Colorado long-term care facilities | Revised November 2026 | David Shepherd, DO, CMD

Purpose: Give infection preventionists and clinical staff a quick guide to when GAS infections in residents or staff must be reported to public health in Colorado, and what the facility should do in either case.

Regulatory basis: Colorado Board of Health, Epidemic and Communicable Disease Control (6 CCR 1009-1), Appendix A, and the CDPHE Reportable Conditions chart. The table below reflects the current rule, adopted January 21, 2026 and effective March 17, 2026 [2]. The 2026 amendments added no new conditions, removed encephalitis, and moved 18 pathogens to laboratory-only reporting [1]; the GAS, toxic shock syndrome, and outbreak requirements below are taken directly from the 2026 rule text [2].
Recheck this table once a year and whenever CDPHE updates the rule (cdphe.colorado.gov/report-a-disease).

1. Quick Reference

Situation	Reportable under 6 CCR 1009-1?	Action
Single **non-invasive** GAS case (strep throat, impetigo, superficial wound) in a resident or staff member	**No.** Not a listed condition when it occurs alone [2].	Treat, place on precautions, and log in facility surveillance (Section 3).
Streptococcal toxic shock syndrome (STSS), anywhere in Colorado	**Yes.** Provider report within **4 days**, statewide [2].	Report to the LPHA or CDPHE. Ask the lab to save the isolate. Start the Section 3 steps.
Invasive GAS in a person living in **Adams, Arapahoe, Denver, Douglas, or Jefferson County**	**Yes, by the laboratory only.** 4-day report of a normally sterile-site isolate; clinical material must be submitted. A wound or surgical isolate is also reportable when accompanied by necrotizing fasciitis or STSS [2,4].	The lab reports, but the facility should still call public health (see the next row).
Invasive GAS in a person living **outside the 5-county Denver metro area** (for example, El Paso or Mesa County)	**Not a listed condition for a single case** [2]. CDPHE asks providers statewide to contact its HAI/AR Program about single invasive cases in healthcare settings [3].	**Facility policy: phone the LPHA or the CDPHE HAI/AR Program (303-692-2700) the same day** for every invasive case. One invasive case in a facility can be the first sign of an outbreak [3,5].

Situation	Reportable under 6 CCR 1009-1?	Action
Suspected outbreak or cluster (any pathogen, including non-invasive GAS)	**Yes.** Known or suspected outbreaks of all types are reportable **immediately** by labs, providers, and facilities [2].	**Phone the LPHA or CDPHE within 4 hours** of identifying a suspected or confirmed outbreak [2].

Why call for every invasive case, even where it is not required? From 2020 to 2023, about 30% of invasive GAS cases in Colorado LTCF residents were part of an outbreak [3]. CDC advises that even one invasive case should prompt an epidemiologic investigation by the facility [5].

2. Definitions

- **Confirmed invasive GAS:** GAS isolated by culture, or detected by nucleic acid testing, from a normally sterile site (blood, CSF, joint, pleural or peritoneal fluid, bone, internal organs). STSS or necrotizing fasciitis with GAS cultured from a wound is also classified as confirmed [9].

- **Probable invasive GAS:** A clinically severe illness (for example, STSS, necrotizing fasciitis, or septic shock) with GAS from a non-sterile site and no other bacterial cause identified [9].

- **Investigation thresholds (CDC LTCF toolkit, applied to residents):**

    - **1 invasive case:** the facility starts an epidemiologic investigation and active surveillance (Section 3, step 7) [5].

    - **2 cases, at least 1 invasive, with the second onset within 4 months of the first:** CDC recommends culturing residents and considering culture of epidemiologically linked staff, in coordination with public health [6].

    - **3 or more cases, at least 1 invasive:** expanded response, including screening for asymptomatic carriers [7].

- **Additional facility triggers (this facility's own criteria; not a Colorado legal definition and not part of CDC's toolkit):** 2 or more culture-confirmed non-invasive GAS cases on the same unit within 4 months, **or** any epidemiologic link between a staff case and a resident case (for example, the same caregiver or the same unit). Treat these as a suspected cluster and call the LPHA.

If it is unclear whether a trigger has been met, **call the LPHA**. Public health decides whether to investigate.

3. Steps for Any Positive GAS Test

1. **Confirm the result** and record the specimen site (throat, wound, or sterile site).

