Alameda County Health Care Services Agency
Public Health Department
www.acphd.org

Colleen Chawla, Director
Kimi Watkins-Tartt, Director
Nicholas Moss, MD, Health Officer

Public Health Department: Main Line (510) 267-8000
COVID-19 Information: (510) 268-2101
COVID-19 Vaccine Appointments: (510) 268-4829

Covid-Influenza-like Illness (C-ILI) Outbreak
COVER SHEET

Date:
To: Fax: Email:

From: Alameda County Public Health Dept. - Acute Communicable Disease Section (ACD)
[Sender is exempt from requiring authorization per HIPAA [citation 164.512 (b)]

Thank you for reporting the Influenza-like Illness (ILI) Outbreak at your facility. A Public Health Nurse/Investigator will contact you with further guidance. Please review the following documents and guidelines:

- ☒ C-ILI Outbreak Recommendations Checklist for Facilities
- ☒ Line List for Facilities
- ☒ Outbreak Summary Form
- ☒ Infection Control Transfer Form
- ☒ COVID-19 and the Flu (ACPHD)
- ☒ Flu and You Fact Sheet (CDC)
- ☒ Handwashing & Approved Disinfectants Effective Against Influenza

Please send the following	Expected Receipt
1. Facility floorplan with room numbers	1. As soon as possible
2. Line list of potential cases	2. Daily until told otherwise
3. Completed outbreak summary form	3. After outbreak determined to be over by Alameda County Public Health

These recommendations are to be used to implement influenza outbreak control measures, in supplementation to Recommendations for the Prevention and Control of Influenza in California SNFs during the COVID-19 Pandemic (CDPH, Oct 2020)

V11/23/21

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Covid-Influenza-Like Illness (C-ILI) Outbreak Recommendations Checklist for Facilities

Contact Name:
Date:
Name of Facility:
Phone:
Fax/Email:
Complete Address:

The purpose of this document is to provide guidance for long term care facilities responding to cases of influenza during the current COVID-19 pandemic. Alameda County Public Health Department has separate guidance for facilities responding to cases and preventing COVID-19 transmission.

Case Definitions

Covid-Influenza-like illness (C-ILI)
Fever (temperature ≥ 100° F or 37.8° C), chills, cough, shortness of breath or difficulty breathing, fatigue, sore throat, runny or stuffy nose, myalgias, headache, vomiting, diarrhea. Change in or loss of taste or smell, although this is more frequent with COVID-19. Similarities and Differences between Flu and COVID-19 | CDC 6/7/21

Covid-Influenza-like illness (C-ILI) Cluster
Two or more cases of C-ILI occurring within 72 hours of each other without laboratory confirmation of influenza

Influenza Outbreak within a residential facility
Two or more cases of ILI within 72 hours of each other **AND** at least 1 case has laboratory confirmed influenza by a molecular test (RT-PCR preferred) Influenza and Respiratory Illness Outbreak Quicksheet (ca.gov) 10/2021

Reporting Requirements

- ☐ When a **C-ILI** confirmed case, cluster or outbreak is identified, immediately report to the Alameda County Public Health Department (ACPHD) at 510-268-2785, Mon-Fri 8:30 am to 5 pm. After hours and on weekends, call Alameda County Fire Dispatch at (925) 422-7595 and ask to speak to the Public Health Duty Officer on call.
- ☐ Report outbreak/cluster to Licensing and Certification East Bay District Office: (510) 620-3900.
- ☐ Residential Care Facilities (RCFE and ARF) should report to Community Care Licensing and Certification Regional Office: (510) 286-4201 and CCLASCPOaklandRO@dss.ca.gov
- ☐ Report cases to CMS in accordance with current guidelines (See COVID-19 Guidance for Hospital Reporting and FAQs (hhs.gov) 6-10-2021
- ☐ Complete attached line list daily for all **new** cases and submit to ACPHD by secure email (LTCFOutbreak@acgov.org) daily until **7 days** after last onset of illness in a C-ILI outbreak with or without lab confirmation
- ☐ Submit a map/floor plan of your facility to ACPHD, if not already submitted for COVID-19response.
- ☐ Submit completed outbreak summary form after outbreak is determined to be over by ACPHD.

