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Division of Communicable Disease Control and Prevention

Acute Respiratory Illness Outbreak Recommendations for Long-Term Care Facilities

October 30, 2025

This guidance was created by the Alameda County Public Health Department (ACPHD) and is intended for use by Long-Term Care Facilities (LTCFs) for the management and containment of acute respiratory illness (ARI) outbreaks. More detailed guidance that includes recommendations about prevention and planning for influenza, COVID-19 and other respiratory outbreaks is available on the California Department of Public Health (CDPH) website.

COVID-19 outbreaks must be reported electronically to ACPHD using the instructions found at https://covid-19.acgov.org/reporting-requirements.page. Report all suspected or confirmed non-COVID-19 ARI outbreaks to ACPHD by calling (510) 267-3250. To report on evenings, weekends, or holidays, call Alameda County Dispatch at (925) 422-7595 and ask to speak with the On Call Public Health Duty Officer. Refer to page 2 for outbreak definitions.

Please review the following documents and guidelines:

- Line List for Facilities
- Outbreak Summary Form
- Inter-Facility Infection Control Transfer Form
- CDPH Respiratory Viruses Hub
- Handwashing & Approved Disinfectants Effective Against Influenza
- Viral Respiratory Pathogens Toolkit for Nursing Homes (CDC)
- Coronavirus Disease 2019 (COVID-19) Recommendations for Personal Protective Equipment (PPE), Resident Placement/Movement, and Staffing in Skilled Nursing Facilities (AFL 23-12)
- Interim Work Exclusion Guidance for Healthcare Personnel with COVID-19, Influenza, and Other Acute Respiratory Viral Infections (AFL 25-01)
- Guidance for Face Coverings as Source Control in Healthcare Settings (CDPH)
- Masking Recommendations for Staff and Visitors in Licensed Health Care Facilities When Respiratory Viruses Circulate (ACPHD)
- Update on COVID-19 Workplace Requirements and Reminders of Guidance on Respiratory Viruses (PIN 25-02)

Documents and other information requested by Public Health may be sent by fax to (510) 273-3744 or secure encrypted email to AcuteCD@acgov.org

Please send the following:	**When to send:**
1. Facility floorplan with room numbers	1. As soon as possible
2. Line list of potential cases	2. Daily
3. Completed ARI outbreak summary form	3. After ACPHD has determined the outbreak is resolved

Note: Privacy Rule (HIPAA) permits covered entities to disclose PHI without authorization to public health authorities or other entities who are legally authorized to receive such reports for the purpose of preventing or controlling disease. This includes the reporting of disease, conducting public surveillance, investigations, or interventions.

Public Health Department
Alameda County Health

Acute Respiratory Illness (ARI)
Outbreak Recommendations Checklist for Facilities

Definitions

Influenza-like illness (ILI)

Fever (oral or equivalent temperature of 100 °F or greater) and cough and/or sore throat in the absence of a known cause other than influenza. Persons with ILI often have fever or feverishness with cough, chills, headache, myalgia, sore throat, or runny nose. Some people, such as older persons, may have atypical clinical presentations, including the absence of fever.

Influenza Outbreak within a LTCF

- At least one case of laboratory-confirmed influenza in the setting of a cluster (≥2 cases) of ILI within a 72-hour period.
- Epi-linkage: Overlap on the same unit or ward, or other patient care location, or having the potential to have been cared for by common HCP within a 72-hour time period of each other.

COVID-19 Outbreak within a LTCF

- ≥2 cases of probable or confirmed COVID-19 among residents identified within 7 days OR
- ≥3 cases of acute illness compatible with COVID-19 among residents with onset within a 72-hour period.
- Epi-linkage: Overlap on the same unit or ward, or other patient care location, or having the potential to have been cared for by common HCP within a 7-day time period of each other.

Non-influenza, non-COVID-19 Respiratory Outbreak within a LTCF

At least one case of a laboratory-confirmed respiratory pathogen, other than influenza or COVID-19, in the setting of a cluster (≥2 cases) of ARI within a 72-hour period.

Acute Respiratory Illness (ARI)

An illness characterized by any two of the following: fever, cough, rhinorrhea (runny nose) or nasal congestion, sore throat, or muscle aches.

Respiratory Outbreak of Unknown Etiology

Two or more cases of ILI or ARI occurring within 72 hours of each other without laboratory confirmation of COVID-19, influenza, RSV or other respiratory pathogen.

Reporting Requirements

All outbreaks must be reported to ACPHD **AND** the licensing authority as applicable.

