COLORADO
Department of Public Health & Environment

RSV outbreak guidelines

Prevention and control in long-term care facilities

2022-2023 Season

Pathogen: Respiratory Syncytial Virus (RSV) causes respiratory tract illness in people of all ages. People at high risk of severe RSV infection include infants and young children, adults with underlying medical conditions, and elderly adults. Adults who are 65 years of age and older with underlying medical conditions may be more susceptible to developing severe disease if they become infected with RSV. Medical conditions such as immunosuppression, chronic obstructive pulmonary disease (COPD), asthma, or congestive heart failure, may increase the risk of patients developing pneumonia or other complications and may lead to hospitalization.

Incubation period: Ranges from 2 to 8 days (typically 4 to 6 days). RSV is more commonly transmitted during peak respiratory illness months during the fall, winter, and early spring.

Symptoms: May include rhinorrhea and sneezing (nasal discharge or runny nose), pharyngitis (sore throat), chills, headache, fatigue, decreased appetite, coughing, wheezing, and/or difficulty breathing. Fever may or may not present as a symptom in adult patients.

Transmission/communicability: Direct and indirect contact with contaminated nasal and oral secretions through coughing and sneezing. People who are infected are usually contagious for 3-8 days. Some patients with weakened immune systems can be contagious for four weeks or longer. Virus-containing droplets can briefly be transmitted through airborne contact. The virus can settle on hard surfaces such as railings or tables for several hours, or on soft surfaces such as hands, tissues or bed sheets for shorter amounts of time.

Treatment: RSV vaccines and antivirals are in development; however, currently there is no specific treatment or prophylaxis in adults for RSV. Supportive care is used to alleviate symptoms. Fever and body ache can be managed with over-the-counter medications such as ibuprofen or acetaminophen. Fluid and water intake should be increased to prevent dehydration. If patients exhibit difficulty breathing or become dehydrated, hospitalization and/or oxygen support may be required. Patients with pre-existing conditions such as asthma, COPD, and congestive heart failure may be at higher risk for hospitalization. RSV infections generally resolve with supportive care in one to two weeks.

The definition of a residential care facility includes nursing homes, assisted living facilities, long-term care facilities, and skilled nursing facilities. Independent living communities may consider these guidelines to be applicable if there is an occurrence of illness among residents that share common areas for dining and social activities.

RSV and COVID-19

During the 2021-2022 RSV season, it is expected that RSV and SARS-CoV-2, the virus that causes COVID-19, will be co-circulating in Colorado communities. The symptomatic presentations of these respiratory illnesses are very similar and may be very difficult to distinguish between based on symptoms alone. Additionally, it is possible for people to be co-infected with SARS-CoV-2 and one or more other respiratory viruses, including influenza and/or RSV. It is also possible for COVID-19 and other respiratory illnesses to occur as simultaneous or separate outbreaks in long-term care facilities (LTCFs). Testing for SARS-CoV-2 is highly recommended to confirm a diagnosis if a resident or multiple residents present with respiratory illness symptoms. Measures for prevention and response of outbreaks of respiratory illness should consider COVID-19 and other respiratory illnesses and defer to the COVID-19 outbreak guidance for long-term care facilities until testing confirms a diagnosis.

While RSV and COVID-19 may share certain symptoms, there are key differences between the two. Notably, both RSV and SARS-CoV-2 are spread from person to person via respiratory droplets produced when the person who is infected coughs, sneezes, or talks. The incubation period for RSV can range from 2 to 8 days and is typically between 4-6 days. The incubation period for COVID-19 is typically five days, however symptoms may occur as soon as two days and up to 14 days after infection. According to CDC, available data suggest that most people with mild-to-moderate COVID-19 remain infectious no longer than 10 days after symptoms onset; however, this may be longer in those with weakened immune systems

Both COVID-19 and RSV may present with the following symptoms: runny nose; fever or feeling feverish/chills; cough; and shortness of breath and/or difficulty breathing. Symptoms of RSV may also include sneezing and decreased appetite. Additionally, elderly 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 with RSV infection and may not present with fever. COVID-19 may symptomatically differ from RSV in that it may present with change or loss of taste or smell as well as fatigue, sore throat, muscle pain or body aches, headache, vomiting, and diarrhea. Continuously refer to CDC for the latest updates on COVID-19.

