

**Recommendations for the Prevention and Control of Influenza  
in California Skilled Nursing Facilities (SNF) during the  
COVID- 19 Pandemic**

California Department of Public Health (CDPH)  
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### [Appendices](#)

([www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/SNF\\_DetectAndControlOutbreaks.aspx](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/SNF_DetectAndControlOutbreaks.aspx))

- A. Sample Surveillance Case Log of Residents with Acute Respiratory Illness and/or Pneumonia
- B. Sample Surveillance Case Log of Health Care Personnel (HCP) with Acute Respiratory Illness and/or Pneumonia
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## Introduction

Skilled nursing facility (SNF) residents are at increased risk for severe disease, hospitalization, and death from infections caused by influenza viruses and the severe acute respiratory syndrome-coronavirus-2 (SARS-CoV-2), the virus that causes COVID-19. In 2020, CDPH developed *Recommendations for the Prevention and Control of Influenza in California Skilled Nursing Facilities (SNF) during the COVID-19 Pandemic*. This updated version includes minor changes to align with the Centers for Disease Control and Prevention (CDC) September 2022 [updates](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html) (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html) in infection control practices to prevent transmission of SARS-CoV-2 and to reflect new clinical knowledge. In addition to this document, SNF should monitor the [Centers for Disease Control and Prevention \(CDC\) influenza](https://www.cdc.gov/influenza/) (www.cdc.gov/flu/), [COVID-19 websites](https://www.cdc.gov/coronavirus/2019-ncov/index.html) (www.cdc.gov/coronavirus/2019-ncov/index.html), and the [CDPH guidance website](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx) (www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx) for updates.

### **What is new about this document?**

- Clinical information about SARS-CoV-2 and variants has been updated throughout the document, including in Table 1, to reflect increased experience and knowledge.
- As of August 2022, the [Advisory Committee on Immunization Practices](https://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm) (www.cdc.gov/flu/professionals/vaccination/vax-summary.htm) recommends that adults aged ≥65 years preferentially receive any one of the following higher dose or adjuvanted influenza vaccines: quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated influenza vaccine (aIIV4).
- Influenza vaccination coverage of healthcare personnel (HCP) in SNF has remained low for the past three influenza seasons and needs to be increased for the health and safety of HCP and residents. See Supplementary Data.
- Infection control practices for COVID-19 have been updated to align with current CDPH recommendations (e.g., vaccination status is not used to inform source control, screening testing, or post-exposure management; quarantine is not required for asymptomatic exposed residents, newly admitted residents, residents returning to facility after a leave of > 24 hours, or exposed HCP; active screening of HCP and visitors for symptoms of respiratory tract infection at the entrance into a SNF is not required).

***How should SNF use this guidance document?***

This document is intended to provide SNF guidance for developing and implementing an influenza prevention and control plan applicable to all influenza seasons. For the most up-to-date guidance on influenza vaccine, treatment, and diagnostic testing, SNF staff should refer to the following CDC websites that are updated annually before each influenza season begins:

[Seasonal Influenza Vaccination Resources for Health Professionals](https://www.cdc.gov/flu/professionals/vaccination/index.htm)

([www.cdc.gov/flu/professionals/vaccination/index.htm](https://www.cdc.gov/flu/professionals/vaccination/index.htm));

[Influenza Antiviral Medications](https://www.cdc.gov/flu/professionals/antivirals/index.htm) ([www.cdc.gov/flu/professionals/antivirals/index.htm](https://www.cdc.gov/flu/professionals/antivirals/index.htm));

[Overview of Influenza Diagnostic Testing](https://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm) ([www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm](https://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm)); [Multiplex Diagnostic Assays](https://www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html)

([www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html](https://www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html)).

Planning for influenza in SNF begins by providing information to residents and families at the time of admission, and to HCP at the time of hire and during annual performance reviews. Before influenza begins circulating in the local community, SNF must be ready with: sufficient influenza vaccine and standing orders for administration; hand hygiene supplies; contracts with laboratory services for influenza virus diagnostics and expanded respiratory panel testing; personal protective equipment (PPE) supplies; antiviral medication orders; point-of-care (POC) test kits to identify influenza and SARS-CoV-2; and established lines of communication between the SNF and the local health department (LHD). Establishing a strong collaborative relationship with the LHD facilitates needed support in the event of an outbreak, vaccine or antiviral agent shortage, testing supply shortages, or if unanticipated events emerge within a given season. Evaluating the experiences at the conclusion of each influenza season will inform the plan for the following year.

CDPH guidance and recommendations are presented in tables:

***Table 1: Similarities and Differences between Seasonal Influenza and COVID-19***

([www.cdc.gov/flu/symptoms/flu-vs-covid19.htm](https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm)). The overlap of clinical presentations and contribution of asymptomatic transmission of SARS-CoV-2 makes it difficult to manage residents based on symptoms alone. Each SNF must therefore develop plans for: testing symptomatic residents for both influenza and SARS-CoV-2; implementation of Transmission-Based Precautions; creating cohorts of residents with influenza within a cohort of residents who are also infected with SARS-CoV-2; and prompt initiation of influenza antiviral agents therapeutically and prophylactically when an influenza outbreak is identified in a facility. Availability of multiplex tests for diagnosis of influenza viruses and SARS-CoV-2 improves efficiency of diagnosis.

***Table 2: Planning for Influenza Illness and Outbreaks in SNF*** provides guidance relevant to three groups of individuals: residents, facility HCP, and family members and other visitors. SNF may use Table 2 as a guide to develop, review, and update plans before the influenza season begins. [Facility HCP](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html) ([www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html)) include all paid and unpaid persons who work in a healthcare setting and provide care or support the delivery of care; HCP are also referred to as staff members (see glossary).

Recommendations related to COVID-19 have been added where appropriate.

**Table 3: Identifying and Controlling Influenza Outbreaks in SNF** contains recommendations for identifying the presence of an influenza outbreak and implementing the plan developed using the guidance from Table 2. SNF may use Table 3 to find specific recommendations for infection control measures and accepting and transferring residents during an outbreak.

***What are the most important messages for SNF leaders to understand about influenza and SARS-CoV-2 during the COVID-19 pandemic?***

1. Vaccination is the most effective tool for prevention of influenza, COVID-19, and their serious complications.<sup>1</sup> **When both SARS-CoV-2 and influenza are circulating in the community, it is critical that SNF optimize all available prevention interventions, including vaccination of HCP and residents.**
  - While the effectiveness of influenza vaccines varies by season, these vaccines can prevent severe disease, ICU admissions, and death.<sup>2,3,4,5</sup>
  - California was the first state to enact regulations requiring long term care facilities (LTCF) to provide influenza vaccine to HCP at no cost and at a convenient time and place for employees during working hours.
  - Results from an annual internet panel survey show that HCP in long term care facilities (LTCF) and home health care have lower influenza vaccine coverage rates (66.4%) than in acute care hospitals (92%) and ambulatory care settings (81.2%) and have plateaued during the previous 2 years. Coverage rates are lower in those LTCFs that neither require nor recommend influenza vaccine for their staff. See Supplementary Data.
  - Immunizing HCP and family members against influenza provides additional protection for the SNF residents who may not mount an adequate immune response to the vaccine.<sup>6</sup>
  - Several studies indicate that vaccine-induced immunity may wane over time. Although timing of the influenza season cannot be predicted, for most seasons vaccination ideally should be offered during September or October. Vaccination during July and August should be avoided unless there is concern that vaccination later in the season might not be possible or there is an indication of an especially early start to the season.<sup>7</sup>
  - Influenza vaccine will neither prevent SARS-CoV-2 infection nor increase the risk of infection with SARS-CoV-2, but receipt of a primary series of COVID-19 vaccine and a booster within the previous 2-4 months prevents the severe disease and complications associated with SARS-CoV-2 infection and that would be anticipated from co-infection with influenza.<sup>8,9</sup> Although not the focus of this guidance document, ensuring that both residents and staff remain up-to-date with COVID vaccination and booster doses is essential.
2. Influenza virus is transmissible to others beginning at 24 hours before an individual has typical signs and symptoms of influenza and for 3-7 days after symptom onset. Older individuals and those who are immunocompromised may not present with classic signs of

influenza.<sup>1</sup> Since signs and symptoms of influenza and COVID-19 are similar, SNF must be vigilant for the possibility of concurrent outbreaks and **develop plans for prompt diagnostic testing of all symptomatic individuals for both influenza and SARS-CoV-2 throughout the influenza season, and even when an outbreak with either pathogen has already been confirmed in the facility.**

