



TEXAS
Health and Human
Services

Texas Department of State
Health Services

PUBLIC HEALTH REGION 1 EPIDEMIOLOGY

Long-Term Care Facilities Guidance Packet

DSHS Northwest Texas

Public Health Region 1 Serving You



Long-Term Care Facilities Guidance Packet

Goal of this Visit/ Packet:

As Director of Nursing, you are a first line of defense against diseases that threaten public health in Region 1. The goal of providing infection prevention and control guidance is to nurture a working relationship between you and your facility and the Texas Department of State Health Services (DSHS) Public Health Region 1 (PHR 1). The Epidemiology Response Team (ERT) hopes to provide information to assist with issues you face now or may face in the future.

Objectives of this Visit/ Packet:

1. Provide contact information for Public Health Region 1 Epidemiology staff, as well as other departments including Tuberculosis, STD/HIV, and Zoonosis
2. Provide clinicians with reference materials:
 - 2025 Notifiable Conditions List and Poster
 - Notifiable Conditions Reporting Form and STD/HIV Reporting Form
 - Updates to Reporting Respiratory Outbreaks Including COVID-19
 - Information on Infectious Diseases Including HAIs/MDROs, Respiratory Viruses, Vaccine Preventable Diseases, and Foodborne/Waterborne Illnesses
 - Infection Prevention and Control Infographics
3. Collect information for contacting key personnel at your facility, including 24/7 emergency contact telephone/pager numbers.

Your commitment to protecting the Public's Health is appreciated!

Epidemiology Response Team, Public Health Region 1
6302 Iola Avenue
Lubbock, Texas 79424
DSHS PHR 1 Epidemiology 24/7 Phone: 806-778-7391
Email: PHR1.EpiReporting@dshs.texas.gov

Useful Links

Texas DSHS PHR 1 Epidemiology and Surveillance <https://www.dshs.texas.gov/regional-local-health-operations/texas-public-health-region-1/public-health-region-1/public-health-region-1-18>
CDC Project Firstline Infection Control Training <https://www.cdc.gov/project-firstline/>
CDC Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19) <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>
CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>
Texas DSHS Measles Outbreak In Texas <https://www.dshs.texas.gov/measles>
Texas DSHS Measles Information for Health Care Providers <https://www.dshs.texas.gov/measles/information-health-care-providers>
Texas DSHS Reported Diseases Annual Reports <https://www.dshs.texas.gov/idps-home/infectious-disease-data-statistics/texas-annual-reports>



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Questions about Reportable Conditions?

Email us at PHR1.EpiReporting@dshs.Texas.gov or send fax to [806-783-6466](tel:806-783-6466)

For more information, visit dshs.texas.gov/idcu

Public Health Region 1

Contact Information for STD/HIV, TB Elimination, & Zoonosis Staff

Physical/Mailing Address: 6302 Iola Avenue, Lubbock, TX 79424

Program

Contact Information

Epidemiology

24/7 Reporting Phone: (806) 778-7391

Fax: (806) 783-6466

Email: PHR1.EpiReporting@dshs.texas.gov

STD/HIV

Point Of Contact: Irene Rodriguez

Phone: (806) 783-6437

Fax: (806) 783-6408

TB Elimination

Point Of Contact: Dezni Taylor

Phone: (806) 783-6420

Fax: (806) 783-6497

Email: dezni.taylor@dshs.texas.gov OR

melanie.lee@dshs.texas.gov

Zoonosis

Point Of Contact: Christi Olszewski

Phone: (806) 783-6484

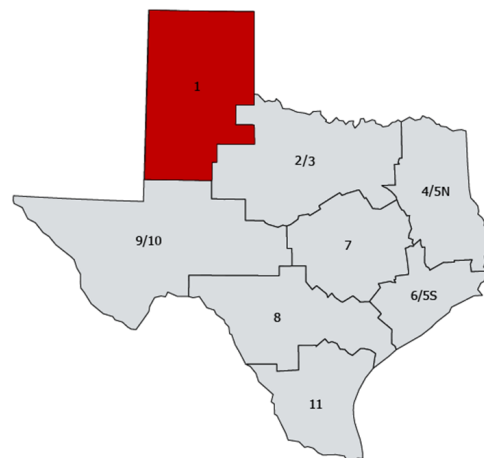
Fax: (806) 783-6466

Email: PHR1Zoonosis@dshs.texas.gov

OR

Point Of Contact: Tonya Finch

Phone: (806) 477-1104



DSHS Northwest Texas

Public Health Region 1 Serving You



TEXAS
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**Texas Department of State
Health Services**

dshs.texas.gov/region1

Important message about HIPAA Privacy Standards to providers and entities that submit protected health information to the Texas Department of State Health Services

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations implemented standards for how information that identifies a patient can be used and disclosed. (Title 45, Code of Federal Regulations (CFR), Parts 160 and 164) The regulations apply to "covered entities" including health-care plans, health-care clearinghouses, and health-care providers. These privacy standards go into effect on April 14, 2003.

The regulations were amended in August 2002 deleting the requirement to obtain an individual's consent for the use and disclosure of private health information for treatment, payment and health care operations. (45 CFR §164.506).

You can continue to submit information you currently submit to DSHS under one or more of the following exceptions in the HIPAA Privacy Standards:

- **USE AND DISCLOSURE REQUIRED BY LAW:**

Section 164.512(a) allows covered entities to use and disclose private health information if the use or disclosure is required by law. For example, DSHS rules require certain diseases, injuries and conditions to be reported to DSHS. Under the "required by law" exception you can continue to comply with these mandatory reporting rules.

- **USE AND DISCLOSURE FOR PUBLIC HEALTH ACTIVITIES:**

Section 164.512(b) permits covered entities to release private health information to a public health authority that is authorized by law to collect and receive information for preventing and controlling disease, injury, or disability. This information includes reporting of; disease, injury, vital statistics like births, deaths, marriages, divorces, etc., public health investigations, and public health interventions. Under this exception you are authorized to release information to DSHS, or other public health authorities. Disclosure can be initiated by either the public health authority or by you, if it is for one of the above reasons.

- **USE AND DISCLOSURE FOR HEALTH OVERSIGHT ACTIVITIES:**

Section 164.512(d) permits covered entities to disclose private health information to a health oversight agency for oversight activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, or other activities necessary for the oversight of the health-care system, government benefit programs, compliance with governmental regulation or compliance with civil rights laws.

- **USE AND DISCLOSURE FOR LAW ENFORCEMENT PURPOSES:**

Section 164.512(f) permits disclosure of private health information to a law enforcement officer for certain law enforcement purposes.

- **USE AND DISCLOSURE TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY:**

Section 164.512(j) permits disclosure of private health information if a covered entity in good faith believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The disclosure must be made to a person who is reasonably able to prevent or lessen the threat, or for identification and apprehension of an individual.

THIS NOTICE IS YOUR AUTHORIZATION UNDER THE ABOVE EXCEPTIONS TO CONTINUE TO REPORT THE INFORMATION YOU CURRENTLY REPORT TO DSHS AND OTHER PUBLIC HEALTH, LAW ENFORCEMENT, AND REGULATORY AUTHORITIES.

Please send questions via Email to: [HIPAA Privacy Officer](#).

Texas Health Safety Code

Sec. 81.061. INVESTIGATION.

(a) The department shall investigate the causes and effects of communicable disease and methods of prevention.

(b) The department may require special investigations of specified cases of disease to evaluate the status in this state of epidemic, endemic, or sporadic diseases. Each health authority shall provide information on request according to the department's written instructions.

(c) The department may investigate the existence of communicable disease in the state to determine the nature and extent of the disease and potential effects on the health of individuals and to formulate and evaluate the control measures used to protect the public health. A person shall provide records and other information to the department on request according to the department's written instructions.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 1087 (H.B. 3576), Sec. 3, eff. September 1, 2017.