Outbreak Control Recommendations

Surveillance

	Conduct daily active surveillance for **C-ILI** among all residents, health care personnel (HCP), and visitors throughout the influenza season.
	Instruct HCP to report signs and symptoms of **C-ILI**: fever, chills, cough, shortness of breath or difficulty breathing, fatigue, sore throat, runny or stuffy nose, myalgias, headache, vomiting**,** and change in or loss of taste or smell, although this is more frequent with COVID-19. COVID-19 vs The Flu
	Monitor staff absenteeism due to respiratory symptoms. Evaluate causes of absence during influenza season.
Confirm the Presence of an Outbreak Through Diagnostic Testing	

	Test residents and HCP with onset of C-ILI symptoms for both influenza and SARS-CoV-2 at the same time to confirm the diagnosis.
	• Wherever available, use multiplex influenza A and B and SARS-CoV-2 (Flu SC2) tests.
	  • CDC's Influenza SARS-CoV-2 Multiplex Assay and Required Supplies
	  • Multiplex Assays Authorized for Simultaneous Detection of Influenza Viruses and SARS-CoV-2 by FDA
	  • Testing Guidance for Clinicians When SARS-CoV-2 and Influenza Viruses are Co-circulating (cdc.gov)
	• Molecular assays (RT-PCR preferred) are strongly recommended for residents. Rapid influenza diagnostic tests (RIDTs) are less sensitive. If a resident was previously tested with a RIDT, confirm the results with a molecular assay.
	• RIDTs may be more appropriate for initial testing of HCP; consider providing a single referral site or performing rapid testing for influenza on site for HCP in order to facilitate prompt testing and reporting of results. Symptomatic HCP with a negative result using RIDT should have results confirmed using multiplex influenza A and B and SARS-CoV-2 tests.

	Collecting the specimen 24-72 hours after symptom onset is optimal for influenza. Follow specimen collection instructions: www.cdc.gov/flu/professionals/diagnosis/index.htm.
	If influenza and SARS-CoV-2 (COVID-19) tests on residents with symptoms of a respiratory tract infection are both negative, send specimens for a complete viral respiratory panel that will include other viruses such as adenovirus, respiratory syncytial virus, human metapneumovirus. Coronaviruses detected on those broad respiratory virus panels are not SARS-CoV-2 unless the report says specifically SARS-CoV-2.
	If there are obstacles to testing, contact ACPHD at (510) 764-7639 or email LTCFoutbreak@acgov.org
Communication	

	As soon as a **C-ILI** outbreak or cluster is detected, in addition to notifying ACPHD and Licensing, notify:
	• Infection preventionist
	• Facility administrator
	• Medical director
	• Heath Services Director
	• HCP and care givers who work at the facility
	• Primary care provider of residents who:
	  o Test positive for influenza
	  o Are a close contact (e.g., roommate) of a resident who tested positive for influenza
	  o Reside on a unit where an outbreak is occurring
	• Residents, family, and visitors

	Distribute outbreak communication letter and fact sheet to residents, their families, and visitors.
	Post signs at facility entrance. Post visual alerts instructing residents, staff, visitors, and volunteers to report symptoms of respiratory infection to a designated person and follow respiratory hygiene/cough etiquette.
	Implement Appropriate Transmission-Based Precautions and Other Infection Control Measures
	Use transmission-based precautions for COVID-19 Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes • For residents with suspected influenza while test results are pending in a facility without COVID- 19 cases, in green (COVID-19 negative, unexposed) areas • For residents with suspected or confirmed influenza who are located in red (COVID-19 confirmed) or yellow areas (COVID-19 exposed or observation) Cohort residents with influenza within the Cohort.
	In addition to the measures recommended for influenza, implement contact precautions in addition to droplet precautions for respiratory viruses other than influenza or COVID-19, pending test results. Many respiratory viruses can cause severe illness and outbreaks in high-risk settings and require contact precautions as part of control measure
	Prioritize single-bed rooms, where available, for residents with suspected influenza pending test results. If single rooms are unavailable, ill residents may remain in their room with spatial separation of at least 6 feet and privacy curtain between residents.
	When influenza only is confirmed, and the resident is not on COVID-19 Transmission based-precautions (not in red or yellow areas), **use the following PPE**: • Use Droplet precautions (surgical mask) plus face shield • Use an N95 or higher respirator plus face shield for aerosol generating procedures • Don gowns and gloves per standard precautions upon entry into the room or at any time in the room when exposure to resident blood, body fluids, secretions or close contact with resident likely. • Add Enhanced Standard precautions for high contact activities with residents at risk for multidrug-resistant organisms (MDRO) • Perform hand hygiene and ensure facemask and face shield are in place upon entry into the room • Remove PPE, discard, and perform hand hygiene upon completion of contact with a resident or when leaving the room • Place facemask on resident and have resident perform hand hygiene and don clean clothes/gown if he/she needs to leave room for medical reasons.