Outbreak definition for RSV-associated outbreaks in a long-term care facility:

- Suspected RSV outbreak: One resident with a positive test for RSV, among one or more other residents with undiagnosed respiratory illness with symptom onset occurring within a one-week period.*
- Confirmed RSV outbreak: Two or more positive cases of RSV among residents with symptom onset occurring within a one-week period.

**The occurrence of respiratory illness among residents should first be considered suspect for COVID-19. If RSV or other respiratory illnesses such as influenza are circulating locally, these pathogens should also be considered suspect until testing proves otherwise. Co-infections of SARS-CoV-2 and other viral respiratory pathogens can and may occur.*

RSV testing

If a resident or health care personnel (HCP) presents with symptoms of respiratory illness, which may also be consistent with symptoms of RSV and influenza, first refer to the COVID-19 long-term care facility guidelines for further instruction on testing for COVID-19. An RT-PCR assay is recommended for RSV testing in older adults (however rapid antigen testing may also be used as an immediate testing response). The sensitivity of RT- PCR assays is greater for RSV detection among adults than rapid antigen testing, and several molecular assays can identify multiple pathogens (including RSV, influenza, and SARS-CoV-2). The CDPHE State Lab has multiple assays to assist with respiratory pathogen detection on a case-by-case basis. Determination of which assay could be used may be discussed between CDPHE, the facility, and the local public health agency. In the event that a symptomatic resident tests negative for influenza, RSV, and SARS-CoV-2 via a rapid antigen test, confirmatory PCR testing is recommended. Additional testing with a full respiratory viral panel may be recommended by a health care provider to distinguish which pathogen(s) is causing the outbreak. Residents who are not symptomatic do not need to be tested for RSV.

Reporting an outbreak

Outbreaks are reportable conditions in Colorado. Report all suspected and confirmed RSV outbreaks to your local health agency. This online REDCap outbreak report form may be used to report RSV outbreaks. Alternatively, an RSV outbreak report form for long-term care facilities is also included in this document, but the REDCap report form is preferred.

Prevention of RSV transmission: General principles

Healthcare facilities should use a multi-faceted approach to decrease the risk of transmission of RSV to protect residents and staff. This includes:

- Implementation of respiratory hygiene and cough etiquette.
- Appropriate management of healthcare personnel (HCP) who are ill.
- Adherence to infection control precautions.
- Implementation of environmental control measures.

Prevention strategies

When an outbreak is suspected, LTCFs should implement additional measures to prevent the transmission of RSV and other respiratory viruses, including COVID-19. Do not wait for confirmation of a diagnosis to implement infection control precautions. Until testing indicates otherwise, if a resident is exhibiting symptoms of respiratory illness, first defer to the COVID-10 long-term care facility guidelines.

1. Staff should follow standard, contact, and droplet precautions (gowns, gloves, N95 or facemask if an N-95 is not available, and eye protection) for any resident with respiratory illness. Ensure staff have been trained on proper use of PPE, including proper donning and doffing.

   Encourage residents to wear a cloth face covering or facemask (if tolerated) any time they leave their room or when staff enter their room to provide care. Surgical masks and N95s should be reserved for HCP.

2. Maintain communication between LTCFs and acute care facilities to ensure that transfers are not admitted with unrecognized respiratory infections. Facilities should defer to the COVID-19 protocol for new admissions for these cases. Ensure transport personnel and the receiving facility are informed of a patient with a confirmed respiratory illness before arrival. This will allow the transport service and health care facility the opportunity to properly prepare and ensure that transfers are not admitted with unrecognized respiratory infections.

