COLORADO
Department of Public Health & Environment

INTERIM Guidelines for Preparation and Response to Single Cases and Outbreaks of COVID-19 in Long-Term Care Settings

Issued: 03/14/2020

Date of Update	Description of Update
03/25/2020	Updates to symptom screening and case symptoms, reporting to public health, surveillance and monitoring, source control, testing, outbreak precautions, discontinuation of isolation, return of residents to the facility following hospitalization or new admission to the facility, return of HCP to work after suspected or confirmed COVID-19, outbreak resolution.
04/09/2020	Updates to outbreak definitions, surveillance and monitoring, specimen collection, infection control, admissions, communication, outbreak resolution and containment
04/17/2020	Updates to outbreak definitions, surveillance and monitoring, universal source control, return of HCP to work after suspected or confirmed COVID-19, and communication.
04/24/2020	Updates to discontinuation of isolation, admission of residents without COVID-19 or with unknown COVID-19 status, return of HCP to work after suspected or confirmed COVID-19.
05/01/2020	Updates to specimen collection, discontinuation of isolation, admission of residents without COVID-19 with unknown COVID-19 status, return of HCP to work after suspected or confirmed COVID-19.
05/15/2020	Updates to admission of residents without COVID-19 or with unknown COVID-19 status
05/29/2020	Updates to testing, specimen collection, and infection prevention and admission of residents without COVID-19 or with unknown COVID-19 status. Added guidance for HCP with potential exposure to COVID-19. New figure added as an appendix (Decision Tree for Resident Admissions)

06/16/2020	**Update to Admission of Residents Without COVID-19 or With Unknown COVID-19 Status. Update to Source Control/What to do when a resident with respiratory illness is identified. Update to Testing. Update to Outbreak Resolution and Containment. Added link to FAQs for Personal Protective Equipment.**
07/22/2020	**Update to Viral Testing, Discontinuation of Isolation, Return of HCP to Work after Confirmed or Suspected COVID-19, Outbreak Resolution and Containment, Appendix.**

Scope: The purpose of this document is to provide guidance to long-term care facilities (LTCFs) when a resident or healthcare personnel is suspected or confirmed to have COVID-19 and to provide recommendations to prevent transmission within the facility. These recommendations are specific for nursing homes, including skilled nursing facilities. Much of this information could also be applied in assisted living facilities. Guidance provided in this document is based on currently available information at the time it was drafted and is subject to change.

Background: A new respiratory disease, coronavirus-19 (COVID-19) is currently spreading globally and there have been instances of community spread within the United States. This disease is caused by the virus SARS-CoV-2. The Colorado Department of Public Health and Environment (CDPHE) is currently monitoring the situation closely. Updated case counts are available on the CDPHE website: Coronavirus Disease 2019 (COVID-19) in Colorado.

Residents of LTCFs, which are often older people and those with underlying health conditions, are at especially high risk for developing serious illness associated with COVID-19. Healthcare workers and close contacts of people with COVID-19 are also at elevated risk for exposure. Respiratory illnesses have the potential to spread easily in these settings due to the communal nature of the environment.

Definition of Healthcare Personnel (HCP): HCP refers to all persons, paid and unpaid, working in healthcare settings engaged in resident care activities, including: resident assessment for triage, entering examination rooms or resident rooms to provide care or clean and disinfect the environment, obtaining clinical specimens, handling soiled medical supplies or equipment, and coming in contact with potentially contaminated environmental surfaces.

Preparation: Steps that LTCFs can take to prepare for community spread of COVID-19 and to prevent introduction of COVID-19 into the facility include:

1. Review the facility emergency plan.
2. Establish relationships with key healthcare and public health partners.
3. Communicate about COVID-19 with your staff.
4. Communicate about COVID-19 with your residents.
5. Ensure proper use of recommended personal protective equipment (PPE).

6. Conduct an inventory of available PPE and ensure adequate supply of PPE.
7. Reinforce sick leave policies and restrict ill HCP from work.
8. Ensure supplies are available for hand hygiene and respiratory etiquette.
9. Restrict visitors according to public health order 20-20 and guidelines from the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC).
10. Cancel group activities and communal dining.
11. Implement active screening of residents and HCP for symptoms and signs of infection (See Surveillance and Monitoring, below).
12. Ensure adequate supplies and procedures for environmental cleaning and disinfection.