	When influenza only is confirmed, and the resident is not on COVID-19 Transmission-basedprecautions (not in red or yellow areas), **use the following room placement strategies**: • Where single-bed rooms are available, these can be used for residents with confirmed influenza. If single rooms are unavailable, residents with laboratory-confirmed influenza may remain in their room with spatial separation of at least 6 feet and privacy curtain between residents; HCP must change PPE and perform hand hygiene between contact with each resident in multi-bedrooms. **When both influenza and COVID-19 are present** in a red or yellow area, **use the following room placement strategies**: • Prioritize cohorting of residents and HCP by COVID-19 status over influenza status and avoid moving residents with suspected or confirmed influenza between COVID-19 cohorts; for example, do not move a resident with suspected or confirmed influenza from a yellow (exposed or observation) to a green (unexposed or recovered) area. • Residents with suspected or confirmed influenza may be cohorted together within the same COVID-19 zone.
	Continue Droplet precautions for 7 days after the resident's illness onset or 24 hours after the resolution of fever or respiratory signs and symptoms, whichever is longer.
	Increase frequency of environmental cleaning to at least twice per shift with a focus on high touch surfaces and common areas.
	Maintain residents on Droplet precautions in their rooms and restrict from activities in common areas including meals.
	Plan workflow from asymptomatic to symptomatic residents. Restrict HCP movement from areas of sick residents to well residents, as feasible.
	Promote respiratory hygiene/cough etiquette and hand hygiene for all residents, staff and visitors.
	Perform repeated audits of HCP adherence to masking for source control, hand hygiene, and other infection control precautions and provide immediate feedback to HCP if deficiencies are observed. • Report trends in audit results to SNF administrators and leaders • Post de-identified adherence monitoring data in HCP break or charting areas • HAI Hand Hygiene Adherance Monitoring Tool • HAI EVS Cleaning and Disinfecting Monitoring Tool • HAI Source Control Monitoring Tool
	Exclude HCP with fever ≥100°F (37.8C) and other C-ILI symptoms from work until at least 24 hours after they no longer have a fever (without the use of fever reducing medicines) or no earlier than 7 days after illness onset. • HCP with a diagnosed COVID-19 infection, with or without laboratory confirmation, should follow the CDC Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection
	For additional guidance, please refer to Recommendations for the Prevention and Control of Influenza Outbreaks In California Skilled Nursing Facilities (CDPH, Oct 2020)
Influenza Vaccination of Residents and Staff	
	Obtain standing vaccination orders from providers for residents and HCP.
	Vaccinate residents with the influenza vaccine at the beginning of every influenza season. Mild illness is not a contraindication to flu vaccinations, and residents may receive vaccination regardless of COVID status.
	Track each resident's vaccination status and calculate resident vaccination rates.
	Offer influenza vaccine to all unvaccinated new admissions.