Texas Administrative Code

Title 25 - HEALTH SERVICES

Part 1 - DEPARTMENT OF STATE HEALTH SERVICES

Chapter 97 - COMMUNICABLE DISEASES

Subchapter A - CONTROL OF COMMUNICABLE DISEASES

Section 97.10 - Confidential Nature of Case Reporting and
Records

(a) All individual morbidity case reports received by the health authority or the Department of State Health Services (department) are confidential records and not public records.

(b) To implement disease control measures authorized in these sections, it may be necessary for the health authority or the department to investigate public or private health records including patient medical records pertinent to the notifiable condition. On request, a person shall provide the department with records, data, and other information according to the written instruction of the department. The health authority and the department shall keep this information confidential.

(c) The department may use information obtained from reports or health records for statistical and epidemiological studies which may be public information as long as the information does not permit the identification of an individual.

Texas Notifiable Conditions - 2025

Report all Confirmed and Suspected cases

24/7 Number for Immediately Reportable – 1-800-705-8868



Unless noted by*, report to your local or regional health department using number above or find contact information at <http://www.dshs.texas.gov/idcu/investigation/conditions/contacts/>



A – L	When to Report	L – Y	When to Report
*Acquired immune deficiency syndrome (AIDS) ¹	Within 1 week	Legionellosis ²	Within 1 week
Amebic meningitis and encephalitis ²	Within 1 week	Leishmaniasis ²	Within 1 week
Anaplasmosis ²	Within 1 week	Listeriosis ^{2, 3}	Within 1 week
Anthrax ^{2, 3, 4}	Call Immediately	Lyme disease ²	Within 1 week
Arboviral infections ^{2, 5, 6}	Within 1 week	Malaria ²	Within 1 week
*Asbestosis ⁷	Within 1 week	Measles (rubeola) ²	Call Immediately
Ascariasis ²	Within 1 week	Melioidosis ^{2, 4}	Call Immediately
Babesiosis ^{2, 6}	Within 1 week	Meningococcal infection, invasive (Neisseria meningitidis) ^{2, 3}	Call Immediately
Botulism (adult and infant) ^{2, 3, 4, 8}	Call Immediately ⁸	Mumps ²	Within 1 work day
Brucellosis ^{2, 3, 4}	Within 1 work day	Paragonimiasis ²	Within 1 week
Campylobacteriosis ²	Within 1 week	Pertussis ²	Within 1 work day
*Cancer ⁹	See rules ⁹	*Pesticide poisoning, acute occupational ¹⁰	Within 1 week
Candida auris ^{2, 3}	Within 1 work day	Plague (Yersinia pestis) ^{2, 3, 4}	Call Immediately
Carbapenem-resistant Enterobacterales (CRE) ^{2, 11}	Within 1 work day	Poliomyelitis, acute paralytic ²	Call Immediately
Chagas disease ^{2, 6}	Within 1 week	Poliovirus infection, non-paralytic ²	Within 1 work day
*Chancroid ¹	Within 1 week	Prion diseases, such as Creutzfeldt-Jakob disease (CJD) ^{2, 12}	Within 1 week
*Chickenpox (varicella) ¹³	Within 1 week	Q fever ²	Within 1 work day
*Chlamydia trachomatis infection ¹	Within 1 week	Rabies, human ²	Call Immediately
*Contaminated sharps injury ¹⁴	Within 1 month	Rubella (including congenital) ²	Within 1 work day
* Controlled substance overdose ¹⁵	Report Immediately	Salmonellosis, including typhoid fever ^{2, 3}	Within 1 week
Coronavirus, novel ^{2, 16}	Call Immediately	Shiga toxin-producing <i>Escherichia coli</i> ^{2, 3}	Within 1 week
<i>Cronobacter</i> spp. in infants, invasive ²	Within 1 week	Shigellosis ²	Within 1 week
Cryptosporidiosis ²	Within 1 week	Smallpox ^{2, 4}	Call Immediately
Cyclosporiasis ²	Within 1 week	*Spinal cord injury ¹⁷	Within 10 work days
Cysticercosis ²	Within 1 week	Spotted fever rickettsiosis ²	Within 1 week
Diphtheria ^{2, 3}	Call Immediately	Streptococcal disease (<i>S. pneumo</i>), invasive ^{2, 3}	Within 1 week
*Drowning/near drowning ¹⁷	Within 10 work days	* Syphilis – primary and secondary stages ^{1, 18}	Within 1 work day
Echinococcosis ²	Within 1 week	*Syphilis – all other stages including congenital syphilis ^{1, 18}	Within 1 week
Ehrlichiosis ²	Within 1 week	<i>Taenia solium</i> and undifferentiated <i>Taenia</i> infection ²	Within 1 week
Fascioliasis ²	Within 1 week	Tetanus ²	Within 1 week
*Gonorrhea ¹	Within 1 week	Tick-borne relapsing fever (TBRF) ²	Within 1 week
<i>Haemophilus influenzae</i> , invasive ^{2, 3}	Within 1 week	*Traumatic brain injury ¹⁷	Within 10 work days
Hansen's disease (leprosy) ¹⁹	Within 1 week	Trichinosis ²	Within 1 week
Hantavirus infection ²	Within 1 week	Trichuriasis ²	Within 1 week
Hemolytic uremic syndrome (HUS) ²	Within 1 week	Tuberculosis (Mycobacterium tuberculosis complex) ^{3, 20}	Within 1 work day
Hepatitis A ²	Within 1 work day	Tuberculosis infection ²¹	Within 1 week
Hepatitis B, C, and E (acute) ²	Within 1 week	Tularemia ^{2, 3, 4}	Call Immediately
Hepatitis B infection identified prenatally or at delivery (mother) ²	Within 1 week	Typhus ²	Within 1 week
Hepatitis B, perinatal (HBsAg+ < 24 months old) (child) ²	Within 1 work day	Vancomycin-intermediate Staph aureus (VISA) ^{2, 3}	Call Immediately
Hookworm (ancylostomiasis) ²	Within 1 week	Vancomycin-resistant Staph aureus (VRSA) ^{2, 3}	Call Immediately
* Human immunodeficiency virus (HIV), acute infection ^{1, 22}	Within 1 work day	Vibrio infection, including cholera ^{2, 3}	Within 1 work day
*Human immunodeficiency virus (HIV), non-acute infection ^{1, 22}	Within 1 week	Viral hemorrhagic fever (including Ebola) ^{2, 4}	Call Immediately
Influenza-associated pediatric mortality ²	Within 1 work day	Yellow fever ²	Call Immediately
Influenza, novel ²	Call Immediately	Yersiniosis ²	Within 1 week
* Lead, child blood, any level & adult blood, any level ²³	Call/Fax Immediately		

In addition to specified reportable conditions, **any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported by the most expeditious means available.** ²⁴ This includes any case of a select agent. ⁴