3. COVID-19 prevention and control strategies also contribute to influenza prevention in SNF<sup>10,11</sup>, including:
  - Universal masking for source control when inside healthcare facilities and avoidance of crowded spaces both within the SNF and the outside community.
  - Systematic surveillance for signs of ILI.
  - Prompt isolation of symptomatic residents in a single room if available, or in current room with spatial separation and curtains drawn between beds.
4. Information concerning when not to visit or work, use of source control when in a SNF, and steps of respiratory hygiene/cough etiquette should be widely disseminated; rapid antigen tests for influenza and COVID-19 should be readily available if needed.
5. SNF must develop plans to be able to accept new admissions while maintaining capacity to care safely for other residents. This requires planning for implementing Transmission-Based Precautions and other infection control measures.
6. When an influenza outbreak is suspected,<sup>1, 12</sup> prompt and simultaneous implementation of all recommended interventions can minimize the size and scope of the outbreak and adverse impact on resident health. Outbreak management requires a collaborative effort among all HCP with specific task assignments and tracking of task completion.
  - Prompt administration of antiviral agents for treatment and prophylaxis will shorten an influenza outbreak and reduce morbidity and mortality.<sup>12</sup>
  - Implementation of Droplet Precautions and separating influenza-infected residents (either in a single room if available, or current room with spatial separation and curtains drawn between beds) will reduce risk of ongoing transmission; **avoid movement of residents with suspected or confirmed influenza into COVID-19 cohorts that are not infected with influenza virus.**
  - Communicate with residents, HCP, and families, throughout the outbreak.
  - Consult with the LHD for additional guidance.

**TABLE 1. [Similarities and Differences between Seasonal Influenza and COVID-19](https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm)**

([www.cdc.gov/flu/symptoms/flu-vs-covid19.htm](https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm))

Characteristics	Influenza Virus	SARS-CoV-2
<b>Signs and symptoms – Same</b>	<ul style="list-style-type: none"> <li>Fever, chills, cough, shortness of breath or difficulty breathing, fatigue, sore throat, runny or stuffy nose, myalgias, headache, vomiting and diarrhea, cardiac complications<sup>13</sup></li> </ul>	
<b>Signs and symptoms – Different</b>	<ul style="list-style-type: none"> <li>Asymptomatic infection uncommon</li> <li>Bacterial superinfection common</li> <li>Clinical appearance consistent with measured hypoxemia</li> </ul>	<ul style="list-style-type: none"> <li>Bacterial superinfection uncommon</li> <li>Measured hypoxemia worse than clinical appearance</li> <li>New loss of sense of taste or smell</li> <li>Multi-system inflammatory syndrome (MIS-C) in children and young adults</li> <li>Thromboembolic complications</li> <li>Delayed and lingering symptoms</li> <li>40% of infected remain asymptomatic but can transmit to others</li> </ul>
<b>Peak symptoms</b>	<ul style="list-style-type: none"> <li>During days 3-7 of illness</li> </ul>	<ul style="list-style-type: none"> <li>During week 2-3 of illness</li> </ul>
<b>Infectivity</b>	<ul style="list-style-type: none"> <li>Less transmissible; contagious from 1 day before symptomatic and for duration of illness</li> <li>More frequent transmission by symptomatic individuals</li> </ul>	<ul style="list-style-type: none"> <li>More transmissible, but varies with circulating strain; contagious from 2 days before onset of symptoms to 10 days, unless immunocompromised and viral shedding is prolonged</li> <li>40% of infections transmitted by pre- or asymptomatic individuals</li> </ul>
	<ul style="list-style-type: none"> <li>Most infectious after symptom onset</li> </ul>	<ul style="list-style-type: none"> <li>Most infectious period during first 5 days of symptoms</li> </ul>
	<ul style="list-style-type: none"> <li>Infectiousness begins 24 hours before symptom onset</li> </ul>	<ul style="list-style-type: none"> <li>Infectiousness begins 48 hours before symptom onset or positive test if remains asymptomatic</li> </ul>
<b>Incubation Period</b>	<ul style="list-style-type: none"> <li>1-4 days (median 2 days)</li> </ul>	<ul style="list-style-type: none"> <li>14 days (median 5 days); shorter incubation periods with some variants, (e.g., omicron)</li> </ul>
<b>Case-Fatality Rate</b>	<ul style="list-style-type: none"> <li>0.1%</li> </ul>	<ul style="list-style-type: none"> <li>&lt; 1% overall with vaccination; varies by age, co-morbidities, vaccination coverage, circulating variant</li> </ul>
<b>Primary route of transmission</b>	<ul style="list-style-type: none"> <li>Respiratory fluid droplets</li> <li>Inhalation of short-range aerosol possible</li> </ul>	<ul style="list-style-type: none"> <li>Respiratory fluid aerosols</li> <li>Fomite less important</li> </ul>
<b>Recommended PPE</b>	<ul style="list-style-type: none"> <li>Surgical mask; eye protection, gown and</li> </ul>	<ul style="list-style-type: none"> <li>N95 respirator, eye protection, gown, gloves</li> </ul>

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Characteristics	Influenza Virus	SARS-CoV-2
	<ul style="list-style-type: none"> <li>gloves if high contact activity</li> <li>• N95 respirator if aerosol-generating procedure (AGP)</li> </ul>	<ul style="list-style-type: none"> <li>• Airborne infection isolation room (AIIR) if AGP</li> </ul>
<b>Risk Factors for Severe Disease – Same</b>	<ul style="list-style-type: none"> <li>• Chronic lung, heart, kidney disease, metabolic disease (diabetes); obesity; immunosuppression; residence in long term care facility; pregnancy</li> <li>Racial and ethnic disparities</li> </ul>	
<b>Risk Factors for Severe Disease – Different</b>	<ul style="list-style-type: none"> <li>• <math>\geq 65</math> years and <math>&lt;2</math> years</li> <li>• Neuromuscular disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Increases with advancing age</li> <li>• Most infants and children have mild or asymptomatic infection</li> </ul>
<b>Diagnostics – Same</b>	<ul style="list-style-type: none"> <li>• For acute infection: nucleic acid amplification (NAAT) and antigen-based assays on respiratory tract specimens, rapid POC and laboratory-based tests</li> <li>Serology not helpful for diagnosis of acute infection</li> </ul>	
<b>Diagnostics – Different</b>	<ul style="list-style-type: none"> <li>• Included in commercially available multiplex respiratory virus panels used in clinical labs</li> </ul>	<ul style="list-style-type: none"> <li>• Influenza and SARS-CoV-2 multiplex panels available</li> </ul>
<b>Treatment available</b>	<ul style="list-style-type: none"> <li>• Prophylactic and therapeutic antiviral agents</li> </ul>	<ul style="list-style-type: none"> <li>• Several antiviral agents (e.g., Remdesivir, Paxlovid) and monoclonal antibodies for treatment</li> <li>• No antiviral agents for prophylaxis at this time</li> <li>• Evusheld monoclonal antibody for prophylaxis in immunocompromised hosts</li> <li>• Increasing immune evasion of recent variants for monoclonal antibodies</li> </ul>
<b>Vaccine</b>	<ul style="list-style-type: none"> <li>• Recommended annually for all <math>\geq 6</math> months of age</li> <li>• Several safe and effective licensed vaccines, including high dose, adjuvanted, and recombinant vaccines for <math>\geq 65</math> years of age</li> </ul>	<ul style="list-style-type: none"> <li>• Primary series recommended for all <math>\geq 6</math> months of age; booster recommendations vary by age; interval not established</li> <li>• Several safe and effective vaccines</li> <li>• mRNA vaccines preferred</li> <li>• Primary series and booster doses reduce hospitalization and death, reduce risk of long COVID-19 and risk of COVID-19 cardiovascular complications</li> </ul>