Resources for preparation can be found here:

- Steps Healthcare Facilities Can Take Now to Prepare for Coronavirus Disease 2019 (COVID-19) (CDC).
- Preparing for COVID-19: Long-term Care Facilities, Nursing Homes (CDC).
- Notice of Public Health Order 20-20.
- FAQs for Personal Protective Equipment

Response

Key Information about COVID-19

- **Agent:** SARS-CoV-2
- **Incubation Period:** Range 2 to 14 days
- **Transmission/Communicability:** The virus is thought to spread mainly from person-to-person.
    - Between people who are in close contact with one another (within about 6 feet),
    - Through respiratory droplets produced when an infected person talks, coughs, or sneezes.
- These droplets can land in the eyes, mouths, or noses of people who are nearby or possibly be inhaled into the lungs.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.

Outbreak Definitions

Outbreak definitions have been standardized across outbreak settings. See Colorado COVID-19 Case and Outbreak Definitions, including the outbreak definition for Healthcare Settings.

Reporting to Public Health

Any suspected or confirmed case or outbreak of COVID-19 should immediately be reported to the local or state public health agency. To report, utilize the COVID-19 Outbreak report form. Send this form to your local public health agency OR to CDPHE by securely emailing a completed form to: **cdphe_haioutbreak@state.co.us**. You may also contact the Colorado Department of Public Health and Environment at 303-692-2700 (8:30 - 5:00, Monday - Friday) or 303-370-9395 (after-hours, holidays and weekends).

Surveillance and Monitoring

Surveillance for Respiratory Illness in Residents during COVID-19: Routinely monitor residents for symptoms (cough, shortness of breath or difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s); consider also rhinorrhea, diarrhea, nausea or vomiting), temperature, and other vital signs, including pulse oximetry daily. **Increase monitoring of all residents to two times daily if there is a resident with suspected or confirmed COVID-19 or a suspected or confirmed COVID-19 outbreak in the facility.**

Residents with the following symptoms should be considered for potential COVID-19:

- Cough
- Shortness of breath, difficulty breathing, or signs of new hypoxemia
- Fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)
- Other symptoms in the setting of a suspected or confirmed COVID-19 outbreak (e.g., rhinorrhea, diarrhea, nausea or vomiting)

Residents should ***also*** be assessed for other etiologies (e.g. influenza, RSV, etc.) according to clinical suspicion and considering local circulation of respiratory viruses.

CDPHE provides a basic tracking tool: Line List Template to Monitor Residents and Staff. Collection of additional variables may be recommended in the setting of a suspected or confirmed COVID-19 outbreak.

Surveillance for Respiratory Illness in HCP during COVID-19

- Screen all staff at the beginning of their shift for fever or respiratory symptoms (cough, shortness of breath or difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s); consider also rhinorrhea, diarrhea, nausea or vomiting) and close contact with an ill household member.
    - Actively take their temperature and document absence of fever and symptoms.
    - Keep a record of other healthcare facilities where your staff are working (these staff may pose a higher risk) and ask about exposure to facilities with recognized COVID-19 cases.

- As part of routine practice, ask HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of respiratory infection.
- CDPHE provides a basic tracking tool: Line List Template to Monitor Residents and Staff. Collection of additional variables may be recommended in the setting of a suspected or confirmed COVID-19 outbreak.

Universal Source Control

- CDC recommends everyone entering the facility wear a cloth face covering while in the building, regardless of symptoms.
- Residents and visitors should, ideally, wear their own cloth face covering upon arrival to the facility.
- Residents may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room.
- All HCP and other staff that come into close proximity with residents (e.g., maintenance staff, environmental services) should wear a medical facemask (not a cloth mask) at all times while they are in the healthcare facility. Facemasks are preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.
- Some staff that do not come in contact with residents (e.g., clerical personnel) might wear a cloth face covering for source control while in the healthcare facility.

Source Control/What to do when a resident with respiratory illness is identified

- Do not wait for confirmation of a diagnosis to implement infection control precautions.
- Place a facemask over the resident's nose and mouth until the resident can be properly isolated. In times of PPE shortages, consider the use of tissues, a cloth face covering, or other barriers to cover the resident's mouth and nose. Ensure that residents have access to a trash receptacle to dispose of used tissues and a method for hand hygiene.
- Place the resident in a private room with the door closed.
    - If roommates are being moved, ensure they are moved to a private room and quarantined for 14 days with the use of transmission-based precautions in the event exposure has occurred and they may have undetected infection.
    - If roommates cannot be moved, ensure at least 6 feet separation between residents and utilize curtains or other physical dividers for separation, ensuring the roommate is quarantined for 14 days with the use of transmission-based precautions. The quarantine period should begin after the last potential exposure to the roommate with COVID-19, and may need to be extended if there is ongoing exposures between roommates.