- Facilities licensed by CDPH Licensing and Certification must report outbreaks to the East Bay District Office.
- Facilities licensed by CDSS must report outbreaks to Community Care Licensing and Certification Regional Office: (510) 286-4201 or CCLASCPOaklandRO@dss.ca.gov

Reporting to ACPHD:

Initial Reporting (non-COVID-19):

- When an ILI or ARI outbreak is identified, immediately report to ACPHD at 510-267-3250, Mon-Fri 8:30 am to 5 pm. After hours and on weekends and holidays, call Alameda County Fire Dispatch at (925) 422-7595 and ask to speak to the On Call Public Health Duty Officer.
- Submit a map/floor plan of your facility with room numbers by email to AcuteCD@acgov.org.
- Complete attached Line list **daily** until instructed to stop for all **new** cases and submit by fax to (510) 273-3744 or by secure encrypted email (AcuteCD@acgov.org) **daily** until instructed to stop.

Initial Reporting (COVID-19):

- See https://covid-19.acgov.org/reporting-requirements.page?
- For hospitalizations and deaths, submit VEOCI hospitalization survey if directed to by investigator or report via SPOT.

➢ Submit a map/floor plan of your facility with room numbers by email to AcuteCD@acgov.org. **After ACPHD has determined that the outbreak has resolved:** ➢ Submit a completed outbreak summary form via email (AcuteCD@acgov.org)

Outbreak Control Recommendations	
Surveillance	
	Conduct daily active surveillance for respiratory illness (e.g., ILI, ARI and COVID-19 signs and symptoms) among all residents, health care personnel (HCP), and visitors throughout the winter respiratory virus season or when levels of circulating virus are elevated. ➢ Non-standard symptoms common in older adults: delirium, falls, fatigue, lethargy, low blood pressure, painful swallowing, fainting, diarrhea, or abdominal pain. ➢ Observe for behavior changes such as being more unsettled, expressing new delusions, wandering more than normal, eating/drinking less than usual, or appearing sleepy.
	Monitor staff absenteeism due to respiratory illness and instruct HCP not to work while ill. HCP with close contact to someone with COVID-19 are not restricted from work but should follow the testing and masking guidance specified in AFL 25-01.
	Encourage residents to report any signs or symptoms of respiratory illness to the facility infection preventionist or another facility designee.
	Implement symptom check at entry to limit or guide masking of symptomatic visitors. Advise symptomatic visitors to postpone non-urgent visits until their symptoms have improved/resolved.
Diagnostic and Screening Testing	
	Test residents, HCP and other staff with respiratory symptoms immediately after symptom onset. Rapid antigen tests are preferred. Co-infections are possible.
	Test for COVID-19 and influenza when both are circulating. **If a rapid antigen (point-of-care) test for COVID-19 or influenza is negative in a person with symptoms, obtain confirmatory testing with a molecular test (e.g. PCR).**
	If RSV is circulating, consider preferential use of a molecular test that includes RSV in addition to COVID-19 and influenza; this could include a full respiratory panel or other multiplex assay. Refer to CDPH Weekly Respiratory Virus Dashboard for information on respiratory viruses circulating in California. Select "Bay Area" as the region to get information on respiratory viral levels, test positivity, Emergency Department visits, hospital admissions and deaths in the Bay Area.
	If influenza, COVID-19 and RSV tests are negative, order a full respiratory panel.
	Testing asymptomatic individuals exposed to COVID-19: ➢ **SNF:** Test immediately (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and if negative, again 5 days after the exposure. If unable to test on days 1, 3 and 5, proceed to Facility-wide or Group-level testing. **See Appendix A for detailed information on contract tracing and facility-wide/group-level response testing strategies.** ➢ **Non-SNF LTCF:** Consider testing residents who are close contacts of someone who tested positive for COVID-19 (e.g. roommates, dining partners, caregivers) 5 days after the exposure. ➢ Post-exposure testing is not generally recommended for HCP or residents who have had a COVID-19 infection in the last 30 days, if they remain asymptomatic. ➢ Testing asymptomatic individuals for influenza, RSV, or other non-COVID-19 respiratory viruses is **not recommended**.
	Additional considerations for influenza and COVID-19 testing can be found at CDC's Testing and Management Considerations for Nursing Home Residents.

Communication	
	As soon as an influenza, COVID-19 or other respiratory pathogen outbreak is identified, in addition to notifying ACPHD and the appropriate licensing authority, notify key stakeholders including the facility infection preventionist, administrator, medical director, health services director, staff, primary care providers of residents, and the residents, family, and visitors.
	Distribute respiratory pathogen prevention information to residents, their families, and visitors.
	When in outbreak, post signs at facility entrances to notify visitors. Post visual alerts instructing residents, staff, visitors, and volunteers to report symptoms of respiratory infection to a designated person and follow hand hygiene and respiratory hygiene/cough etiquette.