   Hospitalized residents with a history of confirmed or suspected RSV can be transferred back to the facility if acute symptoms are resolved or the accepting facility is able to maintain transmission-based precautions.

3. Ensure hand hygiene is performed in accordance with CDC recommendations and implement respiratory hygiene and cough etiquette strategies to reduce transmission of respiratory infections in the facility. For further information, see CDC's website.

4. Defer to the current COVID-19 Residential Care Facility (RCF) Comprehensive Mitigation Guidance for staff with symptoms of respiratory illness. Staff with undiagnosed respiratory illness or those testing positive for COVID-19 should be excluded from work until they meet the return-to-work criteria outlined in the COVID-19 RCF Comprehensive Mitigation Guidance document. Staff who are confirmed positive for RSV and negative for SARS-CoV-2 may return to work when at least 24 hours have passed since their last fever without the use of fever-reducing medications (i.e., ibuprofen or acetaminophen) and other symptoms (e.g., cough) are improving.

5. If visitation is allowed in your facility, all visitors must be screened for symptoms of respiratory illness prior to entering the facility. This form can be used to collect the necessary information. Exclude visitors with symptoms of respiratory illness or those reporting close contact with anyone who has tested positive for, or has symptoms consistent with COVID-19, for at least 14 days.

Response to an RSV outbreak

The following recommendations should be followed for all suspected and confirmed RSV outbreaks. These recommendations are also useful in the control of other respiratory viruses such as influenza and COVID-19. Precautions should be in place for at least two incubation periods (16 days) following the date of symptom onset of the last case of illness. If there are no new cases of illness in that time period, the outbreak can be considered over. However, patients who are immunocompromised and asymptomatic can continue to spread the virus for up to four weeks. This may extend the time period for recommended precautionary protocols. Outbreak control measures should be immediately applied while waiting for test results. Do not wait for a positive test to respond. If the test is negative and there are other symptomatic residents in the facility, outbreak control measures should still be applied.

1. **Until testing proves otherwise**: ALL suspected respiratory illness cases should be treated as potential COVID-19 cases and facilities should defer to the COVID-19 outbreak guidance for infection prevention and control. The facility should follow the appropriate response measures for an RSV outbreak once testing confirms the RSV diagnosis. If testing confirms the presence of both COVID-19 and RSV, guidance measures for RSV are superseded by those of COVID-19, and the facility should follow the COVID-19 outbreak guidelines. If testing confirms the presence of both influenza and RSV, guidance measures for RSV are superseded by those of influenza, and the facility should follow the influenza outbreak guidelines. Symptomatic residents should be tested for RSV, influenza, and COVID-19.

2. **Source control**:
   a. Symptomatic residents should be confined to their rooms or limited to the affected cohort for eight days after illness onset and until 24 hours after they no longer have a fever (without the use of fever-reducing medicines) and other symptoms (e.g., cough) are improving.

   b. Isolation should not impede resident care or the ability to provide social or rehabilitation services in the resident's room, as long as droplet precautions are in place (see below).

c. Asymptomatic residents with close contact to a known positive resident should wear source control when indoors and around others for seven days following the last exposure.

d. People who are elderly 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 with RSV infection and may not present with fever.

e. Additionally, symptomatic residents should wear a surgical mask/facemask when they need to be out of their room or if they are outside of the affected unit, if possible. Avoid transferring residents with symptoms of respiratory infection to unaffected units. If there are multiple outbreaks of different respiratory illnesses, patients should be cohorted in different units by pathogen, if possible.