- Avoid transferring residents with symptoms of respiratory illness to unaffected units or other facilities unless medically necessary. If such a transfer must occur, place the resident in a private room with the door closed.
- Per CDC guidance, residents with known or suspected COVID-19 in the long-term care setting do not need to be placed into an airborne infection isolation room (AIIR) (Preparing for COVID-19: Long-term Care Facilities, Nursing Homes (CDC)).
- Only essential personnel should enter the room. Implement staffing policies to minimize the number of HCP who enter the room.
- If symptomatic residents need to leave their room (e.g., for medical care), the resident should wear a facemask, cloth face covering, or use tissues as source control when they are outside of their room or affected unit. Prioritize facemasks for HCPs.

Source Control/What to do when a HCP with symptoms is identified

- Remind HCP to stay home when they are ill.
- If HCP develop a fever or symptoms of respiratory infection while at work, they should immediately put on a facemask, inform their supervisor, and leave the workplace. In times of PPE shortages, use tissues, a cloth face covering, or other barriers to cover the HCP's mouth and nose. Ill staff should seek medical care if necessary (make sure to call ahead) and practice self-isolation at home.
- Consult occupational health/infection prevention or other appropriate administrative personnel on decisions about further evaluation and return to work. See also the section "Return of HCP to Work after Confirmed or Suspected COVID-19," below. Consult public health as necessary.

Viral Testing (Detection of SARS-CoV-2)

Residents with symptoms (cough, shortness of breath or difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s); consider also rhinorrhea, diarrhea, nausea or vomiting) should be immediately isolated (as outlined above) and tested for COVID-19. **Note that prompt response and COVID-19 testing is necessary to limit transmission and should not wait for results of other virus testing.**

Staff with symptoms (cough, shortness of breath or difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s); consider also rhinorrhea, diarrhea, nausea or vomiting) should be tested for COVID-19 through their usual healthcare provider,alternate testing site, or as part of a public health response.

Postmortem testing for COVID-19 should be completed following undiagnosed deaths suspected to be due to COVID-19.

Once a new case of COVID-19 in a resident or staff has been detected, promptly implement facility-wide testing to identify additional residents and staff with asymptomatic,

pre-symptomatic, or symptomatic infections. The purpose of expanded testing is to facilitate rapid infection prevention interventions, including isolation and cohorting of infected residents, use of appropriate personal protective equipment, and removal of infected staff from the workplace. When one case is detected, there are often others in the facility that can lead to ongoing transmission of COVID-19. Facility leadership should expect to identify multiple asymptomatic and pre-symptomatic residents and HCP with COVID-19 and be prepared to respond rapidly and mitigate potential staffing shortages. Residents previously known to have COVID-19 (on admission) and cared for with appropriate transmission-based precautions will not necessarily trigger facility-wide testing.

Facility leadership should ensure continued testing of all previously negative residents and staff (e.g., once a week) until no new positives are identified and at least 14 days have passed since the most recent positive. Immediately perform viral testing of any resident or HCP who subsequently develops signs or symptoms consistent with COVID-19.

Facilities should work with public health to coordinate initial expanded testing and repeat testing in response to an outbreak and if viral testing capacity is limited.

See the following guidance for expanded testing:

- INTERIM Expanded Testing & Cohorting Public Health Strategy to Prevent SARS-CoV-2 Transmission in Nursing Homes, Skilled-Nursing Facilities, and Assisted Living Residences (CDPHE)
- Testing Guidance for Nursing Homes (CDC)
- Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes (CDC)

CDPHE does not recommend repeat testing of persons who previously tested positive for COVID-19 within 90 days. Recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset at levels where infectiousness is unlikely. A positive PCR during the 90 days after illness onset more likely represents persistent shedding of viral RNA than reinfection. If such a person becomes symptomatic during this 90-day period and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then the person may warrant evaluation for SARS-CoV-2 reinfection in consultation with an infectious disease or infection control expert. Quarantine may be warranted during this evaluation, particularly if symptoms developed after close contact with an infected person. See Duration of Isolation and Precautions for Adults with COVID-19.