**Table 2. Planning for Management of Influenza Illness and Outbreaks in SNF during the COVID pandemic**

ACTIONS	RESIDENTS	HEALTH CARE PERSONNEL (HCP)	FAMILY MEMBERS/VISITORS
<p>1. <b>Educate</b> about the impact of influenza on residents and importance of preventing illness and outbreaks using specific information for each of the three audiences: residents, HCP, family members/visitors. Include information about COVID-19 potential for co-infection and comparison with influenza (Table 1)</p>	<ul style="list-style-type: none"> <li>• Discuss influenza and COVID-19 prevention and management plans at time of resident admission</li> <li>• Prepare resident educational materials such as information sheets and signs in appropriate languages</li> <li>• Schedule educational sessions with opportunities for questions and discussion</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule HCP educational sessions on the facility influenza prevention plan and relationship to the current COVID-19 and multidrug-resistant organisms (MDRO) prevention (Enhanced Standard Precautions) plans.</li> <li>• Include high-risk nature of the population and HCP responsibilities; provide opportunities for questions and discussion.</li> </ul>	<ul style="list-style-type: none"> <li>• Discuss influenza and COVID-19 prevention with family members at the time of resident admission</li> <li>• Include influenza and COVID-19 prevention information sheets in the admission packet provided to families</li> <li>• Prepare information sheets and signs for posting during influenza season and during outbreaks</li> <li>• Share information with SNF ombudsmen</li> <li>• Prepare to answer family/visitor questions</li> </ul>
<p>2. Develop or update the <b>influenza vaccination</b> plan for residents and HCP according to <a href="https://www.cdc.gov/flu/professionals/vaccination/index.htm">ACIP recommendations</a> (www.cdc.gov/flu/professionals/vaccination/index.htm) for the current year</p>	<ul style="list-style-type: none"> <li>• Obtain standing vaccination orders from providers for each resident before influenza season begins</li> <li>• <b>Vaccinate residents; mild illness is not a contraindication to flu vaccination, and residents may receive influenza vaccination regardless of COVID-19 status as long as clinically stable</b> <ul style="list-style-type: none"> <li>◦ Designate an <i>Influenza</i></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Discuss HCP influenza vaccine requirements at time of hire and during annual performance evaluations</li> <li>• Prepare information sheets for HCP describing HCP influenza vaccination requirements, roles and responsibilities, HCP staffing plan during influenza season, and signs for posting in HCP break rooms</li> <li>• Obtain standing vaccination orders from providers for SNF HCP before influenza season begins</li> </ul>	<ul style="list-style-type: none"> <li>• Notify families of facility influenza prevention plan at time of resident admission, including vaccination of residents and HCP before the beginning of influenza season.</li> <li>• Recommend influenza vaccination for families/visitors; SNF is not responsible for providing vaccine to this group</li> <li>• Prepare signs and information sheets for families/visitors that include vaccination</li> </ul>

ACTIONS	RESIDENTS	HEALTH CARE PERSONNEL (HCP)	FAMILY MEMBERS/VISITORS
<p>Develop or update the influenza vaccination plan for residents and HCP according to ACIP recommendations for the current season (<i>continued</i>)</p>	<p><i>Vaccination Week</i></p> <ul style="list-style-type: none"> <li>◦ Continue to vaccinate throughout the influenza season</li> <li>◦ As of August 2022, CDC recommends the high potency, adjuvanted, or recombinant influenza vaccine for individuals <math>\geq 65</math> years of age</li> <li>• SNF should be aware that fever or myalgias resulting from influenza vaccination could complicate clinical evaluation for COVID-19</li> <li>• Track each resident’s vaccination status and room location; calculate resident vaccination rates</li> <li>• If vaccine shortage, consult LHD and communicate revised plan to residents</li> </ul>	<ul style="list-style-type: none"> <li>• Vaccinate HCP <ul style="list-style-type: none"> <li>◦ Designate an <i>Influenza Vaccination Week</i> and vaccinate HCP at <a href="#">no cost</a> (<a href="http://www.dir.ca.gov/title8/5199.html">www.dir.ca.gov/title8/5199.html</a>) and at a reasonable <a href="#">time and place</a> (<a href="http://www.dir.ca.gov/title8/5199.html">www.dir.ca.gov/title8/5199.html</a>); designate different times to accommodate HCP work shifts</li> <li>◦ Continue to vaccinate throughout the influenza season</li> </ul> </li> <li>• Involve facility leadership and HCP thought-leaders to encourage HCP to accept vaccine</li> <li>• Consider using incentives or competitions to increase acceptance of flu vaccination</li> <li>• Discourage declination and exemptions, but develop policy for documentation and management of HCP who do not accept vaccination</li> <li>• Determine acceptable documentation required for HCP vaccination obtained off site</li> <li>• Track vaccination status of each HCP, including location of assignment and role; calculate vaccination rates and provide</li> </ul>	<p>recommendations, referral to primary care provider (PCP) for vaccine and how to find sites in <a href="#">specific geographic areas</a> (<a href="http://www.cdc.gov/flu/freeresources/flu-finder-widget.html">www.cdc.gov/flu/freeresources/flu-finder-widget.html</a>) to obtain vaccine</p> <ul style="list-style-type: none"> <li>• If vaccine shortage, consult LHD and communicate revised vaccination plans to families/visitors</li> </ul>

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ACTIONS	RESIDENTS	HEALTH CARE PERSONNEL (HCP)	FAMILY MEMBERS/VISITORS
Develop or update the influenza vaccination plan for residents and HCP according to ACIP recommendations for the current season <i>(continued)</i>		feedback to SNF leaders and HCP throughout influenza season <ul style="list-style-type: none"> <li>Develop plan with LHD for possible vaccine shortage; communicate to HCP</li> </ul>	
3. Review <b>pneumococcal vaccination</b> status of residents	<ul style="list-style-type: none"> <li>Obtain standing orders for pneumococcal vaccines for residents from their PCPs</li> <li>Ensure that all residents have received pneumococcal vaccines according to current <a href="http://www.cdc.gov/vaccines/schedules/hcp/adult.html">ACIP recommendations</a> (www.cdc.gov/vaccines/schedules/hcp/adult.html); usually done at the time of admission, but if not done then, complete before influenza season begins</li> <li>Schedule additional doses of pneumococcal vaccine as needed</li> </ul>	<ul style="list-style-type: none"> <li>SNF are not responsible for providing pneumococcal vaccines to HCP; refer to PCP or clinic if questions</li> </ul>	<ul style="list-style-type: none"> <li>SNF are not responsible for providing pneumococcal vaccines to families/visitors; refer to PCP or clinic if questions</li> </ul>
4. Ensure daily active <b>surveillance for influenza-like illness (ILI)</b> during influenza season and until at least 1 week after last confirmed influenza case, while continuing	<ul style="list-style-type: none"> <li>Develop process to conduct daily active surveillance for ILI during influenza season and until at least 1 week after last confirmed influenza case in the facility, using resident log (Appendix A); note, this ILI log is different from the linelist</li> </ul>	<ul style="list-style-type: none"> <li>Continue symptom screening of HCP for COVID-19 and ILI during influenza season</li> <li>Develop a process for tracking HCP absenteeism during influenza season, using HCP log (Appendix B); note, this log is different from the linelist used to track COVID-19 test</li> </ul>	<ul style="list-style-type: none"> <li>Develop a communication process to ensure that symptomatic individuals do not visit</li> <li>Develop a process for identifying and recording possible introductions of influenza into the facility by ill family members or visitors</li> </ul>