3. **Infection control**: For all residents with undiagnosed respiratory illness, defer to the personal protective equipment (PPE) FAQ in the COVID-19 long-term care facility guidelines for further instruction on use of PPE. Further information on infection prevention and control of respiratory illness and PPE may be found on CDC'S website.

   a. Standard precautions: Hand hygiene and use of gloves, gown, face mask, eye protection, or face shield, depending on the anticipated exposure. Protection for the eyes, nose, and mouth by using a mask and goggles, or face shield alone, is necessary when it is likely that there will be a splash or spray of any respiratory secretions or other body fluids as defined in "Standard Precautions". Respiratory hygiene and cough etiquette should also be followed. This includes covering the nose and mouth, prompt disposal of used tissues, wearing of surgical masks by HCP when entering a patient's room and interacting with patients, handwashing after contact with respiratory secretions, and maintaining a minimum spatial distance of six feet from people who are symptomatic in common areas. Avoid use of N95 masks on symptomatic residents as they are meant to prevent inhalation of hazardous substances and may impede patient health.

   b. Contact precautions: Gloves, gown, and mask should be worn upon entry to the resident's room, during resident care, and should be properly discarded before exiting the resident's room. Room placement decisions should consider balancing health risks to other patients. If multiple-resident rooms, ≥6 feet spatial separation between beds is advised. Limit patient out-of-room transport to medically-necessary purposes. Use disposable or dedicated patient-care equipment. If common use of equipment for multiple residents is unavoidable, clean and disinfect this equipment before using it with another resident. Prioritize cleaning and disinfection of resident rooms. Use contact precautions during cleaning and disinfection. Ensure resident rooms are frequently cleaned and disinfected. Focus cleaning and disinfection on frequently touched surfaces and equipment in the immediate vicinity of the resident.

   c. Droplet precautions (surgical masks/face masks should be worn upon entry to the resident's room and during resident care):

      - Droplet precautions should not impede the care of residents or provision of social or rehabilitation services in the resident's room. If resident movement or transport is necessary, have the resident wear a surgical mask or procedure mask, if possible.
      - If an RSV diagnosis has not been confirmed, follow the criteria for COVID-19 mask use among HCP and residents here.
      - Residents should wear a cloth face covering or facemask (if tolerated) whenever staff enter their room or when leaving their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

4. **Restricting staff movement**: Designate specific staff members (which includes healthcare, dietary, housekeeping, laundry, and therapy personnel) to a unit/floor/neighborhood/POD consistently and across multiple shifts when possible. If staffing shortages don't allow for such designation, designate staff to care only for infected residents, consistently and across multiple shifts, to limit further transmission to uninfected residents.

   If there are simultaneous respiratory disease outbreaks occurring in the facility, such as RSV and COVID-19, it is recommended that staff are cohorted by pathogen when treating patients (i.e. staff that only treat COVID-19 patients and staff that only treat RSV patients). If cohorting of healthcare personnel by pathogen is not possible,

personal protective equipment (PPE) such as gowns and gloves should be changed in between the care and treatment of patients with different pathogens. Extended use of PPE worn on the head, such as masks or eye protection, is acceptable when treating both COVID-19 positive and RSV positive patients. However, if at any point the mask is removed, it cannot be reused unless it is properly disinfected. More information on use of PPE can be found in the COVID-19 long-term care facility guidelines.

5. **Surveillance**: Implement daily active surveillance of new respiratory illnesses among all healthcare personnel, residents, volunteers, and visitors. Defer to the COVID-19 long-term care facility guidelines first for guidelines on testing staff with respiratory illness symptoms and return-to-work criteria. Staff who have confirmed RSV may only return to work until at least 24 hrs after they no longer have a fever (without the use of fever-reducing medicines such as ibuprofen or acetaminophen) and all other respiratory symptoms are improving. Continue tracking ill residents, staff, and volunteers and monitoring the progression of the outbreak until at least two incubation periods (16 days) following the date of symptom onset of the last case of illness. This line list template can be used to track outbreaks of respiratory pathogens, including RSV, influenza, and COVID-19.

