. **Patient Placement**
   a. Place a patient with suspected or confirmed scabies in a single-person room (with a dedicated bathroom).
      i. If a positive individual has a roommate, that roommate should be moved to prevent further exposure.
      ii. Uncrusted scabies: isolate patient for 24 hours after the start of effective treatment.
      iii. Norwegian crusted scabies: isolate patients with crusted scabies from other patients who do not have crusted scabies; consider assigning a cohort of caretakers to care only for patients with crusted scabies. Isolate until patient meets criteria to discontinue contact precautions, which includes a negative skin scraping.
   b. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with scabies when the number of scabies patients is high.
   c. Limit patient transport and movement outside of their room to medically essential purposes.
6. **Personal Protective Equipment**
   a. Uncrusted scabies: HCP who enter the room of a patient with suspected or confirmed uncrusted scabies should adhere to standard precautions and use gown and gloves.
   b. Norwegian crusted scabies: HCP who enter the room of a patient with suspected or confirmed uncrusted scabies should adhere to contact precautions with protective garments (e.g. gowns, disposable gloves, shoe covers, etc.).
   c. When entering an isolation room, don PPE prior to entering and doff prior to exiting in accordance with CDC guidance.
7. **Duration of TBPs for patients with Scabies**
   a. Uncrusted scabies: Contact precautions should be used until 24 hours have passed since the start of effective treatment.
   b. Norwegian crusted scabies: Contact precautions should be used until the patient has negative skin scrapings.
8. **Environmental Infection Control**
   a. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed scabies.

i. All non-dedicated, non-disposable medical equipment used for the patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.

b. Uncrusted scabies:
   i. Machine wash and dry bedding, clothing, and towels of scabies cases using the hot water and hot dryer cycles (temperatures in excess of 50°C or 122°F for 10 minutes will kill mites and eggs); or seal in plastic bag for at least 72 hours.
   ii. Routine cleaning and vacuuming of the room should be done. Scabies mites do not survive for more than 2-3 days away from human skin.

c. Norwegian crusted scabies:

i. Ensure bedding, clothing, and towels used by a person with crusted scabies is collected and transported in a plastic bag and emptied directly into washer to avoid contaminating other surfaces and items; machine wash and dry all items using the hot water and high heat cycles (temperatures in excess of 50°C or 122°F for 10 minutes will kill mites and eggs); ensure laundry personnel use protective garments and gloves when handling contaminated items.
   ii. Attempt to ensure that all persons who receive treatment have the clothing and bedding they used anytime during the 3 days before treatment machine-washed and dried using the hot water and high heat cycles.
   iii. Clean the room of patients with crusted scabies regularly to remove skin crusts and scales that can contain many mites.
   iv. Thoroughly clean and vacuum the room when a patient with crusted scabies leaves the facility or moves to a new room.

COVID-19 Outbreak Response in Long-Term Care

Outbreak Definition

A single new case of COVID-19 infection in any healthcare personnel (HCP) or resident should be evaluated and it should be determined if others in the facility could have been exposed.

Per 37.114.203 : REPORTABLE DISEASES AND OTHER CONDITIONS OF PUBLIC HEALTH IMPORTANCE - Administrative Rules of the State of Montana (mt.gov), outbreaks in congregate and institutional settings are reportable.

What to do when accepting a new case that is still infectious

1. Place the individual on transmission-based precautions (TBP)
2. Place the individual in a single-person room with a dedicated bathroom if possible or cohort with other COVID-19 cases
3. Admitting a resident who was placed directly in TBPs upon admission does not trigger an outbreak response as long as there were no exposures to other residents or HCP