ACTIONS	RESIDENTS	HEALTH CARE PERSONNEL (HCP)	FAMILY MEMBERS/VISITORS
surveillance for COVID-19 signs and symptoms	<p>used to track COVID-19 test results (contact <a href="mailto:HAIProgram@cdph.ca.gov">HAIProgram@cdph.ca.gov</a> for COVID-19 tracking linelist template)</p> <ul style="list-style-type: none"> <li>• Assign responsibility for daily review and implementation of actions when needed</li> <li>• Develop plan for influenza and COVID-19 diagnostic testing of symptomatic residents (Table 3; Appendix C)</li> <li>• Develop surveillance plan to identify residents who develop influenza after receiving antiviral chemoprophylaxis for 72 hours or more and report to LHD to assess for antiviral resistance</li> </ul>	<p>results.</p> <ul style="list-style-type: none"> <li>• Evaluate causes of absence during influenza season and until at least 1 week after last confirmed influenza case in the facility</li> </ul>	
5. Develop a plan for monitoring influenza activity in the surrounding community and for testing <b>residents and HCP</b> who develop signs of respiratory tract infection during influenza season.	<ul style="list-style-type: none"> <li>• Know which testing methods for influenza and COVID-19, such as single or multiplex POC antigen and molecular tests for both influenza and COVID- 19, will be available to the facility, when they will be available, and their turnaround time</li> <li>• Plan for a surge supply</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a plan for testing symptomatic HCP for both influenza and COVID-19; symptomatic HCP who test negative for influenza using a POC antigen test will need confirmatory influenza PCR testing.</li> <li>• Conduct influenza testing independent of influenza vaccination status</li> <li>• Consider providing a single referral</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare and provide information about the importance of testing for both influenza and COVID-19 when an individual develops respiratory symptoms during the influenza season</li> <li>• Prepare message to refer symptomatic family members to their PCP or clinic for evaluation</li> </ul>

ACTIONS	RESIDENTS	HEALTH CARE PERSONNEL (HCP)	FAMILY MEMBERS/VISITORS
<p>Follow local activity on <a href="http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Influenza.aspx">CDPH influenza website</a> (<a href="http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Influenza.aspx">www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Influenza.aspx</a>). See Appendix C.</p>	<p>of testing materials</p> <ul style="list-style-type: none"> <li>• <b>Develop a plan for testing symptomatic residents for both COVID-19 and influenza throughout the influenza season, even when an outbreak of either pathogen has been confirmed;</b> symptomatic residents who test negative for influenza using a POC antigen test will need confirmatory influenza PCR testing</li> <li>• Conduct influenza testing of symptomatic residents regardless of influenza vaccination status</li> </ul>	<p>site or performing rapid testing for influenza on site to facilitate prompt testing and reporting of results</p>	
<p>6. Develop or update <b>influenza infection control precautions and outbreak management plan</b> (see Table 3)</p>	<ul style="list-style-type: none"> <li>• Continue universal masking for source control</li> <li>• Prepare to implement Transmission-Based Precautions and other infection control measures when needed for single cases and during outbreaks of influenza (see Table 3 for specific recommendations).</li> <li>• Develop a plan for room</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare extra supplies that will be needed by HCP throughout the facility during influenza season and throughout the COVID-19 pandemic such as gowns, gloves, masks, N95 respirators, tissues, waterless hand gel, soap, paper towels</li> <li>• Prepare to conserve PPE if needed during critical supply shortages</li> </ul>	<ul style="list-style-type: none"> <li>• Provide respiratory hygiene/ cough etiquette information and materials (tissues, supplies for hand hygiene, waste receptacles) at facility entrances year-round; provide signage indicating that masks are required for source control within the facility</li> <li>• Prepare outbreak</li> </ul>

ACTIONS	RESIDENTS	HEALTH CARE PERSONNEL (HCP)	FAMILY MEMBERS/VISITORS
<p>Develop or update <b>influenza infection control precautions</b> and <b>outbreak management plan</b>. See Table 3. <i>(continued)</i></p>	<p>placement of residents with influenza when COVID-19 positive residents are in the facility (see Table 3 for specific recommendations)</p> <ul style="list-style-type: none"> <li>Define decision-making process for accepting and transferring residents during influenza season (Table 3)</li> </ul>	<ul style="list-style-type: none"> <li>Train and remind all HCP of infection control measures that reduce the risk of influenza and COVID-19 spread</li> <li>Prepare for increased environmental services needs during influenza season</li> <li>Share outbreak plan with HCP before the beginning of influenza season</li> <li>Update and review policy for sick HCP and communicate policy to HCP</li> <li>Identify contacts in the LHD and CDPH Licensing &amp; Certification (L&amp;C) district office for outbreak reporting, assistance with vaccine, antiviral, or PPE shortages, and assistance with diagnostic testing</li> <li>Provide weekly updates to HCP on status of influenza activity in the facility and in the community during influenza season; refer to the <a href="http://www.cdph.ca.gov/Programs/CI/D/DCDC/Pages/Immunization/InfluenzaWebsite.aspx">CDPH influenza website</a> (<a href="http://www.cdph.ca.gov/Programs/CI/D/DCDC/Pages/Immunization/In">www.cdph.ca.gov/Programs/CI/D/DCDC/Pages/Immunization/In</a></li> </ul>	<p>communication letter for distribution to families/visitors when outbreak occurs</p> <ul style="list-style-type: none"> <li>Prepare outbreak signage for facility entrances.</li> <li>Prepare information stating that symptomatic or exposed individuals should not visit</li> <li>Prepare to perform POC antigen testing for COVID-19</li> <li>Restrict sick visitors</li> <li>Prepare outbreak communication for EMS and outside hospitals when transferring residents with influenza and/or COVID-19 for a higher level of care</li> </ul>

ACTIONS	RESIDENTS	HEALTH CARE PERSONNEL (HCP)	FAMILY MEMBERS/VISITORS
		<p>fluenza.aspx) during influenza season</p>	
<p>7. Develop or update plan for obtaining and prescribing <b>antiviral agents</b> for influenza treatment, chemoprophylaxis and SARS-CoV-2 treatment when co-infected</p>	<ul style="list-style-type: none"> <li>• Know which antiviral agents for influenza treatment and chemoprophylaxis will be available</li> <li>• Define indications and mechanism for obtaining antiviral agents for <b>prompt</b> initiation of treatment or chemoprophylaxis</li> <li>• Identify residents with renal impairment that will require dose adjustment of antiviral agents</li> <li>• Together with PCP and/or medical director plan to flag resident charts for dose adjustments of antivirals needed for underlying conditions, (for example, renal impairment).</li> </ul>	<ul style="list-style-type: none"> <li>• Define indications and mechanism for obtaining antiviral agents for HCP chemoprophylaxis and dose adjustments as needed for underlying conditions</li> </ul>	<ul style="list-style-type: none"> <li>• SNF are not responsible for providing antiviral agents to family members or visitors; refer to PCP or clinic</li> </ul>

ACTIONS	RESIDENTS	HEALTH CARE PERSONNEL (HCP)	FAMILY MEMBERS/VISITORS
<p>8. Develop process to <b>evaluate</b> experiences after influenza season has ended:</p> <ul style="list-style-type: none"> <li>• Illnesses in residents and HCP</li> <li>• Successful strategies</li> <li>• Barriers</li> <li>• Lessons learned</li> <li>• Needs for the following season</li> <li>Impact of COVID-19</li> </ul>	<ul style="list-style-type: none"> <li>• Develop process for tracking and evaluating:               <ul style="list-style-type: none"> <li>◦ Number (%) of residents                   <ul style="list-style-type: none"> <li>▪ Vaccinated</li> <li>▪ Ill</li> <li>▪ Received antiviral treatment or chemoprophylaxis</li> </ul> </li> <li>▪ With influenza and COVID-19 co-infection</li> <li>▪ Transferred to acute care hospital</li> <li>▪ Deceased</li> </ul> </li> <li>◦ Number and duration of influenza outbreaks</li> <li>◦ Successes, challenges</li> <li>• Lessons learned</li> <li>• Obtain feedback from residents</li> </ul>	<ul style="list-style-type: none"> <li>• Develop process for tracking and evaluating:               <ul style="list-style-type: none"> <li>◦ Number (%) of HCP                   <ul style="list-style-type: none"> <li>▪ Vaccinated</li> <li>▪ Absent due to ILI</li> <li>▪ Received antiviral chemoprophylaxis or treatment</li> </ul> </li> <li>▪ With influenza and COVID-19 co-infection</li> </ul> </li> <li>• Lessons learned, challenges</li> <li>• Obtain feedback from HCP</li> </ul>	<ul style="list-style-type: none"> <li>• Develop process for tracking and evaluating:               <ul style="list-style-type: none"> <li>◦ Number of suspected introductions of influenza by visitors</li> <li>◦ Family/visitor understanding, and acceptance of messaging related to influenza in SNF</li> </ul> </li> <li>• Lessons learned, challenges</li> <li>• Obtain feedback from families/visitors</li> </ul>