Transmission-Based Precautions, Isolation and Exclusion	
	While test results are pending: ➢ Use COVID-19 PPE considerations for residents with symptoms of respiratory illness. Precautions for COVID-19 include HCP use of a fit-tested N95 or higher-level respirator, eye protection, gloves and gown. ➢ Residents with symptoms of respiratory illness may remain in their current rooms with measures in place to reduce transmission to roommates (e.g., optimizing ventilation, air purifier, spatial separation of at least 6 feet between residents, privacy curtain between residents). ➢ **Do not place roommates of symptomatic residents with new roommates.**
	If tests are positive: ➢ Refer to Table 1 in CDPH guidance for guidance on PPE and duration of isolation for influenza, RSV, and COVID-19 in SNFs.
	Influenza-confirmed: ➢ For residents who test positive for influenza and negative for COVID-19, transition to droplet precautions. Use eye protection during procedures and patient care activities likely to generate splashes or sprays. ➢ Continue droplet precautions for 7 days after the resident's illness onset or 24 hours after the resolution of fever and improvement in respiratory symptoms, whichever is longer. ➢ Avoid movement of residents that could lead to new exposures (e.g., roommates of symptomatic residents, who have already been potentially exposed, should not be placed with new roommates, if possible).
	COVID-19 confirmed: ➢ **SNF residents:** o Continue transmission-based precautions for duration of 10-day isolation, even if asymptomatic. For residents with severe/critical illness or who are immunocompromised, follow the CDC's Infection Control Guidance: SARS-CoV-2 o Avoid movement of residents that could lead to new exposures (e.g., roommates of symptomatic residents, who have already been potentially exposed, should not be placed with new roommates, if possible). ➢ **Non-SNF LTCF residents:** Continue transmission-based precautions until 24 hours fever-free (without fever-reducing medication) and respiratory symptoms are improving. Residents should be encouraged to mask and take other precautions for 5 days after completing isolation. o Residents in non-SNF LTCFs should follow general CDC guidance for respiratory illness, but facilities can consider implementing a 5-day isolation period if they serve residents at high risk for severe COVID-19 illness. ➢ **Consider checking on residents in isolation every 4 hours for new or worsening symptoms.**

	COVID-19 exposed: ➢ **SNF Residents:** ○ Test immediately (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and if negative, again 5 days after the exposure. If unable to test on days 1, 3 and 5, proceed to Facility-wide or Group-level testing. **See Appendix A for detailed information on contract tracing and facility-wide/group-level response testing strategies.** ○ Exposed contacts should continue to wear a mask when outside their room for 10 days after their exposure, even if tests are negative during that time period. ➢ **SNF Staff:** For high-risk exposures, staff should test on days 1, 3 & 5 and wear high-quality masks for source control for 10 days. For more information, see https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html ➢ **Non-SNF LTCFs:** Consider testing residents and staff who are close contacts of someone who tested positive for COVID-19 (e.g. roommates, dining partners, caregivers) 5 days after the exposure.
	Cohorting: ➢ Residents who test positive for influenza may be roomed together and residents with COVID-19 may be roomed together unless there are other conditions present that prevent appropriate cohorting (e.g., *C. difficile*, colonization with MDRO, co-infections). ○ Prioritize cohorting of residents and HCP by COVID-19 status first, then by influenza status; if necessary, designate a cohort of influenza positive residents within a COVID-19 isolation area. ➢ **SNFs:** Ensure residents with COVID-19 are promptly isolated in a designated COVID-19 isolation area. This may be a designated floor, unit, wing, or group of rooms at the end of a unit that is physically separate and, ideally, includes ventilation measures to prevent transmission to other residents outside the isolation area. See https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-12.aspx ➢ **Non-SNF LTCFs:** Place beds as far apart as possible, when one resident is positive for COVID-19 and cannot be placed in a single room.
	Exclusion of Ill Staff: ➢ Exclude HCP with respiratory illness symptoms from work and have them tested for both influenza and COVID-19. ➢ **SNF Staff:** Follow CDPH's *Interim Work Exclusion Guidance for Healthcare Personnel with COVID-19, Influenza, and Other Acute Respiratory Viral Infections* ○ HCP with suspected or confirmed respiratory viral infection, regardless of whether testing is performed, should: ▪ Not return to work until at least 3 days have passed since symptom onset and at least 24 hours have passed with no fever (without use of fever-reducing medicines), symptoms are improving, and they feel well enough to return to work. ▪ Not return to work until at least 3 days have passed since their first positive test, even if the individual is asymptomatic throughout their infection. ▪ Wear a face mask for source control in all patient care and common areas of the facility (e.g., HCP breakrooms) for at least 10 days after symptom onset or positive test (if asymptomatic), if not already wearing a facemask as part of universal source control masking. ➢ **Non-SNF LTCF Staff:** ○ Staff may not return to work until afebrile >24 hours without fever-reducing medicines and with improvement in respiratory symptoms. ○ It is recommended to wear a mask for 5 days after returning to work.