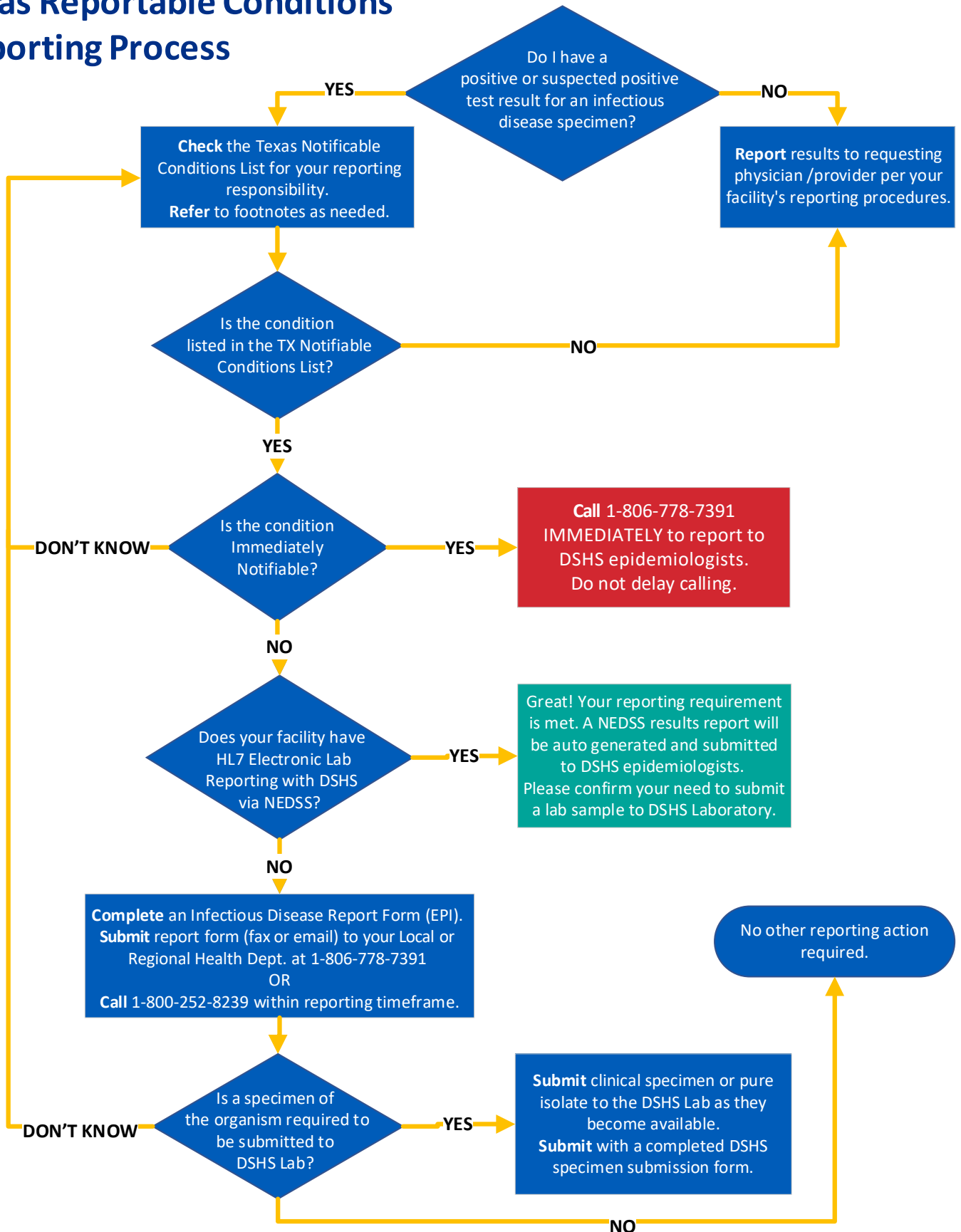
See select agent list at <https://www.selectagents.gov/selectagentsandtoxinslist.html>

*See condition-specific footnotes for reporting contact information

Texas Notifiable Conditions Footnotes - 2025

- ¹ Please refer to specific rules and regulations for HIV/STD reporting and who to report to at: <http://www.dshs.texas.gov/hivstd/healthcare/reporting.shtm>.
- ² Reporting forms are available at <http://www.dshs.texas.gov/idcu/investigation/forms/> and investigation forms at <http://www.dshs.texas.gov/idcu/investigation/>. Call as indicated for immediately reportable conditions.
- ³ Lab samples of the following must be sent to the Department of State Health Services, Laboratory Services Section, 1100 West 49th Street, Austin, Texas 78756-3199 or other public health laboratory as designated by the Department of State Health Services: anthrax (*Bacillus anthracis*; also requested - *Bacillus cereus* isolates that may contain anthrax toxin genes from patients with severe disease or death); botulism, adult and infant (*Clostridium botulinum*); brucellosis (*Brucella* species); *Candida auris*; diphtheria (*Corynebacteria diphtheriae* from any site); all *Haemophilus influenzae*, invasive, in children under five years old (*Haemophilus influenzae* from normally sterile sites); listeriosis (*Listeria monocytogenes*); meningococcal infection, invasive (*Neisseria meningitidis* from normally sterile sites or purpuric lesions); plague (*Yersinia pestis*); salmonellosis, including typhoid fever (*Salmonella* species; also requested - specimens positive for *Salmonella* by culture-independent diagnostic testing (CIDT) methods); Shiga toxin-producing *Escherichia coli* infection (*E. coli* O157:H7, isolates or specimens from cases where Shiga toxin activity is demonstrated); *Staphylococcus aureus* with a vancomycin minimum inhibition concentration (MIC) greater than 2 micrograms per milliliter (µg/mL); all *Streptococcus pneumoniae*, invasive, in children under five years old (*Streptococcus pneumoniae* from normally sterile sites); tuberculosis (*Mycobacterium tuberculosis* complex); tularemia (*Francisella tularensis*); vibriosis (*Vibrio* species; also requested - specimens positive for *Vibrio* by culture-independent diagnostic testing (CIDT) methods); and any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern may require submission of cultures or specimens. Pure cultures (or specimens) should be submitted as they become available accompanied by a current department Specimen Submission Form. See the [Texas Administrative Code \(TAC\) Chapter 97](#): §97.3(a)(4), §97.4(a)(6), and §97.5(a)(2)(C). Call 512-776-7598 for specimen submission information.
- ⁴ Please secure [Select Agent isolates](#) and specimens in accordance with the guidance in the [Select Agent Regulation](#), and immediately initiate a consultation with public health regarding need for further testing or sequencing. Notify any transfer facilities of any test results of high consequence/interest.
- ⁵ Arboviral infections including, but not limited to, those caused by California serogroup viruses, chikungunya virus, dengue virus, Eastern equine encephalitis (EEE) virus, St. Louis encephalitis (SLE) virus, Western equine encephalitis (WEE) virus, West Nile (WN) virus, and Zika virus.
- ⁶ All blood collection centers should report all donors with reactive tests for West Nile virus, Zika virus, *Babesia* species, and *Trypanosoma cruzi* (Chagas disease) to the DSHS Zoonosis Control Branch. If your center uses a screening assay under an IND protocol, please include results of follow-up testing as well. To report, send a secure email to WNV@dshs.texas.gov or fax the report to 512-776-7454. Providing the following: Collection Agency; Unique BUI #; Test Name, Collection Date; Last Name, First Name, Donor Phone Number, Donor Address, Date of Birth, Age, Sex, Race, and Hispanic Ethnicity (Y/N). If your location has a city or county health department, DSHS recommends that you also share this same information with them.
- ⁷ For asbestos reporting information see <http://www.dshs.texas.gov/epitox/Asbestosis-and-Silicosis-Surveillance/>.
- ⁸ Report suspected botulism immediately by phone to 888-963-7111.
- ⁹ For more information on cancer reporting rules and requirements go to <http://www.dshs.texas.gov/tcr/reporting.shtm>.
- ¹⁰ For pesticide reporting information see <https://www.dshs.texas.gov/sites/default/files/epitox/pestrptfrm.pdf>.
- ¹¹ *Escherichia coli* or *Klebsiella* species that are resistant to at least one carbapenem antibiotic or produce a carbapenemase.
- ¹² For purposes of surveillance and notification, Prion diseases, such as Creutzfeldt-Jakob disease (CJD) includes sporadic CJD (sCJD), and also includes sporadic fatal insomnia (sFI), Variably Protease-Sensitive Prionopathy (VPSPr), any genetic CJD (gCJD) or familial CJD (fCJD), fatal familial insomnia (FFI), Gerstmann-Sträussler-Scheinker syndrome (GSS), iatrogenic CJD (iCJD), Kuru, variant CJD (vCJD), and any novel prion disease affecting humans.
- ¹³ Call your [local health department](#) for a copy of the Varicella Reporting Form with their fax number. The [Varicella \(Chickenpox\) Reporting Form](#) should be used instead of an Epi-1 or Epi-2 morbidity report.
- ¹⁴ Applicable for governmental entities. Not applicable to private facilities. ([TAC §96.201](#)) Initial reporting forms for Contaminated Sharps at http://www.dshs.texas.gov/idcu/health/infection_control/bloodborne_pathogens/reporting/.
- ¹⁵ To report a Controlled Substance Overdose, go to <https://odreport.dshs.texas.gov/>.
- ¹⁶ Novel coronavirus causing severe acute respiratory disease includes Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). Call immediately for SARS, MERS, or any other novel coronavirus cases. Coronavirus Disease 2019 (COVID-19) is no longer considered a novel coronavirus and as of March 1, 2024 is no longer a notifiable disease condition in Texas.
- ¹⁷ Please refer to specific rules and regulations for injury reporting and who to report to at <http://www.dshs.texas.gov/injury/rules.shtm>.
- ¹⁸ Laboratories should report syphilis test results within 3 work days of the testing outcome.
- ¹⁹ Reporting forms are available at <https://www.dshs.texas.gov/idcu/disease/hansens/forms.shtm>.
- ²⁰ Reportable tuberculosis disease includes the following: suspected tuberculosis disease pending final laboratory results; positive nucleic acid amplification tests; clinically or laboratory-confirmed tuberculosis disease; and all *Mycobacterium tuberculosis* (*M. tb*) complex including *M. tuberculosis*, *M. bovis*, *M. africanum*, *M. canettii*, *M. microti*, *M. caprae*, and *M. pinnipedii*. See rules and reporting information at <http://www.dshs.texas.gov/idcu/disease/tb/reporting/>.
- ²¹ TB infection is determined by a positive result from an FDA-approved Interferon-Gamma Release Assay (IGRA) test such as T-Spot® TB or QuantiFERON® - TB GOLD In-Tube Test or a tuberculin skin test, and a normal chest radiograph with no presenting symptoms of TB disease. See rules and reporting information at <http://www.dshs.texas.gov/idcu/disease/tb/reporting/>. Please report skin test results in millimeters.
- ²² Any person suspected of having HIV should be reported, including HIV exposed infants.
- ²³ For lead reporting information see <http://www.dshs.texas.gov/lead/Reporting-Laws-Administrative-Code.aspx>.
- ²⁴ For more information on Mpox reporting requirements go to <https://www.dshs.texas.gov/monkeypox/monkeypox-information-public-health>.