6. **Visitors**: For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. For the safety of the residents, in-person visitation should be limited if a visitor is symptomatic and/or infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Additional information about visitation from the Centers for Medicare and Medicaid Services (CMS) is available at Policy & Memos to States and Regions.
    a. Counsel patients and their visitor(s) about the risks of an in-person visit.
    b. Encourage use of alternative mechanisms for patient and visitor interactions, such as video-call applications on cell phones or tablets, when appropriate.
    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. They should minimize their time spent in other locations in the facility.
    e. Visitors should be notified that an outbreak of RSV is occurring in the facility. Signage can be an effective way to communicate this information, but it must be visible.
    f. Visitors are encouraged to perform hand hygiene upon entry into the facility and upon exiting the facility.
    g. Visitors are educated and adhere to isolation precautions. This includes gowning, gloving, masking, proper disposal, and proper hand hygiene.
    h. Visitors who aren't able to wear a mask should be excluded from the facility until illness has resolved. Public health should be contacted to assist with mitigation strategies that are necessary when a visit cannot be delayed.

7. **Documentation**: At minimum, the facility should collect and document the following information for each resident and staff member who is ill using the RSV-Associated Outbreaks in Long Term Care Facility Line List (included at the end of this document):
    a. Illness onset date.
    b. Duration of illness.
    c. Wing/room (residents).
    d. Symptoms.
    e. Hospitalizations/ deaths.

8. **Limiting new admissions**: During a confirmed RSV outbreak, the facility, in conjunction with the state or local health agency, should consider halting new admissions until the outbreak is over. When admissions are allowed residents should be housed in units or areas unaffected by the outbreak and following the guidelines outlined in the COVID-19 RCF guidance document.

9. **Group activities**: Group activities should not occur among affected residents/units until the outbreak has resolved.

10. **Hospital transfers**: If a resident is transferred to the hospital, notify the hospital that the resident is coming from a facility where an outbreak of RSV is occurring. Ensure the resident wears a cloth face covering or mask (which covers both the nose and the mouth) during transport (if tolerated).
11. **Increase frequency of cleaning and disinfection**: Clean and disinfect more frequently than usual (i.e., every 12 hours vs. every 24 hours), emphasizing commonly touched surfaces such as doorknobs and handrails. Begin the disinfection process in areas of lower likelihood of viral contamination and progress to areas with a higher likelihood of viral contamination. 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.
    a. 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 RSV in healthcare settings, including those patient-care areas in which aerosol-generating procedures (AGPs) are performed.
    b. Refer to List N on the EPA website for EPA-registered disinfectants that kill RSV. 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).
    c. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
12. **Common medical equipment**: Consider designating specific items of equipment (blood pressure cuffs, glucometers, etc.) to each resident. If supply does not allow for such designation, designate medical equipment to affected patients or affected units. Each piece of equipment should be adequately cleaned and disinfected (following manufacturers instructions) after each use and before using on the next resident.
13. **Report outbreak to public health**: This online REDCap outbreak report form may be used to report RSV outbreaks. Alternatively, an RSV outbreak report form for long-term care facilities is also included in this document, but the REDCap report form is preferred. Email notifications of outbreaks, submission of outbreak report forms, and questions regarding RSV outbreaks to Emma Schmoll (emma.schmoll@state.co.us) and cdphe_flu_rsv@state.co.us.

For additional information on RSV, please visit the following sites:

- RSV (Respiratory Syncytial Virus)
- For Healthcare Professionals: RSV (Respiratory Syncytial Virus)
- Transmission and Prevention of RSV (Respiratory Syncytial Virus)
- Symptoms and Care of RSV (Respiratory Syncytial Virus)
- https://www.cdc.gov/longtermcare/index.htm
- RSV in Older Adults and Adults with Chronic Medical Conditions
- Older Adults are at high risk for severe RSV infection

Resources

- Guidance for Long-Term Care Facilities | Colorado COVID-19 Updates

COLORADO
Department of Public Health & Environment

RSV outbreak report form

for long-term care facilities

2022-2023 Season

Use the following checklist in conjunction with the latest Guidelines for Prevention and Control of RSV-Associated Outbreaks in Long Term Care Facilities: 2021-2022 Season from the Colorado Department of Public Health and Environment (CDPHE). This checklist may serve as a tool to prevent and control outbreaks of respiratory syncytial virus (RSV) in long-term and residential care facilities and settings.