Specimen Collection

- Follow guidance from CDC and CDPHE regarding which specimens to obtain for COVID-19 testing (e.g., nasopharyngeal or anterior nares specimens). There are multiple acceptable upper respiratory specimens.
    - Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19) (CDC).
    - COVID-19 resources for health care providers and local public health agencies (CDPHE).
- When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a possible COVID-19 patient, CDC recommends:
    - Specimen collection should be performed in a private area, such as an examination room with the door closed.
    - HCP in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors and roommates should not be present for specimen collection.
- In the LTCF setting, consider the following options for appropriate specimen collection activities:
    - Collect the specimen outdoors (if weather allows and is feasible given resident status).
    - Collect the specimen in the resident's room with the door closed.
        - If the resident has roommates, move the roommate to another location while the specimen is being collected, if possible.
        - If roommates cannot be moved, ensure at least 6 feet separation between residents, and use curtains or other physical dividers for seperation.
    - Consider self-collection of anterior nares specimens for residents who are able to do so.
- Clean and disinfect procedure room surfaces promptly in accordance with CDC guidance **(**Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (CDC)**)**.
- For additional guidance for infection prevention during sample collection during expanded testing of residents and staff, see Transmission based precautions for COVID-19 test-based prevention strategies in residential settings.

Infection Control

General Guidance

- Infection prevention and control recommendations have been consolidated into the following checklist: COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities. See the checklist for recommended **prevention measures** that should be implemented immediately to protect residents from possible COVID-19

infection and **rapid response measures** that should be implemented immediately when even a single case of respiratory illness is identified in a resident or during suspected or confirmed outbreaks of COVID-19. **Do not wait for illness to occur before implementing prevention measures as these are intended to prevent infection from occurring and/or spreading in the facility. A delay in implementation could result in increased spread of infection.**

- Also visit CDC's website for infection control guidance (Infection Control (CDC)) and Strategies to Prevent Spread of COVID-19 in LTCFs: Healthcare Facilities (CDC).
- CMS has additional guidance:
    - Guidance for Infection Control and Prevention of Coronavirus Disease 2019(COVID-19) in nursing homes (CMS)
    - Nursing home guidance (CMS)
    - 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios.
- CDPHE and CDC also have guidance for cohorting:
    - Long-Term Care Cohorting Recommendations: Residents with Respiratory Illness & COVID-19 Infections (CDPHE)
    - INTERIM Expanded Testing & Cohorting Public Health Strategy to Prevent SARS-CoV-2 Transmission in Nursing Homes, Skilled-Nursing Facilities, and Assisted Living Residences (CDPHE)
    - Responding to Coronavirus (COVID-19) in Nursing Homes (CDC).

Case Management

- **Management in facility:** Residents with milder illness may be treated in the facility if felt to be medically appropriate by their healthcare provider. For more information about clinical management and treatment, see: Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) (CDC).
- **Acute care management:** Transfer of residents to an acute care facility could be considered in the following circumstances:
    - If a resident requires a higher level of care due to medical necessity.
    - If the LTCF is not able to implement or maintain recommended precautions to appropriately care for and protect other residents, transfer to another facility should be considered in consultation with public health and the accepting facility.
- **Transport:** When transporting residents who require hospitalization, residents should wear a facemask over their nose and mouth to contain secretions. **Ensure transport personnel and the receiving hospital are informed of COVID-19 suspicion or diagnosis before arrival. This will allow the transport service and healthcare facility the opportunity to properly prepare.**

Discontinuation of Isolation

- Residents with mild to moderate illness who are not severely immunocompromised:
    - At least 10 days have passed since symptoms first appeared and
    - At least 24 hours have passed since last fever without the use of fever-reducing medications and

    - Symptoms (e.g., cough, shortness of breath) have improved.
    - Note: For residents who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.
- Residents with severe to critical illness or who are severely immunocompromised1:
    - At least 20 days have passed since symptoms first appeared and
    - At least 24 hours have passed since last fever without the use of fever-reducing medications and
    - Symptoms (e.g., cough, shortness of breath) have improved.
    - Note: For severely immunocompromised residents who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test.
- If transmission-based precautions were started empirically for a symptomatic resident and there is no suspected or confirmed COVID-19 outbreak in the facility, the decision to discontinue empiric precautions by excluding the diagnosis of COVID-19 for a suspected COVID-19 patient can be made based upon having negative results from at least one FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2.
    - If a higher level of clinical suspicion for COVID-19 exists, consider maintaining transmission-based precautions and performing a second test for SARS-CoV-2.
    - If a patient suspected of having COVID-19 is never tested, the decision to discontinue transmission-based precautions can be made based upon using the symptom-based strategy described above.
- Additionally, all residents should remain in their rooms as much as possible, making sure residents remain safe and considering resident well-being and mental health.
- For more information, see Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)

Strategies to Optimize the Supply of PPE

- CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent: Strategies to Optimize the Supply of PPE and Equipment (CDC).
- For resource requests: Concept of Operations (CONOPS) for Coronavirus Disease (COVID-19) Personal Protection Equipment Shortage (CDPHE).
- CDPHE FAQ for Personal Protective Equipment: Questions and Answers: Personal Protective Equipment for Use in Long-Term Care Facilities.