Texas Reportable Conditions Reporting Process



Required TX Notifiable Specimens for Submission to DSHS Laboratory

Required Isolates or Clinical Specimens	Submission Form	Reporting/Specimen Submission and Submission Form Tips
<i>Bacillus anthracis</i> isolates	G-27A	Call Immediately: 1-806-778-7391 Must be shipped as Category A. - Select <i>Bacillus anthracis</i> in Section 5 of G-27A.
<i>Bacillus cereus</i> isolates that may contain anthrax toxin genes from patients with severe disease or death	G-27A	Call Immediately: 1-806-778-7391 - Select "Bacillus cereus suspected of containing anthrax genes" in Section 5 of G-27A.
<i>Clostridium botulinum</i> isolates	G-27A	Call Immediately: 1-806-705-7391 Must be shipped as Category A. - Select appropriate boxes in Sections 3 and 4 of G-27A.
<i>Brucella</i> species isolates	G-27A	Notify DSHS Within 1 Workday. Must be shipped as Category A. - Select <i>Brucella</i> spp. in Section 5 of G-27A.
<i>Candida auris</i> isolates	G-2E	Notify DSHS Within 1 Workday. - Select "Isolates" in Section 4, Box 1 - Select "Candida Identification by MALDI" in Section 4, Box 1.
<i>Corynebacterium diphtheriae</i> isolates	G-2B	Call Immediately: 1-806-778-7391 - Indicate in Section 2 that specimen is associated with an outbreak or for surveillance, per epidemiologist guidance. - Select <i>Corynebacterium diphtheriae</i> in Section 4.1 of G-2B.
<i>Francisella tularensis</i> isolates	G-27A	Call Immediately: 1-806-778-7391 Must be shipped as Category A. - Select <i>Francisella tularensis</i> in Section 5 of G-27A.
<i>Haemophilus influenzae</i> isolates (invasive) from normally sterile sites in children younger than 5 years old	G-2B	- Submit invasive specimens from normally sterile sites in children younger than 5 years only. (e.g., blood or CSF) - Indicate in Section 2 that specimen is associated with an outbreak or is for surveillance. - Select <i>Haemophilus influenzae</i> in Section 4.1 of G-2B.
<i>Listeria monocytogenes</i> isolates	G-2B	- Indicate in Section 2 of G-2B that specimen is associated with an outbreak/for surveillance. - Select <i>Listeria</i> in Section 9 of G-2B.
<i>Mycobacterium tuberculosis</i> complex, isolates of all complex members	G-MYCO	Notify DSHS Within 1 Workday. Must be submitted as Category A. - Check the "MTB Genotyping Only/for Compliance" option in Section 5 of G-MYCO.
<i>Neisseria meningitidis</i> isolates from normally sterile sites or purpuric lesions	G-2B	Call Immediately: 1-806-778-7391 - Indicate in Section 2 of G-2B that specimen is associated with an outbreak or is for surveillance. - Select <i>Neisseria meningitidis</i> in Section 4.1 of G-2B.
<i>Salmonella</i> species isolates, including <i>Salmonella</i> positive specimens (by C1DT)	G-2B	- Indicate in Section 2 of G-2B that specimen is associated with an outbreak or is for surveillance. - Select <i>Salmonella</i> in Section 4.1 of G-2B.
Shiga toxin-producing <i>Escherichia coli</i> (All <i>E. coli</i> O157:H7 isolates and any <i>E. coli</i> isolates/specimens that demonstrate Shiga toxin activity)	G-2B	Must be shipped as Category A. - Indicate in Section 2 of G-2B that specimen is associated with an outbreak or is for surveillance. - Select "Shiga toxin-producing <i>Escherichia coli</i>" in Section 4.1.
<i>Staphylococcus aureus</i> with a vancomycin MIC greater than 2µg/mL (VISA and VRSA)	G-2B	- Indicate in Section 2 of G-2B that specimen is associated with an outbreak or is for surveillance. - Select <i>Staphylococcus aureus</i> in Section 4.1 of G-2B.
<i>Streptococcus pneumoniae</i> isolates from normally sterile sites in children younger than 5 years old	G-2B	- Indicate in Section 2 of G-2B that specimen is associated with an outbreak or is for surveillance. - Select <i>Streptococcus pneumoniae</i> in Section 4.1 of G-2B.
<i>Vibrio</i> species isolates; also submit <i>Vibrio</i> C1DT positive specimens.	G-2B	Notify DSHS Within 1 Workday. - Indicate in Section 2 of G-2B that specimen is associated with an outbreak or is for surveillance. - Select <i>Vibrio</i> sp. or <i>Vibrio cholera</i> in Section 4.1 of G-2B.
<i>Yersinia pestis</i> isolates	G-27A	Call Immediately: 1-800-778-7391 Must be shipped as Category A. - Select <i>Yersinia pestis</i> in Section 5 of G-27A.

Be Kind, Report on Time

Call Us When



You suspect a patient has a notifiable condition that requires immediate reporting.



You see a cluster of patients sharing similar symptoms or suspect a common exposure source.