Infection Control Measures	
	Masking: ➢ **SNFs**: ○ **Staff and visitor masking is strongly recommended in patient care areas of SNFs during winter respiratory virus season (November 1 – March 31) and other periods of increased respiratory virus activity.** ○ Masking for source control should be implemented for staff during a respiratory illness outbreak, regardless of the time of year. See also *Guidance for Face Coverings as Source Control in Healthcare Settings*. ➢ **Non-SNF LTCFs:** Wearing a mask continues to be important for those who are at higher risk for severe respiratory infections and for staff and visitors of Adult and Senior Care facilities where higher risk individuals are present (PIN 25-02). ➢ During an outbreak, encourage source control masking for residents while in common areas.
	Promote cough etiquette and hand hygiene for all residents, staff and visitors.
	Cleaning: ➢ Increase frequency of environmental cleaning using list EPA registered list N products to at least twice per shift with a focus on high touch surfaces and common areas. ➢ For more information about infection control considerations for COVID-19, see the: https://www.cdc.gov/covid/hcp/infection-control/index.html
	Ensure proper ventilation and filtration of indoor air. Refer to CDPH's guidance on *Improving Ventilation Practices to Reduce COVID-19 Transmission Risk in Skilled Nursing Facilities* and *Best Practices for Ventilation of Isolation Areas to Reduce COVID-19 Transmission Risk in Skilled Nursing Facilities, Long-Term Care Facilities, Hospices, Drug Treatment Facilities, and Homeless Shelters*
	Keep symptomatic residents in their rooms and restrict from activities in common areas, including meals. ➢ Consider temporarily pausing communal dining and other group activities for all residents until control measures have been instituted or the outbreak has resolved.
	A resident in isolation for COVID-19 who uses a shower used by multiple residents should be given a shower at the end of the day with maximized ventilation. Environmental Services Personnel and direct care staff should allow adequate time for air filtration clearance before accessing the shower room after use and use list EPA registered list N product to clean and disinfect the shower room before use by another resident. For more information about infection control considerations for COVID-19, see the: https://www.cdc.gov/covid/hcp/infection-control/index.html
	Monitor adherence to hand hygiene, source control masking, and other infection control measures using standardized adherence monitoring tools. Correct deficiencies with individual staff, as needed, and present de-identified adherence monitoring data to staff and facility administrators/leaders.
Vaccination for Residents and Staff	
	Vaccines are the most effective tool for prevention of severe illness and death in LTCF residents. ➢ Encourage all residents and staff to stay up-to-date with vaccinations for COVID-19, influenza, pneumococcal disease, RSV, and other recommended vaccines according to CDPH recommendations. ➢ Obtain standing vaccination orders from providers for residents and staff. ➢ Vaccinate residents and staff for COVID-19 and influenza at the beginning of every respiratory virus season, as well as newly admitted residents who are unvaccinated. Mild illness and egg allergies are not a contraindication for receiving the influenza vaccine. ➢ Offer the COVID-19 and influenza vaccines to residents and staff who previously declined vaccination throughout the respiratory season.

	Track resident and staff vaccination status and calculate vaccination rates. See *FAQs on Reporting Respiratory Pathogens and Vaccination Data- March 2025 (CDC)*.
	Identify residents who are appropriate for Pemgarda, a monoclonal antibody for moderately-to-severely immunocompromised individuals who may not mount an adequate immune response to COVID-19 vaccination. Pemgarda is not a substitute for vaccination and all individuals who can receive vaccination should do so.
Antiviral Treatment	
	Treat all residents with confirmed or suspected COVID-19 or influenza with antiviral medication **as soon as possible, ideally within 48 hours of symptom onset,** for maximum benefit. ➢ For information about recommended influenza antiviral treatment, see CDC influenza antiviral medication webpage. ➢ For information about recommended COVID-19 antiviral treatment, see https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Treatment-Resources-for-Providers.aspx ○ *HEALTH ADVISORY: Reminder to Lower Barriers to Prescribing COVID-19 Therapeutics to Mitigate Impact of COVID-19* ○ *IDSA Guidelines on the Treatment and Management of Patients with COVID-19* ➢ **Treatment should be offered regardless of vaccination status.**
	Create standing orders for antiviral medication administration upon admission. ➢ Identify a supply source for rapidly obtaining antiviral medication for residents. ➢ Define indications and processes for obtaining antiviral agents for resident treatment. ➢ **Consult resident's PCP for any necessary dose adjustments in persons with underlying conditions, such as renal impairment.**
	Do NOT wait for confirmatory test results to initiate treatment unless there is ongoing transmission of another respiratory virus in the facility.
	Antiviral agents for influenza and for COVID-19 may be administered simultaneously when coinfection occurs.
	Antiviral resistance may be possible if the resident is positive for influenza and has progressive illness after 72 hours of treatment. Report to ACPHD and consult with PCP/medical director.