Admissions (See Appendix for Figure)

Admission of Residents with Suspected or Confirmed COVID-19

- Hospitalized residents with a history of suspected or confirmed COVID-19 can be admitted to the facility if transmission-based precautions have been discontinued in the hospital based on the above test-based or non-test-based strategies.

    - If the resident's symptoms are resolved, no further restrictions are necessary unless resident activities are restricted due to an ongoing potential or confirmed outbreak.
    - If the resident has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room to the extent possible making sure residents remain safe and considering resident well-being and mental health, and wear a cloth face covering or facemask (if tolerated) during care activities until all symptoms are completely resolved or at baseline.
- Residents with a history of suspected or confirmed COVID-19 that have not met criteria for discontinuation of transmission-based precautions should go to a facility with adequate personal protective equipment supplies and an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be placed at a facility that has already cared for COVID-19 cases, in a specific unit designated to care for COVID-19 residents.
- If facilities designate a separate floor, unit, wing, or other area for admission of residents with COVID-19, these areas should be designed to separate residents with COVID-19 from residents without COVID-19 or whose COVID-19 status is unknown and include physical separation, separate resident populations, separate staff, separate equipment, and adequate PPE. Consultation with public health is advised during the creation of COVID-19 units, and separate guidance is under development.

Admission of Residents Without COVID-19 or With Unknown COVID-19 Status

- During a suspected or confirmed COVID-19 outbreak, the facility should halt new admissions until the outbreak has been contained (see Outbreak Resolution and Containment section below). It may be possible to admit residents to the facility if an unaffected area can clearly be established; however, consultation with public health is recommended.
- When an outbreak is not occurring or is contained, long-term care facilities should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present.
    - For admission of residents who are not suspected or confirmed to have COVID-19, but whose COVID-19 status is unknown, admit to a private room and consider admission to a separate wing/unit or floor (observation area) in order to observe for 14 days.
    - All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Follow strategies to optimize the supply of PPE when supplies are limited.
    - Testing at the end of this period could be considered to increase certainty that the resident is not infected.
    - If the newly admitted resident develops respiratory illness or develops symptoms compatible with COVID19, follow the infection prevention recommendations for isolation and transmission-based precautions (Standard, Contact, and Droplet Precautions, including eye protection).

- Observation is not necessary following medical appointments as these are assumed to have occurred in a controlled environment in which proper infection control measures were maintained; however, the facility may want to consider a policy which includes assessing a resident's risk of COVID-19 exposure following day trips or overnight visits, when a 14-day observation period would be appropriate.
- Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. In addition, residents with a negative test prior to admission should be managed the same as residents with unknown COVID-19 status, including transmission-based precautions during an observation period. The rationale is that a negative test does not rule out incubating disease that might develop during the observation period.

Healthcare Provider Exposure and Infection

HCP with Potential Exposure to COVID-19

- CDC has guidance to assist with assessment of risk and application of work restrictions for asymptomatic HCP with potential exposure to patients, visitors, or other HCP with confirmed COVID-19: Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 (CDC).
- The feasibility and utility of performing contact tracing of exposed HCP and application of work restrictions depends upon the degree of community transmission of SARS-CoV-2 and the resources available for contact tracing.

Return of HCP to Work after Confirmed or Suspected COVID-19

- HCP with mild to moderate illness who are not severely immunocompromised:
    - At least 10 days have passed since symptoms first appeared and
    - At least 24 hours have passed since last fever without the use of fever-reducing medications and
    - Symptoms (e.g., cough, shortness of breath) have improved.
    - Note: HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.
- HCP with severe to critical illness or who are severely immunocompromised:
    - At least 20 days have passed since symptoms first appeared
    - At least 24 hours have passed since last fever without the use of fever-reducing medications and
    - Symptoms (e.g., cough, shortness of breath) have improved
    - Note: HCP who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.
- If HCP have COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis. However, if concurrent COVID-19 infection is suspected based on association with a suspected or confirmed outbreak, return to work criteria should follow the strategies above.
- After returning to work, HCP should follow return to work practices and work restrictions as outlined by CDC.