You see unusual signs or symptoms that you don't normally see or can't identify.



phr1.EpiReporting@dshs.texas.gov



DSHS PHR 1 Epidemiology Main:
806-744-3577



DSHS Epidemiology Division 24/7:
806-778-7391

Point your camera
here to learn
more about
reporting.



For Office Use Only:

Epidemiologist: _____ County: _____ Onset Date: _____ Report Date: _____



TEXAS DEPARTMENT OF STATE HEALTH SERVICES
PHR 1 Epidemiology and Surveillance

Notifiable Conditions Reporting Form

Version 03-27-19

Please **complete** all spaces as appropriate:

Notifiable Condition: _____

Patient Information

Patient Name: _____ D.O. B. _____ Age _____

Sex: _____ Race: _____ Ethnicity: _____ Hispanic _____ Not Hispanic _____

Address: _____

Street Address City State Zip County

Phone# _____ Alternate Phone# _____

Pregnancy Status: yes/no if yes, how many weeks: _____ Delivery Date: _____

Hepatitis ONLY: (Circle Type) HAV HBV HCV ☐ Acute ☐ Chronic Dx Date: _____
SGOT/AST: _____ Collection Date: _____ SGPT/ALT: _____ Collection Date: _____

Reporting Institute Information

Reported by: _____

Contact Person: _____ Phone # _____

Address: _____

Street Address City State Zip County

Lab Used: _____

Specimen Type: _____ Date of Collection: _____ Lab Report Date: _____

Patient Treatment Information

Reporting Physician: _____ Phone # _____

Date of Treatment: _____ Treatment Given: _____

Admitted? Y N If yes, admit date: _____ Discharge date: _____

Alternative Contact Information

Name: _____ Phone: _____ Relationship to Patient _____

Address: _____

Street Address City State Zip County

Please fax a copy of pertinent lab reports and this form for all notifiable conditions to:

Texas Department of State Health Services
Epidemiology and Surveillance
6302 Iola Avenue Lubbock, TX 79424
Email: PHR1.EpiReporting@dshs.texas.gov
Telephone: (806) 783-6461 Facsimile: (806) 783-6466



Texas Department of State Health Services

HIV/STD Reporting Form

Patient Information:

Name: _____ DOB: ____/____/____ Age: ____ SS# ____-____-____
Sex: ____ Race: ____ Ethnicity: ____ Marital Status: ____ Ph#: _____
Pregnancy Status: Yes / No, If yes how many weeks? _____ PID: Yes / No

Address: _____
Street City State Zip

Reportable Condition 1: _____ Date Collected: ____/____/____
Reportable Condition 2: _____ Date Collected: ____/____/____

Treatment Information:

Date of Treatment: ____/____/____ Treatment Given: _____

Partner Information:

Name: _____ DOB: ____/____/____ SS# ____-____-____
Sex: ____ Race: ____ Ethnicity: ____ Marital Status: ____ Ph#: _____
Pregnancy Status: Yes / No, If yes how many weeks? _____ PID: Yes / No
Address: _____
Street City State Zip

Date of Treatment: ____/____/____ Treatment Given: _____

Reporting Facility:

Reported By (Facility): _____
Contact Person: _____ Phone #: _____
Address: _____
Street City State Zip

Reference Lab (if used): _____

*****Please Attach Copy of Lab Report with HIV/STD Report Form and Mail or FAX to:*****

Texas Department of State Health Services
Attn: HIV/STD Division
6302 Iola
Lubbock, Texas 79424
Fax # (806) 783 - 6408
If any questions, please call (806)783-6437

Form:F50-13029



APIC

Spreading knowledge.
Preventing infection.™

Join APIC-Texas Panhandle

We are seeking active APIC members and non members to join our organizational chapter. The mission of APIC is to advance the science and practice of infection prevention and control. The Texas Panhandle chapter:

- educates healthcare personnel and public health about infectious diseases
- provides the most updated guidance from APIC, CDC, CSTE, WHO, and ACIP
- connect with other frontline members involved in acute care, long term care and outpatient facilities

Texas Panhandle services the South Plains, New Mexico and Oklahoma. Membership to APIC is recommended to join but not required. Our chapter meets monthly online via Zoom and hosts one annual in-person meeting.

For questions about the chapter or to join Texas Panhandle, contact Tiffany Torres ttorres@mylubbock.us or scan the QR code below.



Reporting Respiratory Outbreaks

Reporting Guidance

As of March 2024, Texas no longer requires reporting of most individual COVID-19 cases.

There are some situations in which COVID-19 and other respiratory illnesses are reportable. They include outbreaks or an unusual group expression of the disease.

With the evolving landscape of respiratory surveillance, DSHS recommends the following prioritization to focus resources on areas of highest impact:



Priority 1

Reported COVID-19-associated outbreak(s) and other respiratory illnesses in any population or facility. Includes nursing homes, assisted-living facilities, day cares, correctional facilities, schools, camps, and mass gatherings.



Priority 2

Unusual group expression of COVID-19 and other respiratory illnesses that may be of public health concern per Texas Administrative Code Rule 97.3 should be reported as soon as possible.



phr1.epireporting@dshs.texas.gov



DSHS PHR 1 Epidemiology: 806-783-6448

**Point your camera
here to learn more
about reporting
respiratory outbreaks.**



DSHS Northwest Texas

Public Health Region 1 Serving You



TEXAS
Health and Human
Services

**Texas Department of State
Health Services**

dshs.texas.gov/region1

Respiratory Virus Guidance Snapshot



Core prevention strategies

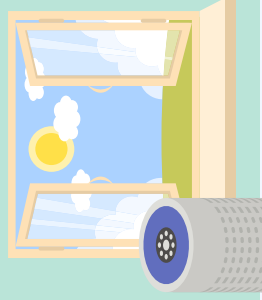
Immunizations



Hygiene



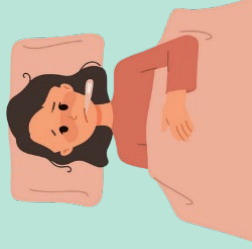
Steps for Cleaner Air



Treatment

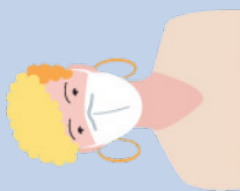


Stay Home and Prevent Spread*



Additional prevention strategies

Masks



Distancing



Tests



Layering prevention strategies can be especially helpful when:

- ✓ Respiratory viruses are causing a lot of illness in your community
- ✓ You or those around you have risk factors for severe illness
- ✓ You or those around you were recently exposed, are sick, or are recovering

***Stay home and away from others until, for 24 hours BOTH:**



Your symptoms are getting better **You are fever-free (without meds)**



Then take added precaution for the next 5 days

Infection Control for Respiratory Viruses

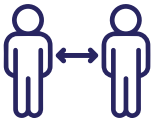
Use the following infection control measures to prevent and slow the spread of respiratory infections in your facility.



Use of well-fitting masks or respirators, that cover a person's mouth and nose, can prevent the spread of germs when people are breathing, talking, sneezing, or coughing.



Encourage everyone in your facility to get recommended vaccinations. Vaccination is a safe and effective strategy for reducing disease spread and staff absenteeism.



Practice physical distancing, particularly in shared spaces such as waiting rooms, and implement screening and triage procedures. Use signs as visual reminders for patients, implement rapid screening, and separate symptomatic patients as soon as possible.



Practice respiratory hygiene and cough etiquette and encourage others to do the same. Provide masks, tissues, and no-touch receptacles for tissue disposal at facility entrances, triage areas, and waiting rooms.



Clean your hands regularly with an alcohol-based hand sanitizer or soap and water. Share key messages and reminders within in your facility by using CDC's [Clean Hands Count](#) resources.