	Assure that all residents have received pneumococcal vaccines according to current CDC recommendations.
	Health Officers for County of Alameda and the City of Berkeley remind providers of their joint Health Officer order mandating that all licensed health care facilities in Alameda County and the City of Berkeley require their health care workers (HCW) to receive an annual influenza vaccination. This Order, issued in 2020, remains in effect for the upcoming 2021-2022 flu season and mandates that health care facilities implement a process for requiring HCW to receive vaccination unless a HCW can produce sufficient documentation to obtain a permitted exemption. Mask wearing is not an adequate substitution for vaccination under this Order. Joint Health Officer Order 20-16b Mandatory Flu Shots for Health Care Workers
	Residents fully vaccinated against COVID-19, residents with close contact with someone with COVID-19, as well as residents in isolation who are asymptomatic with COVID-19, can be vaccinated. For symptomatic residents with suspected or confirmed COVID-19, consider deferring vaccination until discontinuation of isolation is met and the person has recovered from acute illness.
	Continue to offer influenza vaccination to residents and HCP who did not receive this season's vaccine. If vaccine supply is limited or delayed, prioritize the highest risk residents, such as those who require ventilator therapy or have complex underlying medical conditions.
Antiviral treatment	
	Treat all residents with confirmed or suspected influenza with antiviral medication as soon as possible, ideally within 48 hours of symptom onset, for maximum benefit. For information about current recommended influenza antiviral treatment, see the CDC influenza antiviral medication webpage.
	Have standing orders for antiviral medication administration. • Identify a supply source for rapidly obtaining antiviral medication for residents • Define indications and mechanism for obtaining antiviral agents for resident treatment, and dose adjustments as needed for underlying conditions (for example, renal impairment)
	Do NOT wait for confirmatory test results to initiate treatment unless there is ongoing transmission of SARS-CoV-2 in the facility
	Consult resident's PCP for any necessary dose adjustments in persons with underlying conditions, such as renal impairment.
	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.
Antiviral Chemoprophylaxis	
	Obtain orders from medical director or primary care providers for influenza chemoprophylaxis when it is indicated. • Identify a supply source for rapidly obtaining antiviral chemoprophylaxis for residents and staff • Define indications and mechanism 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 residents without ILI in the facility, regardless of vaccination status. If there is a limited supply of antiviral agents, prioritize chemoprophylaxis to: 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 current recommended influenza antiviral chemoprophylaxis, see the CDC influenza antiviral medication webpage.

	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 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: • HCP was vaccinated but the circulating influenza strain is not well matched with vaccine strains • Recently vaccinated and 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 • At high risk for complications of influenza due to age or medical conditions.
Admissions, Re-admissions, and Transferring Residents	
	When planning to accept or transfer of residents who still require isolation for influenza, evaluate the resident's COVID-19 exposure status and test for SARS-CoV-2 as appropriate before movement of resident
	Do not place new admissions on units with symptomatic residents.
	Do not transfer asymptomatic residents to units with residents who have active influenza.
	Before transferring any residents to other departments or facilities, communicate all relevant information to transport personnel and other HCP accepting the resident using the Infection Control Interfacility Transfer Form. Include test results, date of illness onset, antiviral treatment, infection control precautions, and indicate that your facility is experiencing an influenza outbreak.
	Consult with medical director and ACPHD to determine if the facility should be closed to new admissions during an influenza outbreak. • The duration of closures or limiting admissions should be determined for each situation individually. • The effectiveness of the influenza control measures implemented and the availability of a separate, unaffected building or unit to receive new admissions may be considered.
	Hospitalized patients with influenza 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 facility should not be determined by the period of potential virus shedding or recommended duration of Droplet precautions.
	Ensure that new or returning residents with acute respiratory illness are evaluated medically to determine room placement and needed infection control precautions.
	Implement Droplet precautions for returning residents who were hospitalized with influenza and are ready clinically for discharge from the hospital but are still within the 7 day or longer period of required Droplet precautions.
Managing Family and Visitors	
	Follow the policy for visitors during the flu season that has been implemented by the facility for prevention of transmission of COVID-19. • Implement screening of visitors for signs of acute respiratory illness and exclude symptomatic visitors • Require universal masking for source control • Visitors must perform hand hygiene and follow respiratory/cough etiquette. • Educate and encourage influenza vaccination for family and visitors

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Continue to restrict or limit visitation in accordance with COVID-19 protocols

- Outdoor visitation can be continued during an outbreak
- In-room visitation should be discouraged during an influenza outbreak; consult with ACPHD to evaluate whether to completely restrict indoor visitation.