**Table 3. Identifying and Managing Influenza Outbreaks in SNF**

ACTIONS	RECOMMENDATIONS
<p>1. Perform daily active <b>surveillance</b> for respiratory illness in residents and HCP. See Appendix A, B.</p>	<ul style="list-style-type: none"> <li>• In addition to COVID-19 symptom monitoring, during influenza season, usually October-March, conduct daily active surveillance for acute upper respiratory illness and pneumonia among residents and HCP until at least 1 week after the last confirmed case of influenza using a line list (e.g., Appendices A and B)               <ul style="list-style-type: none"> <li>◦ The respiratory illness line lists are different from the line lists used to track serial testing results for COVID-19 (contact <a href="mailto:HAIPProgram@cdph.ca.gov">HAIPProgram@cdph.ca.gov</a> for COVID-19 line list template); continue to use COVID-19 line list for tracking serial test results</li> <li>◦ Include individuals with current or recovered COVID-19 who have new onset of respiratory symptoms</li> <li>◦ Record specific locations of ill residents and HCP assignments and include information about sick HCP and sick visitors, as available</li> </ul> </li> <li>• Review line list daily and take actions needed if suspect influenza cases are identified.</li> </ul>
<p>2. Use <a href="https://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm">diagnostic testing</a> (<a href="https://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm">www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm</a>) for influenza and SARS-CoV-2:</p> <ul style="list-style-type: none"> <li>• Multiplex molecular assays: Influenza A, B, and SARS- CoV- 2, RSV</li> <li>• Rapid molecular assays</li> <li>• Rapid antigen detection assays</li> </ul> <p>See Appendix C.</p>	<ul style="list-style-type: none"> <li>• <b>Test residents with onset of respiratory symptoms for both influenza <u>and</u> SARS-CoV-2 at the same time to confirm the diagnosis</b>; contact the LHD for assistance obtaining multiplex antigen tests and real-time RT-PCR testing for influenza with rapid turn-around time.</li> <li>• Wherever available, use <a href="https://www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html">multiplex influenza A and B and SARS-CoV-2</a> tests (<a href="https://www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html">www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html</a>); multiplex POC testing for both influenza and SARS-CoV-2 should be considered for rapid evaluation of symptomatic individuals, followed by confirmatory real-time RT-PCR testing for <b>negative</b> results.</li> <li>• The lower sensitivity of antigen detection rapid influenza diagnostic tests (RIDTs) increases the risk of not identifying an influenza case; a negative RIDT in a symptomatic individual should be confirmed with real-time RT-PCR testing for influenza, even when the SARS-CoV-2 test is positive.</li> <li>• The lower sensitivity of POC antigen tests for SARS-CoV-2 increases the risk of not identifying a COVID-19 case; a negative POC antigen test for SARS-CoV-2 in a symptomatic individual should be confirmed with real-time RT-PCR testing for SARS-CoV-2, even when the influenza test (RIDT or otherwise) is positive.</li> <li>• <a href="https://www.cdc.gov/flu/professionals/diagnosis/index.htm">Collect specimens</a> (<a href="https://www.cdc.gov/flu/professionals/diagnosis/index.htm">www.cdc.gov/flu/professionals/diagnosis/index.htm</a>) for influenza testing as follows as directed in the kits used for testing</li> </ul>

ACTIONS	RECOMMENDATIONS
<p>Use diagnostic testing for influenza and SARS-CoV (<i>continued</i>)</p>	<ul style="list-style-type: none"> <li>◦ <b>When:</b> 24-72 hours after symptom onset is optimal for influenza</li> <li>◦ <b>What:</b> For diagnosis of influenza, a nasopharyngeal or combined throat and mid-turbinate nasal specimens provide the most accurate results</li> <li>◦ <b>How:</b> Follow directions that accompany the rapid influenza testing kit; use a swab with a synthetic tip (e.g., polyester or Dacron®) and an aluminum or plastic shaft. <b>Specimens collected with swabs made of calcium alginate are NOT acceptable.</b></li> <li>• Follow the recommended protocol for testing for SARS-CoV-2 or when using a multiplex influenza/SARS-CoV-2 test.</li> <li>• Add influenza and SARS-CoV-2 test results to the respiratory illness tracking spreadsheets.</li> <li>• 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.</li> <li>• The presence or absence of influenza will not change the recommended contact tracing or response testing for COVID-19.</li> </ul>
<p>3. <b>Establish presence of an influenza outbreak</b></p>	<ul style="list-style-type: none"> <li>• An influenza outbreak is defined as at least 2 residents with onset of influenza-like illness within 72 hours of each other AND at least 1 resident with laboratory confirmed influenza, preferably by a molecular assay (RT-PCR preferred).</li> </ul> <p><b><i>Influenza outbreaks might occur separately or concurrently with COVID-19 outbreaks; the presence of a confirmed influenza outbreak does not preclude the possibility of a COVID-19 outbreak, nor does a COVID-19 outbreak preclude the possibility of an influenza outbreak.</i></b></p>

ACTIONS	RECOMMENDATIONS
<p><b>4. Communicate</b></p>	<ul style="list-style-type: none"> <li>• As soon as presence of an influenza outbreak is established, notify:               <ul style="list-style-type: none"> <li>◦ Facility Infection Preventionist</li> <li>◦ Facility administration</li> <li>◦ Medical director</li> <li>◦ HCP of facility</li> <li>◦ LHD</li> <li>◦ CDPH L&amp;C district office</li> <li>◦ Residents, family members, visitors</li> </ul> </li> <li>• Distribute influenza outbreak communication letter to residents and their families</li> <li>• Post signs at facility entrances</li> <li>• Remind HCP of their specific tasks according to the influenza outbreak plan.</li> <li>• Document assignments and dates initiated and completed</li> </ul>
<p><b>5. Implement appropriate <a href="https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm">Transmission- Based Precautions</a> (www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm) and other infection control measures for influenza</b></p>	<ul style="list-style-type: none"> <li>• Emphasize and strictly enforce universal source control with facemask or face covering per COVID-19 guidance and respiratory hygiene/cough etiquette for residents, HCP, family members, and visitors               <ul style="list-style-type: none"> <li>◦ Distribute signs and related materials throughout the facility</li> </ul> </li> <li>• Use <a href="https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html">COVID-19 Transmission-Based Precautions</a> (www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html):               <ul style="list-style-type: none"> <li>◦ For residents with suspected influenza while test results are pending in a facility without COVID-19 cases or in areas with residents who do not have COVID-19</li> <li>◦ For residents with suspected or confirmed influenza who are located in COVID-19 isolation areas (“red zone”)</li> <li>◦ 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.</li> </ul> </li> <li>• When influenza <i>only</i> is confirmed, and the resident is not on COVID-19 Transmission-Based Precautions (not in COVID-19 isolation area):               <ul style="list-style-type: none"> <li>◦ <i>PPE</i></li> </ul> </li> </ul>

ACTIONS	RECOMMENDATIONS
<p>Implement appropriate <u>Transmission- Based Precautions</u> and other infection control measures for influenza, <i>(continued)</i></p>	<ul style="list-style-type: none"> <li>▪ Use Droplet Precautions (surgical mask) plus eye protection; HCP may continue to wear N95 respirators plus eye protection per extended use when caring for multiple residents with influenza.</li> <li>▪ Use an N95 or higher respirator plus eye protection for AGP</li> <li>▪ Add gloves and gown per Standard Precautions when contact with blood or body fluids is anticipated</li> <li>▪ Add Enhanced Standard Precautions for high contact activities with residents at risk for MDRO</li> <li>▪ Perform hand hygiene and ensure facemask and eye protection are in place upon entry into the room</li> <li>▪ Don gowns and gloves upon entry into the room or at any time in the room when exposure to resident secretions or close contact with resident likely</li> <li>▪ Remove PPE, discard, and perform hand hygiene upon completion of contact with a resident or when leaving the room</li> <li>▪ Place facemask on resident and have resident perform hand hygiene and don clean clothes if he/she needs to leave room for medical reasons</li> <li>▪ Continue Droplet Precautions for 7 days after the resident’s illness onset or 24 hours after the resolution of fever or respiratory signs, whichever is longer</li> <li>◦ <i>Room placement</i> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ 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</li> </ul> </li> <li>◦ <i>Other</i> <ul style="list-style-type: none"> <li>▪ Increase frequency of environmental cleaning with focus on high touch surfaces and common areas</li> <li>▪ Maintain residents on Droplet Precautions in their rooms and restrict from activities in common areas including meals</li> </ul> </li> </ul>