Outbreak definition for RSV-associated outbreaks in a long-term care facility:

- Suspected RSV outbreak: One resident with a positive test for RSV, among one or more other residents with undiagnosed respiratory illness with symptom onset occurring within a 1-week period.*
- Confirmed RSV outbreak: Two or more positive cases of RSV among residents with symptom onset occurring within a one-week period.

**The occurrence of respiratory illness (fever [>100° F orally] and/or [new cough or sore throat]) among residents should first be considered suspect for COVID-19. If RSV or other respiratory illnesses such as influenza are circulating locally, these pathogens should also be considered suspect until testing proves otherwise. Co-infections of SARS-CoV-2 and other viral respiratory pathogens can and may occur.*

RSV symptoms may include:

- Rhinorrhea & sneezing (nasal discharge or runny nose).
- Pharyngitis (sore throat).
- Chills.
- Headache.
- Fatigue.
- Decreased appetite.
- Coughing.
- Wheezing and/or difficulty breathing.
- Fever (may or may not present as a symptom in adult patients).

Outbreak Checklist

If one or more residents present with respiratory symptoms, first defer to the COVID-19 RCF Comprehensive Mitigation Guidance document until testing confirms the cause of the illness or outbreak. Do not wait for confirmation of a diagnosis to implement infection control precautions. The following checklist should be referred to if testing indicates an outbreak of RSV only. If there is a co-outbreak of COVID-19 and RSV (or other respiratory illness such as influenza), COVID-19 outbreak response measures supersede those of RSV and should be followed accordingly.

Residents

- ☐ Residents with symptoms of respiratory illness are confined to their rooms (isolated) or limited to the affected unit (cohorted) until the outbreak is over.
  - Symptomatic residents should be confined to their rooms or limited to the affected unit for: Eight days after illness onset and until 24 hours after they no longer have a fever (without the use of fever-reducing medicines) and other symptoms (e.g., cough) are improving.
  - Elderly persons 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 with RSV infection and may not present with fever.
- ☐ Do not wait for confirmation of illness to confine (isolate) or cohort symptomatic residents as ongoing transmission can occur during this time.
- ☐ If transport is necessary, have the patient wear a mask and communicate information about the patients' illness with appropriate personnel before transferring them (internal and external transports).

- [ ] New admissions should be limited or housed in unaffected areas until the outbreak is over.
- [ ] Cancel group activities until the outbreak is over (at least two incubation periods (16 days) after the date of symptom onset of the last case of illness).
- [ ] Continued viral shedding can occur up to four weeks among patients who are immunocompromised; therefore, the time period for recommended precautionary protocols may be extended for these people for this time frame.
- [ ] Increase cleaning frequency of common areas and commonly touched surfaces using a List N, EPA-approved disinfectant intended to target viral respiratory pathogens such as RSV and/or SARS-CoV-2.
- [ ] Infection control measures must be maintained until the outbreak is over (at least two incubation periods (16 days) after the date of symptom onset of the last case of illness).

Staff

- [ ] Staff are informed of RSV cases and the following infection control precautions are implemented:
  - Standard precautions.
  - Contact precautions.
  - Droplet precautions.
  - Proper hand hygiene.
  - Assessing for compliance.
- [ ] Healthcare personnel that are confirmed positive for RSV are excluded from work when at least 24 hours have passed since their last fever without the use of fever-reducing medications (i.e., ibuprofen or acetaminophen) and all other respiratory symptoms (i.e., cough) are improving.
- [ ] Staff are wearing a mask at all times, which covers their mouth and nose (masks worn below the nose are not effective).
- [ ] All staff movement is restricted:
  - Designate all staff (e.g., healthcare workers, environmental services, dietary, etc.) to a certain unit/floor/neighborhood/POD. Do not allow staff members to work in both affected and unaffected units. Staff treating or interacting with residents should be cohorted by pathogens if possible. If this is not possible, HCP should change gowns and gloves between treating residents affected by different pathogens.
  - Symptomatic staff excluded from resident care/contact until they no longer have a fever without the use of fever-reducing medications and all other symptoms are improving.