Chemoprophylaxis (Influenza Only)
Obtain orders from medical director or PCP for influenza chemoprophylaxis when it is indicated. • Identify a supply source for rapidly obtaining antiviral chemoprophylaxis for residents and staff. • Define indications and processes for obtaining chemoprophylaxis, and dose adjustments as needed for underlying conditions (for example, renal impairment).
As soon as an outbreak is identified, provide antiviral chemoprophylaxis to all non-ill residents in the facility, regardless of vaccination status. If there is a limited supply of antiviral agents, prioritize chemoprophylaxis for: 1. Roommates and residents on the same floor or unit as residents with active influenza 2. Residents in the same building with shared HCP Consult with medical director and ACPHD for further guidance. For information about recommended influenza antiviral chemoprophylaxis and dosage, see the CDC influenza antiviral medication webpage.
For control of influenza outbreaks in LTCFs, CDC recommends antiviral chemoprophylaxis for at least 2 weeks and at least 7 days after the last known case was identified, whichever is longer.
Obtain influenza testing for any resident who develops signs or symptoms of ILI or ARI after receiving an antiviral agent for at least 72 hours. Report positive results to ACPHD due to the possibility of antiviral resistance.

Strongly consider antiviral chemoprophylaxis for HCP if:

- Exposure to influenza occurred within 2 weeks of receiving injectable vaccine; do NOT give antiviral chemoprophylaxis until at least 12 days after administration of intranasal live-attenuated (LAIV) vaccine.
- HCP was not vaccinated due to a medical contraindication or are at high risk for complications of influenza due to age or medical conditions.

Admissions, Re-Admissions and Transferring Residents

Use the Inter-Facility Infection Control Transfer Form when transferring residents to a different facility or unit.

Hospitalized patients with respiratory pathogens should be discharged when they no longer require the level of care provided in an acute care setting. **Hospital discharge and admission or re-admission to a LTCF should not be delayed or prevented due to the respiratory virus status of the patient.**

- Implement droplet precautions for returning residents who were hospitalized with influenza and are ready for discharge from the hospital but are still within the 7 day or longer period of required droplet precautions.
- Implement transmission-based precautions for returning residents who were hospitalized with COVID-19 and are ready for discharge from the hospital but are still within the 10 day or longer period of required transmission-based precautions.
- See Table 1 in CDPH guidance for PPE and duration of isolation for COVID-19, influenza and RSV.

New Admissions: Do not place new admissions on units with symptomatic residents.

- If a resident begins showing respiratory symptoms upon their return to the facility, place in a single room (if available) and test the resident for influenza/COVID-19/RSV.
- **Do not require testing before accepting admission.** Testing newly admitted, asymptomatic residents without known exposures for COVID-19 upon arrival is an effective strategy for identifying COVID-19 cases, when circulation is moderate or high. Refer to CDPH Weekly Respiratory Virus Dashboard for information on respiratory viruses circulating in California. Select "Bay Area" as the region to get information on respiratory viral levels, test positivity, Emergency Department visits, hospital admissions and deaths in the Bay Area.
  - Test on day 1, and, if negative, test again 3 days and 5 days after their admission to inform the type of infection control precautions used (e.g., room assignment/cohorting, or PPE) and prevent unprotected exposures.
  - Use empiric transmission-based precautions pending initial test result.
  - Residents who leave the facility for >24 hours should be treated as a new admission.
- Asymptomatic new admissions **with close contact to someone with COVID-19**, regardless of vaccination status, should be tested promptly (day 1) and, if negative, again 3 days and 5 days after the exposure.

When planning to accept or transfer residents who still require isolation for influenza, evaluate the resident's COVID-19 exposure status and test for COVID-19 as appropriate before moving resident.

Do not transfer asymptomatic residents to units with residents who have active influenza or COVID-19.

Consult with facility medical director and ACPHD to determine if the facility should be closed to new admissions during an influenza or COVID-19 outbreak.

- The duration of closure or limiting admissions should be determined for each situation individually.
- Facility-wide and prolonged closure are not necessary if transmission is controlled and there is an unaffected location available where new admissions can be placed.

Managing Family and Visitors

During an ARI outbreak:

- Consider implementing visitor restrictions, such as limiting the number of visitors and excluding young children.
- Implement screening of visitors for signs of ARI and exclude symptomatic visitors.