Clean and disinfect regularly. Lobby areas, cafeterias, and waiting rooms are all high-traffic spaces where germs can spread. It's also important to disinfect reusable devices and not reuse disposable items.



Check that the air handling in your facility is functioning as it should. Make sure air vents aren't blocked, and consult with facilities management to ensure the heating, ventilation, and air conditioning, or HVAC, system is working efficiently for proper ventilation.

For more information on infection control recommendations for healthcare settings, visit

<https://bit.ly/3O1UXhM>

www.cdc.gov/ProjectFirstline

**WE HAVE THE POWER
TO STOP INFECTIONS.
TOGETHER.**



Medidas de control de infecciones para virus respiratorios

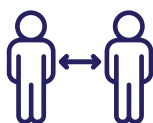
Use las siguientes medidas de control de infecciones para prevenir y desacelerar la propagación de infecciones respiratorias en su centro médico.



El uso de mascarillas o respiradores que se ajusten bien y cubran la boca y la nariz puede prevenir la propagación de microbios cuando las personas respiran, hablan, estornudan o tosen.



Anime a todas las personas en su centro médico a que se pongan las vacunas recomendadas. La vacunación es una estrategia segura y eficaz para reducir la propagación de enfermedades y el ausentismo del personal.



Practique el distanciamiento físico, especialmente en los lugares compartidos, como las salas de espera, e implemente procedimientos de detección y triaje. Use carteles como recordatorios visuales para los pacientes, implemente pruebas rápidas de detección y separe a los pacientes sintomáticos lo antes posible.



Practique la higiene respiratoria y precauciones al toser y anime a los demás a hacer lo mismo. Proporcione mascarillas, pañuelos desechables y recipientes que no se tengan que tocar para desecharlos en las entradas del centro médico, así como en áreas de triaje y salas de espera.



Límpiese las manos regularmente con un desinfectante de manos a base de alcohol o con agua y jabón. Comparta mensajes clave en su centro médico mediante el uso de los recursos de la campaña [Las Manos Limpias Cuentan](https://www.cdc.gov/campaigns/cleanhands/) de los CDC.



Limpie y desinfecte con regularidad. Las áreas de entrada, las cafeterías y las salas de espera son espacios con mucho tránsito de personas donde los microbios se pueden propagar. También es importante desinfectar los dispositivos reutilizables y no volver a usar los artículos desechables.



Verifique que el sistema de circulación de aire en su centro médico esté funcionando adecuadamente. Asegúrese de que las rejillas de ventilación no estén obstruidas y consulte con la gerencia del centro médico para cerciorarse de que el sistema de calefacción, ventilación y aire acondicionado (HVAC) esté funcionando de forma eficiente para que haya una ventilación adecuada.

Para obtener más información sobre las recomendaciones de control de infecciones en entornos de atención médica, consulte

<https://bit.ly/3O1UXhM>



COVID-19

Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

Updated Mar. 18, 2024

Summary of Recent Changes

Updates as of September 23, 2022



- In most circumstances, asymptomatic HCP with higher-risk exposures **do not** require work restriction.
- Updated recommendations for testing frequency to detect potential for variants with shorter incubation periods and to address the risk for false negative antigen tests in people without symptoms.

[Previous updates](#)

Key Points

- In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2.

Background

This interim guidance is intended to assist with the following:

1. Determining the duration of restriction from the workplace for HCP with SARS-CoV-2 infection.
2. Assessment of risk and application of workplace restrictions for asymptomatic HCP with exposure to SARS-CoV-2.

Guidance addressing recommended infection prevention and control practices including use of source control by HCP is available in [Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\)](#)

Employers should be aware that other local, territorial, tribal, state, and federal requirements may apply, including those promulgated by the Occupational Safety and Health Administration (OSHA).

Evaluating Healthcare Personnel with Symptoms of SARS-CoV-2 Infection

HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays.

When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.

- If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.

For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses.

Return to Work Criteria for HCP with SARS-CoV-2 Infection

The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immunocompromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

HCP with [mild to moderate illness](#) who are *not* [moderately to severely immunocompromised](#) could return to work after the following criteria have been met:

- At least 7 days have passed *since symptoms first appeared* if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), **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.

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP who were asymptomatic throughout their infection and are *not* [moderately to severely immunocompromised](#) could return to work after the following criteria have been met:

- At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP with **severe to critical illness** who are **not moderately to severely immunocompromised** could return to work after the following criteria have been met:

- At least 10 days and up to 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.
- The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific HCP. For a summary of the literature, refer to [Preventing Spread of Respiratory Viruses When You're Sick](#).

HCP who are **moderately to severely immunocompromised** may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy (as described below) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.

Test-based strategy

HCP who are symptomatic could return to work after the following criteria are met:

- Resolution of fever without the use of fever-reducing medications, **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

HCP who are not symptomatic could return to work after the following criteria are met:

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

Return to Work Criteria for HCP Who Were Exposed to Individuals with Confirmed SARS-CoV-2 Infection

Exposures that might require testing and/or restriction from work can occur both while at work and in the community. Higher-risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an [aerosol-generating procedure](#).

Other exposures not classified as higher-risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touch their eyes, nose, or mouth. When classifying potential exposures, specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source control) should be evaluated on a case-by-case basis. These factors might raise or lower the level of risk; interventions, including restriction from work, can be adjusted based on the estimated risk for transmission.

For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged¹ close contact² with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection³ and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)⁴
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

Following a higher-risk exposure, HCP should:

- Have a series of three viral tests for SARS-CoV-2 infection.
 - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
 - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Follow all [recommended infection prevention and control practices](#), including wearing well-fitting source control, monitoring themselves for fever or [symptoms consistent with COVID-19](#), and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develop fever or [symptoms consistent with COVID-19](#) should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

Work restriction is not necessary for most asymptomatic HCP following a higher-risk exposure, regardless of vaccination status. Examples of when work restriction may be considered include:

- HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure;
- HCP is moderately to severely immunocompromised;
- HCP cares for or works on a unit with patients who are moderately to severely immunocompromised;
- HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions;

If work restriction is recommended, HCP could return to work after either of the following time periods:

- HCP can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and all viral testing as described for asymptomatic HCP following a higher-risk exposure is negative.
- If viral testing is not performed, HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.

In addition to above:

- HCP should follow all [recommended infection prevention and control practices](#), including wearing well-fitting source control, monitoring themselves for fever or [symptoms consistent with COVID-19](#), and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
- Any HCP who develop fever or [symptoms consistent with COVID-19](#) should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. In general, HCP who have had prolonged close contact with someone with SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures above.

Footnotes:

1. For this guidance an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, **any duration** should be considered prolonged if the exposure occurred during performance of an [aerosol generating procedure](#).
2. For this guidance it is defined as: a) being within 6 feet of a person with confirmed SARS-CoV-2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.
3. Determining the time period when the patient, visitor, or HCP with confirmed SARS-CoV-2 infection could have been infectious:
 - a. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets [criteria for discontinuation of Transmission-Based Precautions](#)
 - b. For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious.
 - i. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
4. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with SARS-CoV-2 infection, facemasks still confer some level of protection to HCP, which was factored into this risk assessment if the patient was also wearing a cloth mask or facemask

Definitions:

Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). For this guidance, HCP does not include clinical laboratory personnel.

Immunocompromised: For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the [Interim Clinical Considerations for Use of COVID-19 Vaccines](#).

- Other factors, such as end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about need for work restriction if the HCP had close contact with someone with SARS-CoV-2 infection. However, people in this category should still consider continuing to practice physical distancing and use of source control while in a healthcare facility, even if they have received all COVID-19 vaccine doses, including booster dose, as recommended by [CDC](#).
- Ultimately, the degree of immunocompromise for the HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.

SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines)

The studies used to inform this guidance did not clearly define “severe” or “critical” illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the [National Institutes of Health \(NIH\) COVID-19 Treatment Guidelines](#) are one option for defining severity of illness categories. The highest level of illness severity experienced by the patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions.

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen (SpO2) $\geq 94\%$ on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 $<94\%$ on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of $>3\%$), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates $>50\%$.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children; thus, hypoxia should be the primary criterion to define severe illness, especially in younger children.

Fever: For the purpose of this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.0°F (37.8°C) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunocompromised, or taking certain fever-reducing medications (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs]).

Facemask: OSHA defines facemasks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as ‘medical procedure masks’.” Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: 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), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. **They are not personal protective equipment (PPE) appropriate for use by healthcare personnel.** Guidance on design, use, and maintenance of cloth masks is available.

More Information

[Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#)

[Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)

Summary of Changes

As of December 23, 2021

Due to concerns about increased transmissibility of the SARS-CoV-2 Omicron variant, this guidance is being updated to enhance protection for healthcare personnel (HCP), patients, and visitors, and to address concerns about potential impacts on the healthcare system given a surge of SARS-CoV-2 infections. These updates will be refined as additional information becomes available to inform recommended actions.

- Ensure that SARS-CoV-2 testing is performed with a test that is [capable of detecting](#)  SARS-CoV-2, even with currently circulating variants in the United States.
- Updated recommendations regarding when HCP with SARS-CoV-2 infection could return to work
- The definition of higher-risk exposure was updated to include use of a facemask (instead of a respirator) by HCP if the infected patient is not also wearing a facemask or cloth mask.
- Added options that would allow asymptomatic HCP with a higher-risk exposure who have not received all COVID-19 vaccine doses, including booster dose, as recommended by [CDC](#) to return to work prior to the previously recommended 14-day post-exposure period of work restriction, assuming they do not develop symptoms or test positive for SARS-CoV-2.

As of September 10, 2021

The interim guidance was updated to:

- Combine information from previously posted CDC guidance addressing when healthcare personnel (HCP) with SARS-CoV-2 infection could return to work and risk assessment and work restriction for HCP with higher-risk exposure to SARS-CoV-2
- Clarify the recommended intervals for testing asymptomatic HCP with a higher-risk exposure.

As of March 10, 2021

- Clarified that asymptomatic HCP who are fully vaccinated and have a higher-risk exposure as described in this guidance do not need to be restricted from work; [possible exceptions and additional information is available](#).

As of February 16, 2021:

- Clarified that work restriction of asymptomatic HCP with a higher-risk exposure who have recovered from SARS-CoV-2 infection in the prior 3 months might not be necessary. [Additional information about this scenario is available](#).
- Clarified that work restriction of fully vaccinated HCP with a higher-risk exposure continues to be recommended. [Additional information is available](#).

Updates as of Dec 14, 2020:

- Include a link to the Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2, which provides guidance on testing potentially exposed healthcare personnel.
- Clarify that, in general, healthcare personnel with travel or community-associated exposures where quarantine is recommended should be excluded from work for 14 days after their last exposure.

Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19

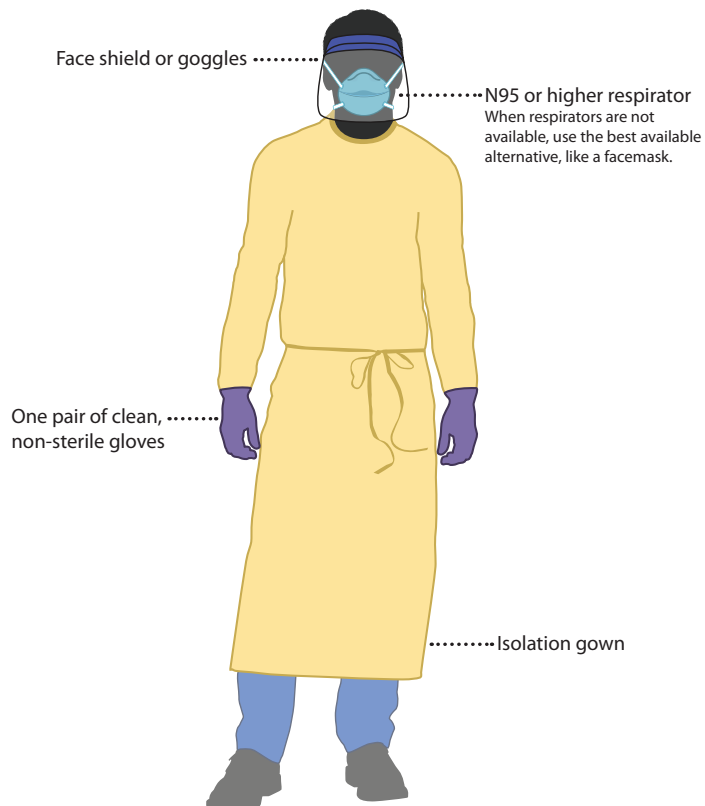
Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

- **Receive comprehensive training** on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- **Demonstrate competency** in performing appropriate infection control practices and procedures.

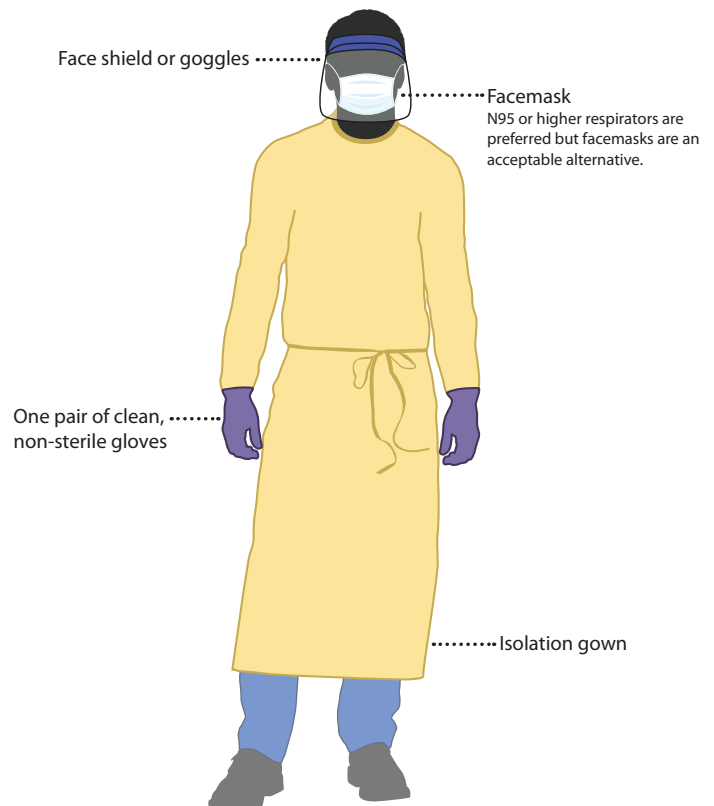
Remember:

- PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).
- PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.

Preferred PPE – Use N95 or Higher Respirator



Acceptable Alternative PPE – Use Facemask



www.cdc.gov/coronavirus

Donning (putting on the gear):

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.

1. **Identify and gather the proper PPE to don.** Ensure choice of gown size is correct (based on training).
2. **Perform hand hygiene using hand sanitizer.**
3. **Put on isolation gown.** Tie all of the ties on the gown. Assistance may be needed by another HCP.
4. **Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).** If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.*
 - » **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
 - » **Facemask:** Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. **Put on face shield or goggles.** When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. **Put on gloves.** Gloves should cover the cuff (wrist) of gown.
7. **HCP may now enter patient room.**

Doffing (taking off the gear):

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing.