ACTIONS	RECOMMENDATIONS
<p>Implement appropriate <u>Transmission- Based Precautions</u> and other infection control measures for influenza, <i>(continued)</i></p>	<ul style="list-style-type: none"> <li>▪ Plan workflow from asymptomatic to symptomatic residents, always observing hand hygiene and other infection control precautions (such as using gowns and gloves) between resident contacts</li> <li>▪ Restrict HCP movement from areas of sick residents to well residents, as feasible</li> <li>▪ 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</li> <li>▪ Report trends in audit results to SNF administrators and leaders</li> <li>▪ Post de-identified adherence monitoring data in HCP break or charting areas</li> </ul>
<p>6. <u>Treat with antiviral agents</u> (<a href="http://www.cdc.gov/flu/professionals/antivirals/links.htm">www.cdc.gov/flu/professionals/antivirals/links.htm</a>) as recommended</p>	<ul style="list-style-type: none"> <li>• Treat all residents with confirmed or suspected influenza with the currently recommended <u>antiviral medication</u> (<a href="http://www.cdc.gov/flu/professionals/antivirals/links.htm">www.cdc.gov/flu/professionals/antivirals/links.htm</a>) as soon after symptom onset as possible, but ideally within 48 hours of onset, for maximum benefit; consider empiric treatment for roommates of residents with confirmed influenza</li> <li>• Do NOT wait for confirmatory test results to initiate influenza treatment unless there is ongoing transmission of SARS-CoV-2 in the facility</li> <li>• Antiviral agents for influenza and for SARS-CoV-2 may be administered simultaneously when co-infection occurs; see <u>NIH treatment guidance</u> (<a href="http://www.covid19treatmentguidelines.nih.gov/special-populations/influenza/">www.covid19treatmentguidelines.nih.gov/special-populations/influenza/</a>)</li> <li>• Consult resident’s PCP for any necessary dose adjustments in residents with underlying conditions, such as renal impairment</li> <li>• Be aware of the possibility of resistance to the antiviral agent used if resident has continued progressive illness after 72 hours of treatment, if positive for influenza. Consult LHD for information on antiviral resistance and for alternative treatment recommendations.</li> </ul>

ACTIONS	RECOMMENDATIONS
<p>7. <b><u>Administer antiviral chemoprophylaxis</u></b> (<a href="http://www.cdc.gov/flu/professionals/antivirals/links.htm">www.cdc.gov/flu/professionals/antivirals/links.htm</a>) as recommended</p>	<ul style="list-style-type: none"> <li>• Obtain orders from PCPs for influenza chemoprophylaxis when it is indicated</li> <li>• As soon as the presence of an influenza outbreak is established, provide influenza <a href="http://www.cdc.gov/flu/professionals/antivirals/links.htm">antiviral chemoprophylaxis</a> (<a href="http://www.cdc.gov/flu/professionals/antivirals/links.htm">www.cdc.gov/flu/professionals/antivirals/links.htm</a>) with the currently recommended antiviral agent at the recommended dosage regimen to all non-ill residents in the entire facility or in the building affected, regardless of vaccination status. If there is a limited supply of antiviral agents: <ul style="list-style-type: none"> <li>◦ Give top priority for chemoprophylaxis to roommates and residents on the same floor or unit as residents with active influenza</li> <li>◦ Prioritize residents in the same building with shared HCP</li> <li>◦ Consult with medical director and LHD for further guidance</li> </ul> </li> <li>• CDC recommends antiviral chemoprophylaxis for at least 2 weeks, and continuing for at least 7 days after the last known case was identified</li> <li>• Obtain influenza testing (in addition to SARS-CoV-2 testing) for any resident who develops signs or symptoms of ILI after receiving an antiviral agent for at least 72 hours and report positive result to the LHD due to possibility of antiviral resistance. Consult LHD for current information on resistance and recommendations for alternative chemoprophylaxis agents</li> <li>• Consider referring HCP for antiviral chemoprophylaxis in any of the following circumstances: <ul style="list-style-type: none"> <li>◦ If vaccinated and the circulating influenza strain is not well matched with vaccine strains</li> <li>◦ If recently vaccinated and exposure to influenza occurred within 2 weeks of receiving injectable vaccine; do NOT give antiviral chemoprophylaxis until at least 14 days after the intranasal live-attenuated (LAIV) vaccine was received</li> <li>◦ HCP who were not vaccinated due to a medical contraindication or are at high risk for complications of influenza due to age or medical conditions</li> <li>◦ At high risk for complications of influenza due to age or medical conditions</li> </ul> </li> </ul>
<p>8. Define process for <b>accepting and transferring residents</b></p>	<ul style="list-style-type: none"> <li>• During the times when SARS-CoV-2 is co-circulating, acceptance and transfer policies will be determined primarily by the processes established for COVID-19</li> <li>• 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</li> </ul>

ACTIONS	RECOMMENDATIONS
<p>Define process for accepting and transferring residents (<i>continued</i>)</p>	<ul style="list-style-type: none"> <li>• Before transferring residents with suspected, probable or confirmed influenza to other departments or facilities, communicate all relevant information to transport personnel and other HCP accepting the resident in another department or facility.               <ul style="list-style-type: none"> <li>◦ Information should include test results, date of illness onset, antiviral treatment, and needed infection control precautions</li> </ul> </li> <li>• SNF must develop plans for managing new admissions and providing care for residents with influenza who require Droplet Precautions, while still maintaining capacity to provide care safely for other residents</li> <li>• Do not place new admissions on units with symptomatic residents</li> <li>• Do not transfer asymptomatic residents to units with residents who have active influenza</li> <li>• Consult with the medical director and LHD to determine if the facility should be closed to new admissions due to an influenza outbreak               <ul style="list-style-type: none"> <li>◦ Determine the duration of closures or limiting admissions for each situation individually.</li> <li>◦ Consider the effectiveness of the influenza control measures implemented within the facility.</li> <li>◦ Facility-wide and prolonged closures are not necessary if transmission is controlled and there is an unaffected location available where new admissions can be placed</li> </ul> </li> <li>• Hospitalized patients with influenza should be discharged when they no longer require the level of care provided in an acute care setting. Discharge from hospital and admission or re-admission to SNF should not be determined by the period of potential virus shedding or recommended duration of Droplet Precautions</li> <li>• Ensure that new or returning residents with acute respiratory illness are evaluated medically by the SNF to determine room placement and needed infection control precautions</li> <li>• Develop plan to implement Droplet Precautions for returning residents who were hospitalized with influenza and are ready clinically for discharge from the acute care setting, but are still within the 7 day or longer period of required Droplet Precautions</li> </ul>
<p><b>9. Manage healthcare personnel (HCP)</b></p>	<ul style="list-style-type: none"> <li>• Encourage well HCP who have not received annual influenza vaccine to accept vaccine.               <ul style="list-style-type: none"> <li>◦ Provide at <a href="http://www.dir.ca.gov/title8/5199.html">no cost</a> (www.dir.ca.gov/title8/5199.html) and at a <a href="http://www.dir.ca.gov/title8/5199.html">reasonable time and place</a> (www.dir.ca.gov/title8/5199.html) for employees during working hours.</li> </ul> </li> <li>• Instruct HCP who develop respiratory symptoms when away from facility to contact supervisor, not</li> </ul>