Visitors

For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. For the safety of the residents, in-person visitation should be limited if a visitor is symptomatic and/or infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Additional information about visitation from the Centers for Medicare and Medicaid Services (CMS) is available at Policy & Memos to States and Regions.

- [ ] Counsel patients and their visitor(s) about the risks of an in-person visit.
- [ ] Encourage use of alternative mechanisms for patient and visitor interactions, such as video-call applications on cell phones or tablets, when appropriate.
- [ ] 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.
- [ ] Visitors should be instructed to only visit the patient room. They should minimize their time spent in other locations in the facility.
- [ ] Visitors are notified that an outbreak of RSV is occurring in the facility. Signage can be an effective way to communicate this information, but it must be visible.
- [ ] Visitors are encouraged to perform hand hygiene upon entry into the facility and upon exiting the facility.

- [ ] Visitors are educated and adhere to isolation precautions. This includes gowning, gloving, masking, proper disposal, and proper hand hygiene.
- [ ] Visitors who are less than 12 years of age should be excluded from the facility until illness has resolved.

Surveillance

- [ ] Conduct daily active surveillance (e.g., line list and/or calendars) for new illness among residents and staff until at least two incubation periods (16 days) after symptom onset of the last case of illness have passed. A line list template can be found here.
- [ ] Monitor the progression of the outbreak (note if there is spread between units and/or resident rooms).
- [ ] Report the outbreak (suspected or confirmed) to local or state public health. Local public health will report the outbreak to CDPHE.

  This online REDCap outbreak report form may be used to report RSV outbreaks. Alternatively, an RSV outbreak report form for long-term care facilities is also included in this document, however the REDCap report form is preferred. Email notifications of outbreaks, submission of outbreak report forms, and questions regarding RSV outbreaks to Emma Schmoll (emma.schmoll@state.co.us) and cdphe_flu_rsv@state.co.us.
- [ ] Complete the outbreak form and email to Emma Schmoll (emma.schmoll@state.co.us) or cdphe_flu_rsv@state.co.us when the outbreak has ended (two incubation periods or 16 days have passed with no new RSV cases since the date of symptom onset of the last case of illness).

COLORADO
Department of Public Health & Environment

RSV outbreak report form

for long-term care facilities

2022-2023 Season

Respiratory illness: [Fever (>100° F orally)] and/or [new cough or sore throat]

RSV Outbreak

- Suspected: One resident with a positive test for RSV, among two or more other residents with undiagnosed respiratory illness within a one-week period.
- Confirmed: Two or more positive cases of RSV among residents.

Date of report:			State-assigned outbreak #:	
Are there any other active outbreaks in the facility? Select answer			What type?	
Facility information				
Facility name:			Phone:	
Facility type: Select answer	Other:			
Address:		Email:		
City:	Zip:	County:		
Person reporting:		Title:		
Outbreak information				
Number of residents/staff:	Residents		Staff	
- in facility				
- with non-influenza respiratory illness (with or without a positive RSV test)				
- hospitalized				
- tested				
- with **positive** tests				
Type of test performed:	☐ Rapid	Qty performed:	☐ Rapid	Qty performed:
	☐ PCR	Qty performed:	☐ PCR	Qty performed:
	☐ Unknown	Qty performed:	☐ Unknown	Qty performed:
Date of symptom onset or positive test of the *first* case of RSV detected in this outbreak:				
Date of symptom onset or positive RSV test of the *final* case of RSV for this outbreak:				
Status of outbreak (see definitions above): Select answer				

Questions? Contact your local health department

To report an outbreak: Submit completed form to CDPHE (cdphe_flu_rsv@state.co.us) or Emma Schmoll (emma.schmoll@state.co.us)