- For more information, see Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)

Communication

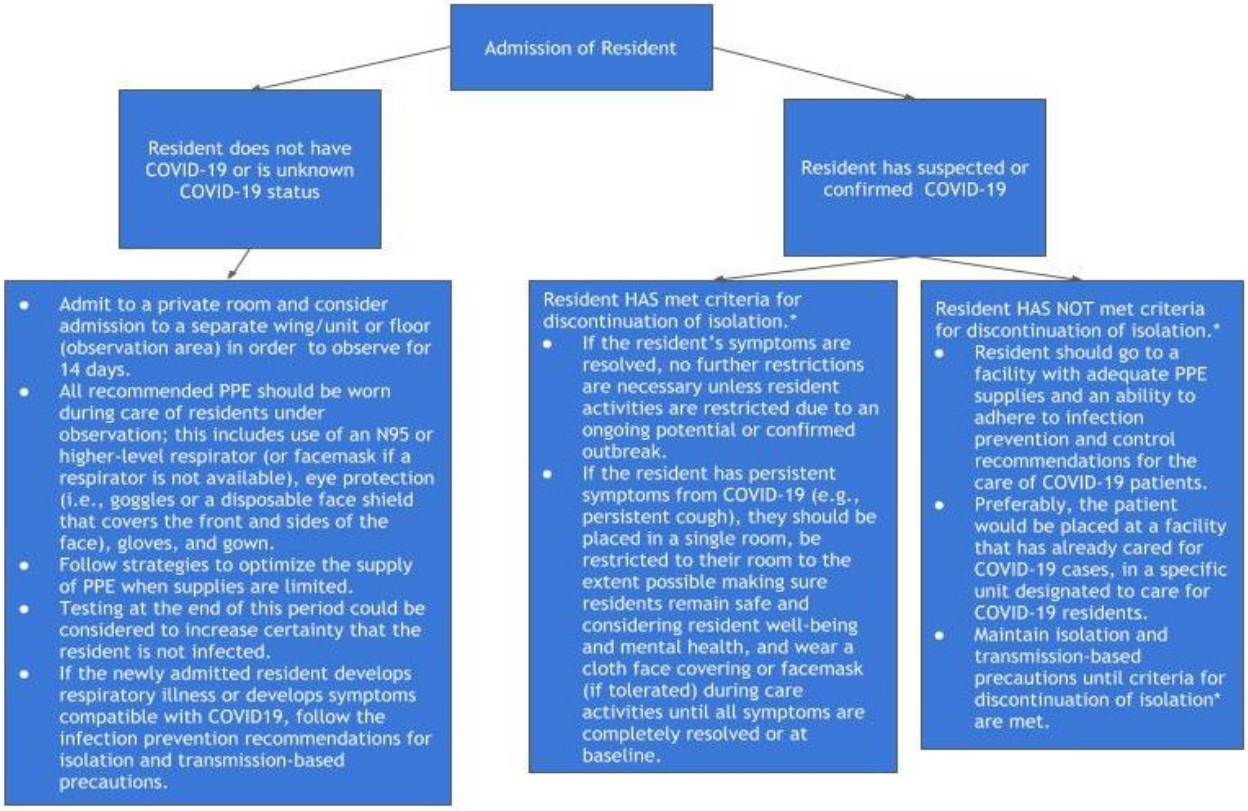
- Communicate with staff, residents, and families about the suspected or confirmed COVID-19 outbreak, and steps the facility is taking to halt the outbreak.
- Confirmed outbreaks will be publicly reported by facility name on the CDPHE website: https://covid19.colorado.gov/outbreak-data.

Outbreak Resolution and Containment

- See Colorado COVID-19 Case and Outbreak Definitions, Healthcare Settings for the definition of outbreak resolution.
- An outbreak may be considered contained 14 days after the onset of symptoms (fever or respiratory symptoms) or date of specimen collection (if asymptomatic) of the last case (in residents or staff), with infection prevention and control precautions in place during that time.
- Consideration can be given to unit-specific outbreak containment in consultation with public health.

Appendix

Figure. Decision Tree for Resident Admissions



*CDPHE recommends use of the symptom-based or time-based strategies for discontinuation of transmission-based precautions in most cases. See text for details.