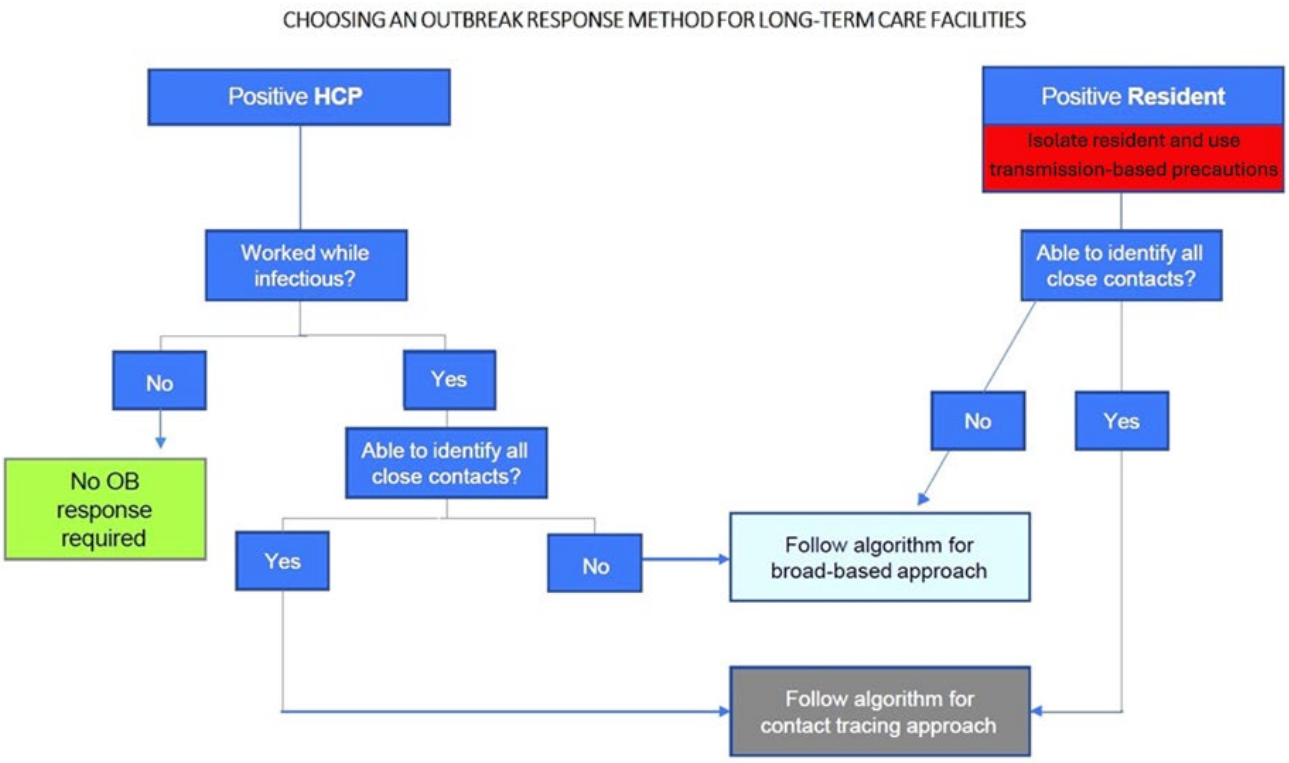
- Require universal masking for source control.
- Require visitors to perform hand hygiene and follow respiratory/cough etiquette.
- Educate and encourage routine and seasonal vaccination for family and visitors.
- Encourage outdoor visitation, as feasible. Avoid visitation in indoor common areas.