Outbreak Response Checklist

- ☐ **Evaluate residents/HCP for COVID-19 signs/symptoms**
- ☐ **Notify local public health**
- ☐ **COVID-19 positive resident placement and TBP continuation:**
  - Place the individual in a single-person room with a dedicated bathroom if possible or cohort with other COVID-19 cases
- ☐ **Perform contact tracing**
- ☐ **Visitation: ***
  - Visitors should be notified of outbreak status and steps to take if entering
- ☐ **Communal activities: ***
  - Masks should be worn, and social distancing should be observed
- ☐ **Assess staffing needs**
- ☐ **Environmental cleaning:**
  - Dedicated equipment should be used for individuals on TBPs when possible
  - Make sure that all disinfectants used are on the EPA List N
- ☐ **Closure of outbreak:**
  - A facility must go 14 days without a new positive case or exposure for local public health to close the outbreak.

PPE Use

During outbreak status the following PPE should be worn anywhere staff could encounter residents:

- NIOSH-approved N95 respirator
- Eye protection

When entering a room of an individual on TBPs to provide care or clean the following should be worn:

- Gown
- Gloves
- NIOSH-approved N95 respirator
- Eye protection

*If the outbreak warrants, may be stopped at the discretion of the facility or local public health to decrease transmission risk

https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

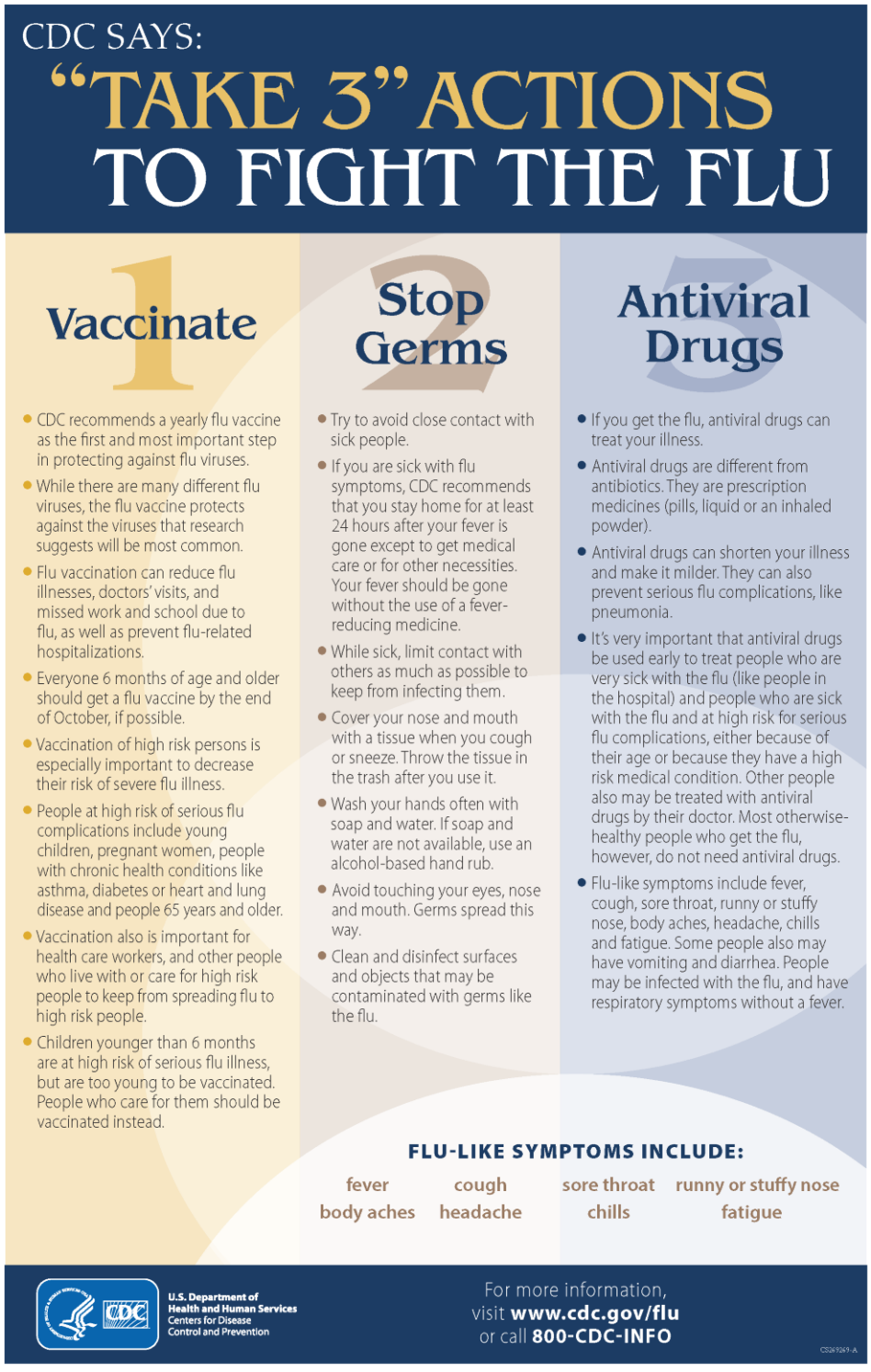
Coughs and Sneezes Cause Diseases

Click on the disease names for infection control guidance

	COVID-19	Influenza	Respiratory Syncytial Virus