ACTIONS	RECOMMENDATIONS
	<p>to come to work, and to obtain testing for both COVID-19 and influenza.</p> <ul style="list-style-type: none"> <li>◦ If influenza is the only respiratory tract infection (COVID-19 test negative), HCP should follow the facility policy for return to work for influenza – at minimum do not return to work until afebrile &gt;24 hours without antipyretic treatment and with improvement in respiratory symptoms or no earlier than 5 days after illness onset</li> <li>• Instruct HCP who develop respiratory symptoms during the work shift to               <ul style="list-style-type: none"> <li>◦ Ensure that facemask is in place, inform supervisor and promptly leave the facility</li> <li>◦ Obtain COVID-19 and influenza diagnostic tests</li> </ul> </li> <li>• Offer or refer ill HCP for influenza testing and empiric antiviral treatment as described above in #7.</li> </ul>
<p><b>10. Manage visitors</b></p>	<ul style="list-style-type: none"> <li>• Follow the policy for visitors during the flu season that has been implemented by the facility for prevention of transmission of COVID-19. If there are no COVID-19 restrictions, then implement visitor restrictions for influenza as follows:               <ul style="list-style-type: none"> <li>◦ Implement screening of visitors for signs of acute respiratory illness and exclude symptomatic visitors</li> </ul> </li> <li>• Educate and encourage influenza vaccination for visitors</li> <li>• Ensure universal masking or wearing facial coverings for source control/respiratory hygiene/cough etiquette</li> <li>• Instruct visitors to use a facemask for source control and for their own protection when in the room of a resident on Droplet Precautions</li> <li>• Consider implementing visitor restrictions, such as limiting the number of visitors and excluding young children, if not already in place for COVID-19.</li> </ul>
<p><b>11. Review vaccine records</b></p> <ul style="list-style-type: none"> <li>a. Influenza vaccine (residents, HCP)</li> <li>b. Pneumococcal vaccines (residents)</li> </ul>	<ul style="list-style-type: none"> <li>• Verify that the influenza vaccination plan from Table 2 has been implemented</li> <li>• Encourage and vaccinate residents and HCP who declined previously. Focus on areas with groups of unimmunized individuals and the highest risk residents (e.g., those who require ventilator therapy or have complex underlying medical conditions)</li> <li>• Ensure that residents admitted during an outbreak have received pneumococcal vaccines as per current <a href="http://www.cdc.gov/vaccines/schedules/hcp/adult.html">ACIP recommendations</a> (www.cdc.gov/vaccines/schedules/hcp/adult.html) and schedule reminders for providing any additional indicated doses</li> </ul>

ACTIONS	RECOMMENDATIONS
<p><b>12. Determine end of influenza outbreak</b></p>	<ul style="list-style-type: none"> <li>• If no new cases of influenza have been identified for at least 1 week 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.</li> <li>• Consult the LHD to assist in determining the outbreak endpoint</li> <li>• As soon as end of outbreak is confirmed, notify:               <ul style="list-style-type: none"> <li>◦ Facility Infection Preventionist, administration, medical director</li> <li>◦ HCP of facility</li> <li>◦ LHD</li> <li>◦ L&amp;C district office</li> <li>◦ Residents, family members, visitors</li> </ul> </li> </ul>
<p><b>13. Perform assessment of outbreak control measures:</b></p> <ul style="list-style-type: none"> <li>a. Successful strategies</li> <li>b. Barriers</li> <li>c. Lessons learned</li> <li>d. Needs for the following season</li> <li>e. Impact of COVID 19</li> </ul>	<ul style="list-style-type: none"> <li>• Upon completion of the influenza season, evaluate outbreak control processes and experiences:               <ul style="list-style-type: none"> <li>◦ Number (%) of residents vaccinated; ill; received anti-viral treatment or chemoprophylaxis; transferred to acute care hospitals; and deceased</li> <li>◦ Number and duration of outbreaks</li> <li>◦ Number (%) vaccinated and ill HCP</li> <li>◦ Number (%) of residents, no. (%) of HCP with co-infection with influenza and COVID 19</li> <li>◦ Successes</li> <li>◦ Challenges</li> </ul> </li> <li>• Obtain feedback from residents, HCP, families/visitors</li> </ul>

## GLOSSARY

**[Aerosol-generating procedures \(AGPs\)](http://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control)** ([www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control](http://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control)). Procedures that generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking, or breathing. There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of AGPs for healthcare settings. Examples of procedures that are most frequently considered AGPs include: nebulizer treatments, sputum induction, open suctioning of the airway, endotracheal intubation, cardiopulmonary resuscitation.

**[Cloth face covering](http://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html)** ([www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html](http://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html)): Textile (cloth) covers that are intended for source control. They are not personal protective equipment (PPE); however, cloth face coverings may provide minimal protection to the wearer against respiratory viral particles when in the community.

***Cohorting***: The practice of grouping patients infected, colonized with or exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. Individuals who are suspected to have the same infection (for example, influenza) may be cohorted during an outbreak without confirmatory testing; therefore, it is important to treat each bed space in a cohort separately, performing hand hygiene and changing PPE between contacts with individuals in the cohort. However, during the COVID-19 pandemic, all individuals with symptoms of respiratory tract infection should be tested for both influenza and SARS-CoV-2 and individuals with influenza should remain in their designated COVID-19 category. Cohorting also refers to assigning the same staff members to care for individuals in one cohort of residents and not other resident cohorts within a work shift.

***COVID-19***: Coronavirus infectious disease caused by the SARS-CoV-2 that first emerged in December 2019 and caused a worldwide pandemic.

**[Diagnostic tests for influenza](http://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm)** ([www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm](http://www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm)): There are three types of laboratory tests used for diagnosis of influenza on respiratory tract specimens from a nasopharyngeal (NP) swab or combined mid-turbinate nasal and throat swabs:

- 1) Rapid diagnostic influenza test (RIDT)
  - a. Widely available, detects influenza antigens with results within 15 minutes
  - b. Sensitivity 50-70%, specificity 90-95%; therefore, 30-50% of influenza cases will not be detected
  - c. Some RIDT will not distinguish influenza subtypes A and B
- 2) Molecular assays including real-time reverse transcription polymerase chain reaction (real-time RT-PCR); real-time RT-PCR is the preferred test.
  - a. Results available in 1-8 hours; rapid molecular assays produce results in 15-30 minutes

- b. Very high sensitivity
  - c. Single or multiplex; detects influenza subtypes (A and B)
  - d. Preferred test to confirm the presence of an outbreak
- 3) Viral culture
- a. Not readily available and rarely performed
  - b. Results available in 1-10 days

CDC has summarized the [Multiplex Assays Authorized for Simultaneous Detection of Influenza Viruses and SARS-CoV-2 by FDA](https://www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html) (www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html) available at the time of posting of this document.

**Droplet Precautions** (www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm): A set of practices to prevent transmission of pathogens through close respiratory or mucous membrane contact with respiratory secretions. A single patient room is preferred for patients who require Droplet Precautions. When a single patient room is not available, assess the risks associated with other patient placement options such as cohorting or keeping the patient with an existing roommate. For patients in multi-bedrooms, maintain spatial separation of at least 6 feet and draw the privacy curtain between patient beds. Health care personnel don a surgical mask upon room entry (a respirator is not necessary). Facemasks should be changed when wet and between patient contacts. Residents on Droplet Precautions who must be transported outside of the room should wear a mask if tolerated and follow respiratory hygiene/cough etiquette.

**Enhanced Standard Precautions** (PDF)

(www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/Enhanced-Standard-Precautions.pdf): The use of gowns, gloves and frequent hand hygiene when performing high contact activities with residents who have medical devices in place or unhealed wounds and have increased risk of colonization and transmission of MDRO. If there is suspected or confirmed ongoing transmission of an MDRO within a facility, Contact Precautions is recommended for individuals known to be colonized or infected with the MDRO.

***Eye protection:*** A properly fitting device to shield the eyes and conjunctivae from respiratory viral particles. Eyeglasses do NOT provide sufficient protection. Appropriately fitted, indirectly-vented **goggles** or a **face shield** with crown and chin protection that wraps around the face to the point of the ear to reduce the likelihood that a splash could go around the edge of the shield and reach the eyes can be used for eye protection. Face shields are preferred for the increased facial coverage. A face shield without a mask does not provide adequate source control.