See also: QSO-20-39-NH *Nursing Home Visitation - COVID-19 (REVISED)*

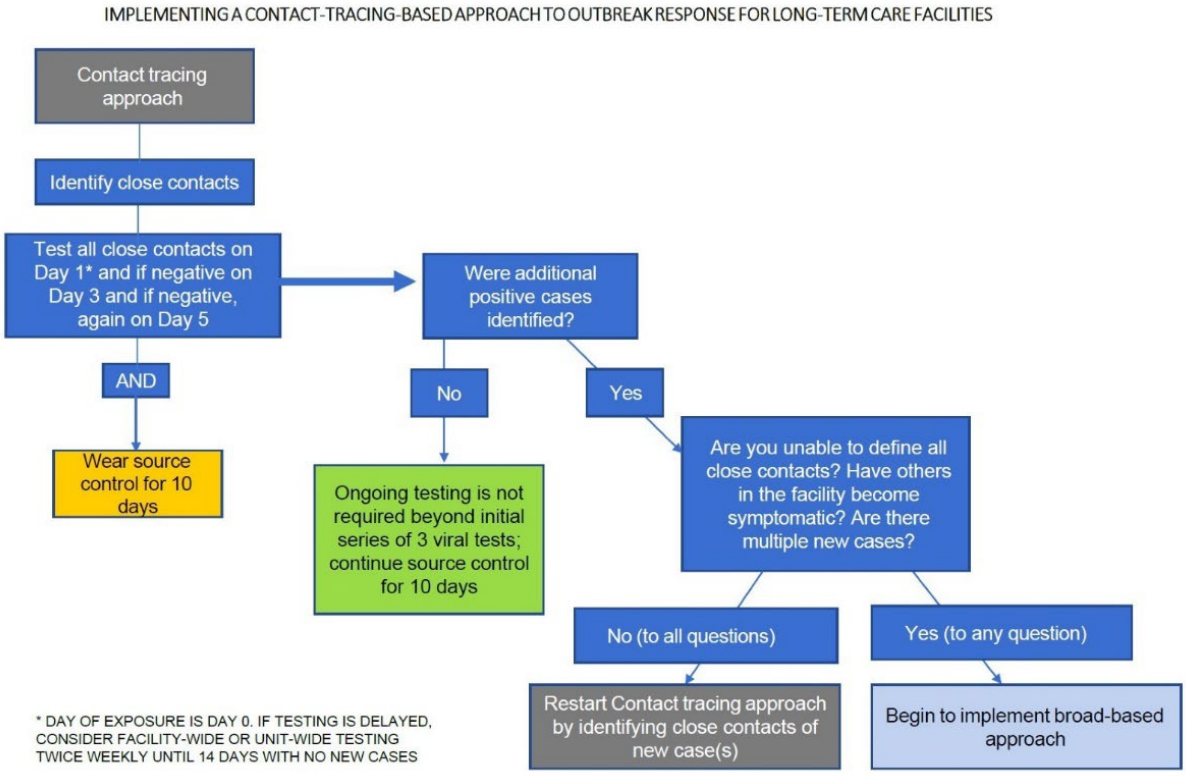
Assess Outbreak Control Measures

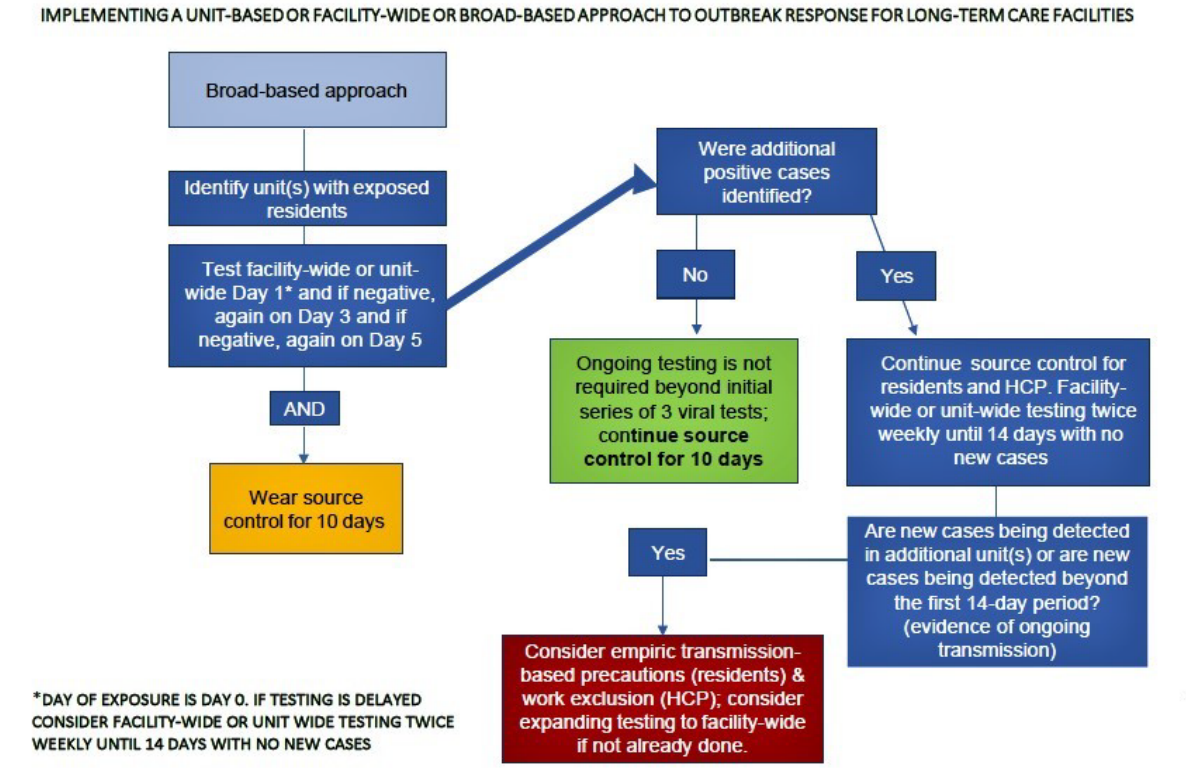
- **Influenza:** If no new or suspected cases of influenza have been identified for at least 7 days after the last confirmed case of influenza, it is reasonable to consider an influenza outbreak resolved and discontinue outbreak control measures.
  - When you receive notification from ACPHD that your influenza outbreak is considered resolved, complete the Outbreak Summary form and send to ACPHD.
- **COVID-19:**
  - If using the Contact Tracing approach to testing, surveillance for new cases should continue until there are no new positives when testing close contacts on day 1, 3 and 5 plus 5 additional days of surveillance.
  - If using the Facility-wide or Unit-based approach to testing, surveillance for new cases should continue until: 1) There are no new cases when testing on day 1, 3, and 5 plus 5 additional days of surveillance, or 2) Two consecutive weeks (14 days) of testing every 3-4 days reveals no positive test results for residents.
- **RSV:** For RSV outbreaks, use a 10-day period after the last confirmed case to define the end of an outbreak.
- For non-influenza, non-RSV, non-COVID-19 respiratory outbreaks, resolution of the outbreak will be determined in consultation with ACPHD. Outbreak control measures can typically be discontinued when there have been no new cases for two median incubation periods, which varies depending on the pathogen.