Common Symptoms	Fever Cough Sore Throat Runny or Stuffy Nose Muscle or Body Aches Headaches Fatigue Loss of Taste or Smell Nausea or Vomiting Diarrhea Shortness of Breath	Fever Cough Sore Throat Runny or Stuffy Nose Muscle or Body Aches Headaches Fatigue **Very Rapid Onset**	Runny Nose Cough Decrease in Appetite Sneezing Fever Wheezing
Level of Infectivity and Incubation Period	More Contagious *Time from Exposure to Symptomatic*: 2-14 days	Contagious *Time from Exposure to Symptomatic*: 1-4 days	Very Contagious *Time from Exposure to Symptomatic*: 4-6 days
Transmission-Based Precautions	Standard Droplet Contact	Standard Droplet	Standard Contact
PPE Usage	Gloves Gown Eye Protection NIOSH-approved N95	Eye Protection Surgical Mask or NIOSH-approved N95	Gown Gloves Surgical Mask or NIOSH-approved N95
Rapid Testing (Antigen)	Yes **Can be performed by the facility**	Yes **Performed through provider**	Yes **Performed through provider**
PCR Testing	Yes **Performed by lab via provider order**	Yes **Performed by lab via provider order**	Yes **Performed by lab via provider order**
Single Case Reportable?	Yes **Per ARM 37.114.203*	Yes, but will not put the facility into outbreak status. Please report case to locals. **Per ARM 37.114.203*	No
Outbreak Reportable?	Yes **Per ARM 37.114.203*	Yes **Per ARM 37.114.203*	Yes **Per ARM 37.114.203*
Reporting Requirements to Local Public Health	Single cases Any positive tests performed by facility Outbreaks Deaths Hospitalizations	Single cases Hospitalizations Deaths Outbreaks	Outbreaks

The highest transmission of respiratory diseases typically occurs during the winter months

