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Health Alert

Date: July 22, 2024
To: Yolo County Skilled Nursing Facilities
From: Dr. Aimee Sisson, MD, MPH, Yolo County Health Officer
Subject: Respiratory virus outbreak prevention, control, and reporting in skilled nursing facilities

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This Health Alert reviews updated recommendations for respiratory virus infection prevention in skilled nursing facilities (SNFs), along with changes to respiratory virus case and outbreak reporting.

Background

Since the end of the State and local COVID-19 emergencies on February 28, 2023, State and local policies related to COVID-19 and other respiratory viruses have continued to change to address respiratory virus risk in healthcare settings, account for prevention and treatment tools, and streamline reporting requirements.

Infection Prevention and Control

Yolo County Public Health encourages skilled nursing facilities to follow the Centers for Disease Control and Prevention's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for routine infection prevention and control practices for COVID-19, as directed by CDPH Licensing and Certification Program All Facilities Letter 22-07.2.

Skilled nursing facilities should also follow recommendations outlined in the California Department of Public Health (CDPH) Healthcare-Associated Infections Program's Recommendations for Prevention and Control of COVID-19, Influenza, and other Respiratory Viral Infections in Skilled Nursing Facilities 2023-2024.

Yolo County Public Health strongly encourages skilled nursing facilities to evaluate each new case of COVID-19 to determine if others in the facility have been exposed, and to test all residents and healthcare personnel (HCP) identified as close contacts using either contact-tracing or broad-based testing approaches, as reflected in CDC guidance. **Local data from November 2023 to March 2024 show that 70% of facilities that reported one initial case identified additional cases after testing close contacts, underscoring the importance of additional investigation by facilities.**

Case and Outbreak Reporting

As of March 12, 2023, AFL 23-09 is no longer in effect and SNFs are directed to refer to AFL 23-08, Requirements to Report Outbreaks and Unusual Infectious Disease Occurrences. For facility outbreaks of COVID-19, influenza, pneumonia, other respiratory viral pathogens, or gastroenteritis (e.g., norovirus), the AFL directs facilities to The Council for Outbreak Response: Healthcare-Associated Infections and Antimicrobial-Resistant Pathogens (CORHA) investigation and reporting thresholds and outbreak definitions. All COVID-19-related hospitalizations and deaths associated with a SNF should be reported to Public Health. A summary of respiratory virus reporting guidance is below; facilities are encouraged to review the linked definitions and corresponding guidance in their entirety on the CORHA website.

COVID-19:

	Long-Term Care Facilities (LTCF)
Threshold for Additional Investigation by Facility	≥1 case of suspect†, probable* or confirmed COVID-19 among HCP†† or residents OR ≥3 cases of acute illness compatible with COVID-19 among residents with onset within a 72h period
Threshold for Reporting to Public Health	≥2 cases of probable* or confirmed COVID-19 among residents identified within 7 days OR ≥2 cases of suspect†, probable* or confirmed COVID-19 among HCP†† **AND** ≥1 case of probable* or confirmed COVID-19 among residents, with epi-linkage§,¶ OR ≥3 cases of acute illness# compatible with COVID-19 among residents with onset within a 72h period
Outbreak Definition	≥2 cases of probable* or confirmed COVID-19 among residents, with epi-linkage¶ OR ≥2 cases of suspect†, probable* or confirmed COVID-19 among HCP†† **AND** ≥1 case of probable* or confirmed COVID-19 among residents, with epi-linkage§,¶ **AND** no other more likely sources of exposure for at least 1 of the cases

***Probable case** is defined as a person meeting presumptive laboratory evidence. Presumptive laboratory evidence includes the detection of SARS-CoV-2 specific antigen in a clinical or post-mortem specimen using a diagnostic test performed by a CLIA-certified provider (includes those tests performed under a CLIA certificate of waiver).

†Suspect case is defined as a person meeting supportive laboratory evidence OR meeting vital records criteria with no confirmatory or presumptive laboratory evidence for SARS-CoV-2. Supportive laboratory evidence includes the detection of SARS-CoV-2 specific antigen by immunocytochemistry OR detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight.

††Healthcare Personnel (HCP), defined by CDC, include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). Facilities should prioritize investigations of cases in HCP whose duties require them to have close contact with patients or visitors. Healthcare facility infection prevention or occupational health

personnel should, wherever feasible, interview HCP with COVID-19 to identify likely sources of exposure and assess whether there are epi-linkages with other HCP or patient cases.

¶Epi-linkage among patients or residents is defined as overlap on the same unit or ward, or other patient care location (e.g., radiology suite), or having the potential to have been cared for by common HCP within a 7-day time period of each other. Determining epi-linkages requires judgment and may include weighing evidence whether or not patients had a common source of exposure.

§Epi-linkage among HCP is defined as having the potential to have been within 6 ft for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms; for example, worked on the same unit during the same shift, and no more likely sources of exposure identified outside the facility. Determining epi-linkages requires judgment and may include weighing evidence whether or not transmission took place in the facility, accounting for likely sources of exposure outside the facility. During periods of surge and high community transmission rates, it may be impossible to determine whether HCP case exposures and transmission occurred within or outside the facility. However, hospitals should still report suspected outbreaks.

If resident tests negative for both influenza and SARS-CoV-2, consider testing with a multiplex respiratory viral panel.

Influenza:

	Long-Term Care Facilities, including Skilled Nursing Facilities (SNFs)
Threshold for Additional Investigation by Facility	≥1 resident with influenza-like illness (ILI; fever and cough or sore throat)
Threshold for Reporting to Public Health	≥1 lab confirmed‡ case with 2 or more residents with ILI identified within 72h of each other in residents
Outbreak Definition	≥ 2 lab confirmed‡ cases identified within 72h of each other in residents and epi link†

†Epi link is defined as common exposure within the facility, e.g., patients residing on the same unit or cared for by same healthcare personnel with symptom onset within 72 hours of each other.

‡Lab confirmed cases should be of the same type/subtype if diagnostic testing allows

How to Report

Report cases to Public Health by faxing Confidential Morbidity Reports and line lists to (530) 669-1549 or sending an encrypted email to CMR.FAX@yolocounty.org. Complete directions and corresponding forms are found on the Yolo County Communicable Disease Reporting webpage .