Assess Outbreak Control Measures

If no new cases of influenza have been identified for at least 7 days after the last confirmed case of influenza, it is reasonable to consider the influenza outbreak over and resume new admissions to previously affected units, or as determined by COVID-19 status.

When no new C-ILI cases have been detected after the surveillance period determined by ACPHD, fully complete the enclosed Outbreak Summary form.

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Line List for Facilities v.11.06.2020

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

Demographics							Illness Description									Laboratory Test					Outcome				
Name	Staff or Resident (S/R)	Unit / Floor	Room / Bed #	Age	Sex	Vaccinated > 14 d prior (Y/N)	Onset date of symptoms	Temperature	Fever > 100° F (Y/N)	Cough (Y/N)	Sore throat (Y/N)	Myalgia (Y/N)	Rhinorrhea (Y/N)	Active COVID Infection (Y/N)	Other Symptoms (Specify)	Rapid Test (+/-)	PCR (+/-)	Other test (specify)	Influenza type (A or B)	If Flu A, which subtype [e.g. H1N1, H1, H3, unsubtyped, etc.]	Antiviral treatment start date	Hospitalized (Y/N)	Alternate Diagnosis? (Y/N)	Death (Y/N) & Date	Comments (include any alternate diagnosis)

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Outbreak Summary Form

v.11.06.2020

Name of Facility:_____ Today's Date: _____

	Total # of Residents and Staff	# Who Received Influenza Vaccine ≥14 Days Before the Outbreak Began	# Who Received Catch-Up Influenza Vaccine After Outbreak Began	# Who Did Not Receive Influenza Vaccine	# of Ill Residents and Staff*	# of Ill Who Received Antiviral Treatment	# of Non-Ill Who Received Antiviral Chemo-prophylaxis	# of Ill Who Developed Symptoms After 72 hours of Antiviral Treatment or Chemo-prophylaxis	# Transferred to Acute Care Hospital	# of Deaths
Residents										
Staff										

*Ill resident or staff is defined as a person who has laboratory-confirmed influenza (i.e., a positive influenza test result) OR who meets the COVID-Influenza-Like Illness (C-ILI) case definition (Fever ≥100°F, chills, cough, shortness of breath or difficulty breathing, fatigue, sore throat, runny or stuffy nose, myalgias, headache, vomiting and diarrhea.).

INFECTION CONTROL TRANSFER FORM

This form should be sent with the patient/resident upon transfer. It isNOT meant to be used as criteria for admission, only to foster the continuum of care once admission has been accepted.

Affix patient label here

Demographics

Patient/Resident *(Last Name, First Name)*:

Date of Birth:	**MRN:**	**Transfer Date:**
Sending Facility Name:		
Contact Name:	**Contact Phone:**	
Receiving Facility Name:		

Current suspected/confirmed COVID-19 outbreak at sending facility? ☐ **Yes** ☐ **No**

Is this patient/resident a suspected/confirmed COVID-19 case? ☐ **Yes** ☐ **No**

Precautions and PPE

Currently in Isolation Precautions? ☐ **YesIf Yes, check:** ☐ Contact ☐ Droplet ☐ Airborne ☐ Other:

☐ **No** isolation precautions (currently)

PERSONAL PROTECTIVE EQUIPMENT CONSIDERATIONS

☐ ☐ ☐ ☐

CHECK ALL PPE TO BE CONSIDERED AT RECEIVING FACILITY

Organisms

If the patient currently or in the past had a culture positive for a multi-drug resistant (MDR) organismor other organism of significance to infection control/prevention, indicate organism details below and send culture report with susceptibilities to receiving facility.