Public Health IN THE 406


CDC SAYS:
"TAKE 3" ACTIONS TO FIGHT THE FLU
1 Vaccinate
CDC recommends a yearly flu vaccine as the first and most important step in protecting against flu viruses.
While there are many different flu viruses, the flu vaccine protects against the viruses that research suggests will be most common.
Flu vaccination can reduce flu illnesses, doctors' visits, and missed work and school due to flu, as well as prevent flu-related hospitalizations.
Everyone 6 months of age and older should get a flu vaccine by the end of October, if possible.
Vaccination of high risk persons is especially important to decrease their risk of severe flu illness.
People at high risk of serious flu complications include young children, pregnant women, people with chronic health conditions like asthma, diabetes or heart and lung disease and people 65 years and older.
Vaccination also is important for health care workers, and other people who live with or care for high risk people to keep from spreading flu to high risk people.
Children younger than 6 months are at high risk of serious flu illness, but are too young to be vaccinated. People who care for them should be vaccinated instead.
2 Stop Germs
Try to avoid close contact with sick people.
If you are sick with flu symptoms, CDC recommends that you stay home for at least 24 hours after your fever is gone except to get medical care or for other necessities. Your fever should be gone without the use of a fever-reducing medicine.
While sick, limit contact with others as much as possible to keep from infecting them.
Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
Wash your hands often with soap and water. If soap and water are not available, use an alcohol-based hand rub.
Avoid touching your eyes, nose and mouth. Germs spread this way.
Clean and disinfect surfaces and objects that may be contaminated with germs like the flu.
3 Antiviral Drugs
If you get the flu, antiviral drugs can treat your illness.
Antiviral drugs are different from antibiotics. They are prescription medicines (pills, liquid or an inhaled powder).
Antiviral drugs can shorten your illness and make it milder. They can also prevent serious flu complications, like pneumonia.
It's very important that antiviral drugs be used early to treat people who are very sick with the flu (like people in the hospital) and people who are sick with the flu and at high risk for serious flu complications, either because of their age or because they have a high risk medical condition. Other people also may be treated with antiviral drugs by their doctor. Most otherwise-healthy people who get the flu, however, do not need antiviral drugs.
Flu-like symptoms include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills and fatigue. Some people also may have vomiting and diarrhea. People may be infected with the flu, and have respiratory symptoms without a fever.
FLU-LIKE SYMPTOMS INCLUDE:
fever
cough
sore throat
runny or stuffy nose
body aches
headache
chills
fatigue
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
For more information,
visit www.cdc.gov/flu
or call 800-CDC-INFO

Older Adults
are at High Risk for Severe RSV Infection

Respiratory syncytial virus, or RSV, is a common virus that affects the lungs and breathing passages

RSV infections can be dangerous for certain adults. Adults at highest risk for severe RSV infection include:

- Older adults, especially those 65 years and older
- Adults with chronic heart or lung disease
- Adults with weakened immune systems

Each year, it is estimated that between 60,000–120,000 older adults in the United States are hospitalized and 6,000–10,000 of them die due to RSV infection.

Severe RSV infection

When an older adult gets RSV infection, they typically have mild cold-like symptoms including runny nose, sore throat, cough, and headache. But RSV can sometimes lead to serious conditions such as:

- Pneumonia (infection of the lungs)
- More severe symptoms for people with asthma
- More severe symptoms for people with chronic obstructive pulmonary disease (COPD) (a chronic disease of the lungs that makes it hard to breathe)
- Congestive heart failure (when the heart can't pump blood and oxygen to the body's tissues)

Older adults who get very sick from RSV may need to be hospitalized. Some may even die. Older adults are at greater risk than young adults for serious complications from RSV because our immune systems weakens when we are older.

Scientists are working to develop vaccines

There is no vaccine to prevent RSV infection yet, but scientists are working hard to develop one. If you are concerned about your risk for RSV, talk to your doctor.

www.cdc.gov/rsv

How to protect yourself and loved ones

RSV circulation starts in the fall and peaks in the winter. If you are at high risk for severe RSV infection, or if you interact with an older adult, you should take extra care to stay healthy:

- **Wash your hands often**
  Wash your hands often with soap and water for 20 seconds. If soap and water are not available, use an alcohol-based hand sanitizer. Washing your hands will help protect you from germs.
- **Keep your hands off your face**
  Avoid touching your eyes, nose, and mouth with unwashed hands. Germs spread this way.
- **Avoid close contact with sick people**
  Avoid close contact, such as kissing, and sharing cups or eating utensils with people who have cold-like symptoms.
- **Cover your coughs and sneezes**
  Cover your mouth and nose with a tissue when coughing or sneezing. Throw the tissue in the trash afterward.
- **Clean and disinfect surfaces**
  Clean and disinfect surfaces that people frequently touch, such as doorknobs. When people infected with RSV touch surfaces and objects, they can leave behind germs. Also, when they cough or sneeze, droplets containing germs can land on surfaces and objects.
- **Stay home when you are sick**
  If possible, stay home from work, school, and public areas when you are sick. This will helpprotect others from catching your illness.