APPENDIX A


CHOOSING AN OUTBREAK RESPONSE METHOD FOR LONG-TERM CARE FACILITIES
Positive HCP
Worked while infectious?
No
Yes
No OB response required
Able to identify all close contacts?
Yes
No
Positive Resident
Isolate resident and use transmission-based precautions
Able to identify all close contacts?
No
Yes
Follow algorithm for broad-based approach
Follow algorithm for contact tracing approach

Appendix A (cont.)





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Line List for Facilities

v.10.30.2025

Name of Facility: _____ Today's Date: _____ ☐ No new illness to report today

Demographics							Symptoms							Laboratory Test						Outcomes				
Name	Staff or Resident (S/R)	Unit / Floor	Room / Bed #	Age	Sex	Vaccinated > 14 d prior (Y/N)	Onset date of symptoms	Temperature	Cough (Y/N)	Sore throat (Y/N)	Myalgia (Y/N)	Rhinorrhea (Y/N)	Other Symptoms (Specify)	Rapid Test (+/-)	PCR (+/-)/lab-based test	COVID-19 (Y/N)	Influenza (Y/N) & type (A or B)	If Flu A, which subtype [e.g. H1N1, H1, H3, unsubtyped, etc.]	RSV (Y/N)	Antiviral treatment start date	Hospitalized (Y/N)	Pneumonia (Y/N)	Death (Y/N) & Date	Comments (include any alternate diagnosis)

RESPIRATORY OUTBREAK SUMMARY FORM

Facility/Organization Name: _____ Date: _____ Completed By: _____

Categories		Resident	Staff
Total Census Resident and Staff			
# of Resident and Staff Vaccinated ≥14 Days Before Outbreak Began	Influenza		
	COVID-19		
	RSV		
# Who Received Catch-Up Influenza Vaccine After Outbreak Began			
# Who Received Catch-Up COVID-19 Vaccine After Outbreak Began			
# Who Received RSV Vaccine After Outbreak Began			
# Not Vaccinated (Any)			
# of Ill			
# Ill Who Received Treatment (COVID-19 and/or Influenza as applicable)	Treated for COVID-19		
	Treated for Influenza		
# Non-Ill Who Received Prophylaxis for Influenza			
# of Ill Who Developed Symptoms After 72 hours of Antiviral Treatment or Chemo-prophylaxis for Influenza			
# Hospitalized due to Influenza, COVID-19, or RSV as applicable			
# of Deaths due to Influenza, COVID-19, or RSV			

*Ill residents or staff is defined as a person who has laboratory-confirmed influenza (i.e., a positive influenza test result) OR who meets the Influenza-Like Illness (ILI) case definition (Fever ≥100°F and cough and/or sore throat in the absence of a known cause other than influenza

Public Health Department
Alameda County Health

Handwashing and Approved Disinfectants Effective Against Influenza

Handwashing Instructions

Handwashing is the best way to prevent spreading germs to others. The proper way to wash your hands is as follows:

- Wet your hands with clean, running water and apply soap. Use warm water if it isavailable.
- Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails.
- Scrub your hands including the palms, back of hands, between finger, and under nails. Continue scrubbing hands for at least 20 seconds, or about the time it takes to hum the "Happy Birthday" song from beginning to end twice.
- Rinse your hands well under clean, running water.
- Dry your hands using a clean paper towel or air dryer. If possible, use a paper towel to turn off the faucet.

If soap and water are not available, use an alcohol-based hand sanitizer as follows:

- Apply product to the palm of one hand (read the label to learn the correctamount).
- Rub your hands together.
- Rub the product over all surfaces of your hands and fingers until your hands are dry.

More information about handwashing can be found at the CDC handwashing webpage.

Environmental Disinfection

The influenza virus can be killed by many common household and hospital-grade disinfectants, including bleach and ammonia-based products. See the EPA List of Products Effective Against Influenza A Virus on Hard Surfaces for a detailed list of products that are appropriate to use for cleaning and disinfection during an influenza outbreak.