**Facemask**

(www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/PersonalProtectiveEquipment/ucm055977.htm): A loose-fitting, disposable device that creates a physical barrier between the mouth and nose of the wearer and potential

contaminants in the immediate environment. Facemasks are not to be shared and may be labeled as surgical, isolation, dental or medical procedure masks.

Facemasks may come with or without a face shield. If worn properly, a facemask is meant to help block large-particle droplets, splashes, sprays or splatter that may contain germs (viruses and bacteria), keeping it from reaching the mouth and nose of the person wearing it.

Facemasks also help contain and reduce exposure of an individual's saliva and respiratory secretions to others. Facemasks are not intended to be used more than once. If the mask is damaged, soiled, or wet, or if breathing through the mask becomes difficult, remove it, discard it safely, and replace it with a new one.

**Hand hygiene** ([www.cdc.gov/handhygiene/](http://www.cdc.gov/handhygiene/)): A general term that applies to any one of the following:

- Handwashing with plain (non-antimicrobial) soap and water);
- Antiseptic hand wash (soap containing antiseptic agents and water);
- Antiseptic hand rub (waterless antiseptic product, most often alcohol-based, rubbed on all surfaces of hands); or
- Surgical hand antisepsis (antiseptic hand wash or antiseptic hand rub performed preoperatively by surgical personnel to eliminate transient hand flora and reduce common hand flora).

**Healthcare personnel (HCP)** ([www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html](http://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)) also referred to as healthcare workers (HCWs): All paid and unpaid persons who work in a healthcare setting; for example, any person who has professional or technical training in a healthcare-related field and provides patient care in a health care setting or any person who provides services that support the delivery of health care such as dietary, housekeeping, engineering, maintenance personnel.

***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. This definition is used for influenza surveillance worldwide.

***Influenza Outbreak within a residential facility***: At least two residents with onset of influenza-like illness (ILI) within 72 hours of each other AND at least one resident has laboratory confirmed influenza by a molecular test (RT-PCR preferred).

**Isolation** ([www.cdc.gov/quarantine/](http://www.cdc.gov/quarantine/)): Separation of infected individual from others; applies to infection with both influenza viruses and SARS-CoV-2 in this document. Recommendations for use of Transmission-Based Precautions and other infection control practices are determined by the route(s) of transmission of the specific suspected or proven infectious agents.

***Long-term care facilities***: Institutions, such as skilled nursing facilities (SNF), nursing homes and facilities that provide health care to people including children, who are unable to manage

independently in the community. This care may represent custodial or chronic care management or short-term rehabilitative services. In California, long term care facilities are licensed by CDPH Licensing and Certification (L&C), including skilled nursing facilities (SNF), congregate living health facilities, intermediate care facilities (ICF), ICF/developmentally disabled (DD), ICF/DD Continuous Nursing, and ICF/DD – Habilitative, and ICF/DD – Nursing

**[Personal protective equipment \(PPE\)](#)** (PDF) ([www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf](http://www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf)): A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, goggles, face shields, and gowns. See [CDC recommendations](#) for infection control practices updated September 23, 2022 ([www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html](http://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)) and [recommendations for influenza PPE](#) ([www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm](http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm)) for details.

**[Quarantine](#)** ([www.cdc.gov/quarantine/](http://www.cdc.gov/quarantine/)): People who have been exposed to an infectious disease are separated from others and restricted from movement until it is known that they did not acquire the infection (usually for the incubation period). Although quarantine was recommended for SARS-CoV-2 exposed SNF residents during the first two years of the pandemic, it is no longer generally recommended and designation of a quarantine area as a “yellow zone” is not necessary.

**[Respirators](#)** ([www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html](http://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html)): A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents, including those in aerosols), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare. Some examples include N95 respirators, elastomeric respirators, and powered air-purifying respirators (PAPR). Consult [CalOSHA](#) (PDF) ([www.dir.ca.gov/dosh/Cal-OSHA\\_influenza\\_guidance\\_11-5-10.pdf](http://www.dir.ca.gov/dosh/Cal-OSHA_influenza_guidance_11-5-10.pdf)) standards for specific regulations pertaining to respirators for seasonal influenza.

### **[Respiratory hygiene/ cough etiquette](#)**

([www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm](http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm)): A combination of measures to minimize the transmission of respiratory pathogens via droplet or airborne routes in healthcare settings. Respiratory hygiene/cough etiquette includes:

- Covering the mouth and nose during coughing and sneezing.
- Using tissues to contain respiratory secretions with prompt disposal into a no-touch receptacle.
- Turning the head away from others and maintaining spatial separation, ideally  $\geq 6$  feet, when coughing.
- Performing hand hygiene after contact with respiratory secretions or items contaminated with respiratory secretions.
- Offering a facemask to persons who are coughing to decrease contamination of the

surrounding environment.

**SARS-CoV-2:** Severe acute respiratory syndrome-coronavirus-2, the virus that causes coronavirus infectious disease-19 (COVID-19).

**Source Control** ([www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html](http://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)): Use of respirators or well-fitting facemasks or cloth face coverings to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

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### **Additional Resources**

- [Preparing for the 2020-2021 Flu Season](https://www.cdc.gov/flu/)  
(www.cdc.gov/flu/)
- [Coronavirus \(COVID-19\)](https://www.cdc.gov/coronavirus/2019-nCoV/index.html)  
(www.cdc.gov/coronavirus/2019-nCoV/index.html)
- [CDPH Guidance for COVID-19](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx)  
(www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx)
- [Influenza Vaccination Coverage among Health Care Personnel — United States, 2018–19 Influenza Season](https://www.cdc.gov/flu/fluview/hcp-coverage_1819estimates.htm)  
(www.cdc.gov/flu/fluview/hcp-coverage\_1819estimates.htm)

**Supplementary Data**

**Influenza Vaccination Rates of HCP during 2019-2022 Seasons: Annual Internet Panel Surveys**

<b>Group</b>	<b>2019-2020</b> % vaccinated (95% CI)	<b>2020-2021</b> % vaccinated (95% CI)	<b>% point change *</b> 2019-'20 to 2020-'21	<b>2021-2022</b> % vaccinated (95% CI)	<b>% point change **</b> 2020-'21 to 2021-'22
<b>All HCP</b>	<b>80.7</b> (76.9, 84.6)	<b>75.9</b> (71.3 to 80.1)	<b>-4.9</b> (-10.7, 1.0)	<b>79.9</b> (76.6 to 82.9)	<b>4.0</b> (-1.4 to 9.4)
<b>Long-term care facility / home health care</b>	<b>73.8</b> (65.5, 82.0)	<b>66.0</b> (57.6, 73.6)	<b>-7.8</b> (-19.1, 3.5)	<b>66.4</b> (57.5 to 74.4)††	<b>0.4</b> (-11.0 to 12.0)
<b>Hospital</b>	<b>92.1</b> (88.3, 96.0)	<b>91.6</b> (87.8, 94.5)	<b>-0.5</b> (-5.5, 4.4)	<b>92.0</b> (89.6 to 94.1)	<b>0.4</b> (-3.6 to 4.4)
<b>Ambulatory care</b>	<b>79.8%</b> (74.0, 85.6)	<b>77.3</b> (63.9, 87.6)	<b>-2.5</b> (-15.1, 10.1)	<b>81.2</b> (77.2 to 84.7)	<b>3.9</b> (-8.5 to 16.3)

\* [Influenza Vaccination Coverage Among Health Care Personnel — United States, 2020–21 Influenza Season](https://www.cdc.gov/flu/fluview/hcp-coverage_1920-21-estimates.htm) (www.cdc.gov/flu/fluview/hcp-coverage\_1920-21-estimates.htm)

\*\*Razzaghi H. Srivastav A, dePerio MA, et al. Influenza and COVID-19 Vaccination Coverage Among Health Care Personnel —United States, 2021–22. MMWR 2022; 71: 1319-26.

†† Statistically significant (p<0.05) when compared with Ref in the same season