Centers for Disease Control and Prevention
National Center for Immunization and Respiratory Diseases

CS280240
October 2022

CLOSTRIDIOIDES DIFFICILE (formerly known as Clostridium difficile)

Clostridioides difficile (also known as *C. diff*) is a bacterium that causes diarrhea and colitis (an inflammation of the colon). *C. diff* infection can be life-threatening.

IMPACT

C. diff infection is estimated to cause almost half a million illnesses in the United States each year, and an estimated 29,300 deaths.[1]

About **1 in 6 patients** who get *C. diff* infection will get it again in the subsequent 2–8 weeks.[1]

One in 11 people over 65 diagnosed with a healthcare-associated *C. diff* infection die within a month.[2]

RISK

People are 7 to 10 times more likely to get *C. diff* infection while taking an antibiotic and during the month after.[3]

Extended stays in healthcare settings, such as hospitals and nursing homes, also increase their risk.

More than 80% of *C. diff* deaths occur in people 65 and older.

SPREAD

C. diff spreads when people touch surfaces that are contaminated with poop from an infected person.

Or when people don't wash their hands with soap and water.

It can also happen when one healthcare facility fails to notify another when it transfers a patient with *C. diff*.

Healthcare professionals can help PREVENT *C. diff* by:

BE ANTIBIOTICS AWARE
SMART USE. BEST CARE

Optimizing the way they prescribe antibiotics.

Using the tests that give the most accurate results.

Rapidly identifying and isolating patients with *C. diff*.

Wearing gloves and gowns when treating patients with *C. diff*—and remembering that hand sanitizer doesn't kill *C. diff*.

Cleaning surfaces in rooms where *C. diff* patients are treated with EPA-approved, spore-killing disinfectant (see list K).

cdc.gov/cdiff

[1] Guh AY, Mu Y, Winston LG et al. N Engl J Med 2020;382:1320–30. DOI: 10.1056/NEJMoa1910215
[2] Lessa FC, Mu Y, Bamberg WM et al. N Engl J Med 2015;372:825–34. DOI: 10.1056/NEJMoa1408913
[3] Hensgens MPM, Goorhuis A, Dekkers OM, Kuijper EJ. J Antimicrob Chemother 2011. DOI: 10.1093/jac/dkr508

CS316107-A

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Stop Norovirus!

Norovirus causes diarrhea and vomiting. It spreads easily from an infected person to others, especially in long-term care facilities. Elderly residents are more likely to become very sick or die from norovirus.

Protect yourself and elderly residents from norovirus.

WASH YOUR HANDS

Wash your hands often with soap and water for at least 20 seconds each time and avoid touching your mouth.

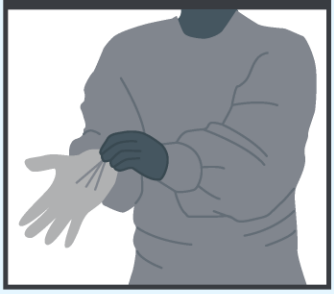
CLEAN SURFACES

Use a bleach-based cleaner or other approved product* to disinfect surfaces and objects that are frequently touched.

WASH LAUNDRY

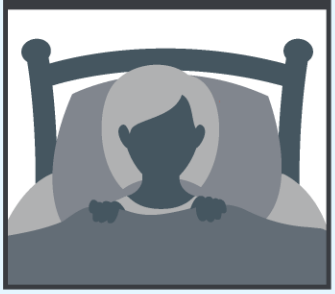
Remove and wash soiled clothes and linens immediately, then tumble dry.