2. **Treat** the case. For pharyngitis, penicillin or amoxicillin for 10 days is first-line; a first-generation cephalosporin is an option for non-anaphylactic penicillin allergy [10]. Invasive disease is treated per the hospital or infectious diseases team.

3. **Place residents on precautions** while results are pending and until 24 hours of effective antibiotic therapy [5]:

    - Throat GAS: Droplet Precautions.

    - Wound, skin, ostomy, or device-site GAS: Contact **and** Droplet Precautions, continued until drainage stops or is contained by a dressing.

    - Staff should keep wearing a facemask for all wound care and invasive device handling until the outbreak is over.

4. **Staff work restriction:** Exclude staff with known or suspected GAS infection until GAS is ruled out or until they have had 24 hours of effective antibiotic therapy. Exposure alone does not require work restriction or prophylaxis [8]. Staff working while ill has been linked to GAS clusters in skilled nursing facilities [11]. In a systematic review of LTCF outbreaks from all pathogens, about 60% of studies

reported cases among staff [12].

5. **Log the case** in facility surveillance (date, unit, room, caregivers, specimen site) so linked cases can be found [16].

6. **Ask the laboratory to save the isolate** for possible strain typing (emm typing or whole-genome sequencing) [5,6].

7. **For any invasive case:** look back through the past month of resident records (including referral hospital and lab results), ask all residents and staff (including consultants) about GAS symptoms, and keep active surveillance going for 4 months after the most recent case [5].

8. **Check against Sections 1 and 2.** If a report or a facility trigger applies, go to Section 4.

4. When to Call Public Health

1. **Phone the LPHA or CDPHE.** For a suspected or confirmed outbreak, call within 4 hours of identifying it [2]. For a single invasive case outside the Denver metro area, call the same day (facility policy) [3]. CDPHE HAI/AR Program: 303-692-2700 [3].

2. Have ready: a line list of cases (resident or staff, unit, onset date, specimen site, outcome), staff assignments, current precautions, and isolate status.

3. Notify the medical director, the director of nursing, and the administrator.

4. Start **active surveillance** on the affected unit(s) for pharyngitis, skin or wound infection, fever, and sepsis, and culture any new suspected cases [5].

5. **Wait for public health guidance** before starting carriage screening or chemoprophylaxis. Screening, treating carriers, and in some outbreaks mass prophylaxis have been used to end LTCF GAS outbreaks [6,7,13,14,15].

6. Reinforce hand hygiene, wound-care technique, and sick-leave policies. Lapses in hand hygiene and wound care are a recurring finding in LTCF GAS outbreaks [16,17].

5. Documentation

- Keep the line list, a record of all public health communications (date, time, contact name), and copies of any guidance received.

- Review GAS surveillance data at the infection control or QAPI committee [16].

References

1. Colorado Medical Society. Revised disease reporting regulations, webpage, and posters (summary of the 2026 amendments to 6 CCR 1009-1). https://www.cms.org/revised-disease-reporting-regulations-webpage-and-posters/

2. Colorado Board of Health. 6 CCR 1009-1, Epidemic and Communicable Disease Control, including Regulation 2 and Appendix A. Adopted January 21, 2026; effective March 17, 2026 (Colorado Secretary of State). https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=12431&fileName=6+CCR+1009-1

3. CDPHE Health Facilities and Emergency Medical Services Division. Changes to approach to public health follow-up of invasive group A Streptococcus. June 5, 2024. https://healthfacilitiescommunity.blogspot.com/2024/06/changes-to-approach-to-public-health.html

4. CDPHE. Reportable diseases and conditions for laboratories, effective March 2026 (copy posted by UCHealth Memorial Hospital laboratory). Current posters: cdphe.colorado.gov/report-a-disease. https://www.testmenu.com/MemorialHospital/TestDirectory/SiteFile?fileName=sidebar%5CCDPHE+Reportable+Disease+and+Conditions+March2026.pdf

5. Centers for Disease Control and Prevention (CDC). Group A Strep LTCF Toolkit. Scenario: 1 invasive case. https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/investigating-1-case.html

6. CDC. Group A Strep LTCF Toolkit. Scenario: 2 cases (at least 1 invasive). https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/investigating-2-cases.html

7. CDC. Group A Strep LTCF Toolkit. Scenario: 3+ cases. https://www.cdc.gov/group-a-strep/php/ltcf-toolkit/investigating-3-cases.html

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