Methicillin-resistant *Staphylococcus aureus* (MRSA)‡	☐	☐ No known MDR organism or communicable diseases
Vancomycin-resistant *Enterococcus* (VRE)‡	☐	
MDR *Acinetobacter* species, resistant to carbapenem antibiotic(s) ‡	☐	
MDR_____ *(organism name)* resistant to carbapenem antibiotic(s) without carbapenemase production (non-CP-CRE)‡	☐	
Carbapenemase-producing_____ *(organism name)* resistant to carbapenem antibiotic(s) (CP-CRE)#	☐	
Enterobacteriaceae† resistant to expanded-spectrum beta-lactam antibiotics (ESBL)‡	☐	
Clostridium difficile (C. diff)	☐	
Other (identify) ^:	☐ **(current or ruling out*)**	
***Additional information if known:**		

Symptoms/Risk Factors for Transmission

Check yes to any that currently apply:**

☐ Cough/uncontrolled respiratory secretions
☐ Incontinent of urine
☐ Vomiting
☐ Concerning rash (e.g., vesicular)
☐ Acute diarrhea or incontinent of stool
☐ Draining wounds
☐ Other uncontained bodily fluid/drainage

****NOTE: Appropriate PPE required if incontinent/drainage/rash NOT contained.**

☐ No Symptoms requiring additional PPE

Other MDRO Risk Factors

Is the patient currently on antibiotics? ☐ **Yes** ☐ **No**

Antibiotic:	**Dose, Frequency:**	**Treatment for:**	**Start date:**	**Stop date:**

Does the patient currently have any of the following devices? ☐ **Yes** ☐ **No**

☐ Tracheostomy/Endotracheal tube
☐ Central line/PICC, Date inserted:
☐ Urinary catheter, Date inserted:
☐ Suprapubic catheter
☐ Percutaneous gastrostomy tube
☐ Hemodialysis catheter
☐ Colostomy
☐ Rectal tube

†includes *E.coli, Enterobacter, Klebsiella, Proteus, Serratia, Citrobacter* and others

‡MDRO infection prevention precautions: https://www.cdc.gov/infectioncontrol/guidelines/mdro/index.html

#Intensified MDRO Control Efforts: https://www.cdc.gov/infectioncontrol/guidelines/mdro/table3-2-intensified-control.html

^e.g. lice, scabies, disseminated shingles, norovirus, influenza, TB

COVID-19 vs The Flu

What to know about COVID-19 and the Flu

Symptoms of COVID-19 and Influenza (the Flu) can be similar. If you are experiencing any emergency warning signs, such as trouble breathing, bluish lips or face, persistent pain or pressure in the chest, new confusion or inability to wake/stay awake, seek emergency medical care immediately.

COVID-19 and the Flu are caused by different viruses but are spread in similar ways. The best ways to protect yourself from getting sick are to:

- Get vaccinated against COVID-19 and the Flu—you can receive both vaccines at the same time.
- Wear a face covering and keep a 6-foot distance from people who do not live in your household.
- Wash hands frequently with soap and water for at least 20 seconds; if unavailable, use hand sanitizer.

SYMPTOMS (Common / Less Common / Not Common)	COVID	FLU
Fever/Chills	✓	✓
Cough	✓	✓
Body Aches/Headache	✓	✓
Tiredness	✓	✓
Loss of Taste/Smell	✓	✗
Runny/Stuffy Nose	✓	–
Sore Throat	–	–
Shortness of Breath	✓	–
Severity	Varies. Older adults and those with underlying conditions are at a higher risk of severe illness. Seems to cause more severe illness in more people than flu.	Varies. Young children, older adults, and people with certain chronic conditions are at a higher risk of severe illness.

If you are sick with the flu, stay home and away from others until after:

- ❑ At least 24 hours have passed since you stopped having a fever, without use of fever-reducing medication; **OR**
- ❑ At least 4-5 days have passed since illness onset if no fever.

If you test positive for COVID-19 AND have symptoms, stay home until after:

- ❑ At least 10 days have passed since your symptoms started; **AND**
- ❑ At least 24 hours have passed since you stopped having a fever, without use of fever-reducing medication; **AND**
- ❑ All other symptoms have improved.

If you test positive for COVID-19 without symptoms, stay home until after:

- ❑ At least 10 days have passed since your positive test.

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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 is available.
- 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 correct amount).
- 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

See EPA-approved Agents Against Influenza A Virus on Hard Surfaces