USE GOWN AND GLOVES



Use gown and gloves when touching or caring for patients to reduce exposure to vomit or fecal matter.

STAY HOME WHEN SICK



If you're sick, stay home and don't take care of or visit people in long-term care facilities for at least 2 days after your symptoms stop.

For more information, visit www.cdc.gov/norovirus

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

*Use a chlorine bleach solution with a concentration of 1000-5000 ppm (5-25 tablespoons of household bleach [5.25%] per gallon of water) or other disinfectant registered as effective against norovirus by the Environmental Protection Agency(EPA) at http://www.epa.gov/oppad001/list_g_norovirus.pdf

CS287713-C


How to Clean Up After a Norovirus Incident
Step 1: Protect yourself. Put on disposable gloves and mask.
Step 2: Wipe up vomit and poop with paper towels and put them in a plastic trash bag.
Step 3: Pour a bleach cleaner on all surfaces that may have vomit or poop on them. Leave the bleach on surfaces for at least 5 minutes.
-Make your own bleach cleaner by adding ¾ cup of bleach to 1 gallon of water
Step 4: Clean all surfaces AGAIN with hot water and soap.
Step 5: Remove your disposable gloves and mask and throw away
Step 6: Remove and wash all laundry
Step 7: Wash your hands with soap and water
Clean up right away and keep others from getting sick.
PublicHealth IN THE 406
MONTANA COMMUNICABLE DISEASE EPIDEMIOLOGY


How to Wash Your Hands
Looking for some 20 second songs to sing while you scrub?
1. Row, Row, Row Your Boat 2x
2. Twinkle, Twinkle Little Star 2x
3. If You're Happy and You Know It 2x
4. Happy Birthday 2x
5. Encanto's The Family Madrigal Chorus 2x
6. Frozen's Let It Go Chorus 1x
1
or
HAND SANITIZER
Pick either hand sanitizer or soap and water. If using soap and water, get your hands wet and add soap.
2
Scrub the inside of your hands
3
Scrub the tops of your hands with your hands on top of each other
4
Scrub between your fingers with your hands together
5
Scrub the tops of your fingers
6
Scrub your thumbs
7
Scrub your fingertips
Soap
Hand Sanitizer
8
Rinse your hands
9
Dry your hands
You are all set!
You are all set!
PublicHealth IN THE 406

STOP

AIRBORNE PRECAUTIONS

STOP

EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.

Put on a fit-tested N-95 or higher level respirator before room entry.

Remove respirator after exiting the room and closing the door.

Door to room must remain closed.

CS19-306149-A

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STOP

CONTACT PRECAUTIONS

STOP

EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.

PROVIDERS AND STAFF MUST ALSO:

Put on gloves before room entry.
Discard gloves before room exit.

Put on gown before room entry.
Discard gown before room exit.

Do not wear the same gown and gloves for the care of more than one person.

Use dedicated or disposable equipment.
Clean and disinfect reusable equipment before use on another person.

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CS319-306149-A

STOP

DROPLET PRECAUTIONS

STOP

EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.

Make sure their eyes, nose and mouth are fully covered before room entry.

or

Remove face protection before room exit.

CS19-306149-A

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STOP

ENHANCED BARRIER PRECAUTIONS

STOP

EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.

PROVIDERS AND STAFF MUST ALSO:

Wear gloves and a gown for the following High-Contact Resident Care Activities.

- Dressing
- Bathing/Showering
- Transferring
- Changing Linens
- Providing Hygiene
- Changing briefs or assisting with toileting
- Device care or use:
  - central line, urinary catheter, feeding tube, tracheostomy
- Wound Care: any skin opening requiring a dressing

Do not wear the same gown and gloves for the care of more than one person.

CS319-306149-A

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