1. **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. **Remove gown.** Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.*
3. **HCP may now exit patient room.**
4. **Perform hand hygiene.**
5. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. **Remove and discard respirator (or facemask if used instead of respirator).*** Do not touch the front of the respirator or facemask.
 - » **Respirator:** Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
 - » **Facemask:** Carefully untie (or unhook from the ears) and pull away from face without touching the front.
7. **Perform hand hygiene after removing the respirator/facemask** and before putting it on again if your workplace is practicing reuse.

**Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices.*



What is RSV

Respiratory Syncytial Virus



What Is RSV?

RSV is a highly contagious virus that affects the respiratory system, which includes the lungs and breathing passages. Most people who get RSV recover quickly but it can be serious for infants and older adults. RSV is the most common cause of hospitalization in U.S. infants.

What Is Nirsevimab?

Nirsevimab (Beyfortus) is an immunization designed to help prevent RSV in infants through their first RSV season. The immunization is recommended for all infants younger than eight months who are born during or entering their first RSV season.

Where Can Infants Get Nirsevimab?

Nirsevimab is covered by the Texas Vaccines for Children (TVFC) program, a state funded program that provides vaccines at a low administrative cost to those who qualify.

When Should Infants Get Immunized?

Infants should get nirsevimab during the RSV season. This starts in the fall and peaks in the winter. Talk to your child's health care provider about the right time for your child to be immunized based on your community's RSV season.

Who Should Get Vaccinated?

Nirsevimab is recommended for all infants younger than 8 months born during RSV season.

Infants younger than 8 months who were born before or after the RSV season should receive nirsevimab before the start of their first RSV season.

Infants and young children 8 through 19 months of age who are at risk for severe RSV disease should receive the immunization before the start of their second RSV season.

Those Who Are Most At Risk:

- ⚠️ Premature or have chronic lung disease
- ⚠️ Severe cystic fibrosis
- ⚠️ The severely immunocompromised
- ⚠️ American Indian or Alaskan native



Immunization Timeline Example

If your child is born in December, a single dose of nirsevimab is recommended within one week after birth.

If your child is born in June, it is recommended a single dose be given to infants (younger than eight months) before the start of their first RSV season.



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What is RSV

Respiratory Syncytial Virus



What Is RSV?

Respiratory Syncytial Virus Infection (RSV) is a highly contagious virus that affects the respiratory system, which includes the lungs and breathing passages. Most people who get RSV recover quickly but it can be serious for infants and young children, pregnant women, and older adults.

What RSV Vaccines Are Available?

- Abrysvo is recommended for pregnant women in weeks 32-36 during pregnancy.
- Any FDA-licensed RSV vaccine is recommended for all adults ages 75 and older and adults ages 60-74 with increased risk of severe illness.

When Should Adults Get Vaccinated?

RSV vaccines are typically administered before or during the RSV season, September – January. Consult healthcare providers about vaccine eligibility, timing, and any potential risks or side effects.



Protect yourself and others, find more information on where to get vaccinated. Scan the QR code to learn more

Who Should Get Vaccinated?

RSV can lead to severe illness and hospitalizations in vulnerable populations.

Adults ages 75 and older: This population is at higher risk of severe RSV complications.

Adults ages 60-74 with underlying medical conditions.

Those Who Are Most At Risk:

- ⚠️ Chronic heart or lung disease
- ⚠️ The severely immunocompromised
- ⚠️ Underlying health conditions
- ⚠️ Living in nursing homes



RSV And Pregnancy

RSV is especially dangerous to infants. Pregnant women between 32-36 weeks of pregnancy should be vaccinated during RSV season.

This passive immunity helps protect the baby during the critical first few months of life, when they are most vulnerable to severe RSV infections and not old enough to get vaccinated against RSV.

Little immune systems deserve a fighting chance

Respiratory Syncytial Virus (RSV) is a seasonal virus that can be dangerous for babies. Babies under a year old, especially those six months or younger, and infants with chronic illness are at the highest risk. Babies between 8 and 19 months old who are entering their second RSV season may be at increased risk if they have another severe disease.

Signs and Symptoms



Congestion



Fever



Runny nose



RSV is transmitted in similar ways to colds or the flu. Avoid kissing or holding baby while sick.



Short, rapid breathing



Irritability



Trouble feeding



Decreased appetite



Worsening cough

RSV Facts



It's Common

Two out of three babies will get RSV by age one.



It's Serious

RSV is the top reason babies go to the hospital.



It's Seasonal

RSV typically runs from fall to spring.



It's Up To You

Keeping surfaces clean and staying away from sick people can lower your chance of illness.



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Texas Department of State Health Services
Immunizations Section
Stock # 23-XXXXXX
Rev 9/24

Treating Influenza (Flu)



Information for People at High Risk for Serious Flu Complications



Do you have Asthma, Chronic Obstructive Pulmonary Disease, Diabetes, or Heart Disease?

If so, you are at high risk of serious illness if you get flu. Treatment with an influenza antiviral drug can mean the difference between having milder illness instead of very serious illness that could result in a hospital stay. This fact sheet provides information about using prescription antiviral drugs to treat influenza in people at high risk for serious flu complications.

Why am I at greater risk of serious flu complications?

Your medical condition makes it more likely that you will get complications from flu, like pneumonia. Flu also can make long-term health problems worse, even if they are well-managed. People with asthma, chronic obstructive pulmonary disease, or heart failure may experience worsening of their conditions and have difficulty breathing. Diabetes (type 1 and 2) can make the immune system less able to fight flu. Also, flu illness can raise blood sugar levels.

Can flu be treated?

Yes. There are prescription medications called “antiviral drugs” that can be used to treat influenza illness. Antiviral drugs fight influenza viruses in your respiratory tract. They are different from antibiotics, which fight against bacterial infections.

What should I do if I think I have flu?

Check with your doctor promptly if you are in a group at high risk for serious complications and you get flu symptoms. Symptoms of flu can include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills, and fatigue. If you get flu, antiviral drugs are a treatment option. Your doctor may prescribe antiviral drugs to treat your flu illness.

Should I still get a flu vaccine?

Yes. Antiviral drugs are not a substitute for getting a flu vaccine. While flu vaccines can vary in how they work, flu vaccination is the first and best way to prevent influenza. You should receive flu vaccine every year. Antiviral drugs are a second line of defense to treat flu if you get sick.

What are the benefits of antiviral drugs?

Antiviral treatment works best when started within two days of getting symptoms. Antiviral drugs can lessen fever and other symptoms and shorten the time you are sick by about one day. They also can prevent serious flu complications, like pneumonia when treatment is started early.

For people at high risk of serious flu complications, early treatment with an antiviral drug can mean the difference between having a milder illness instead of a more serious illness that could result in a hospital stay. For adults hospitalized with flu illness, some studies have reported that early antiviral treatment can reduce the risk of death.

What antiviral drugs are recommended?

There are four FDA-approved influenza antiviral drugs recommended by CDC: oseltamivir (available as a generic version or under the trade name Tamiflu®), zanamivir (trade name Relenza®), peramivir (trade name Rapivab®), and baloxavir marboxil (trade name Xofluza®). Oseltamivir is available as a pill or liquid, and zanamivir is a powder that is inhaled. Peramivir is administered intravenously by a health care provider. Baloxavir is a pill given as a single dose by mouth.



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Health and age factors known to increase a person's risk for developing flu-related complications:

- Asthma
- Neurological and neurodevelopmental conditions
- Blood disorders (such as sickle cell disease)
- Chronic lung disease (such as chronic obstructive pulmonary disease [COPD] and cystic fibrosis)
- Endocrine disorders (such as diabetes mellitus)
- Heart disease (such as congenital heart disease, congestive heart failure, and coronary artery disease)
- Kidney disorders
- Liver disorders
- Metabolic disorders (such as inherited metabolic disorders and mitochondrial disorders)
- People who are obese with a body mass index [BMI] of 40 or higher
- People younger than 19 years of age on long-term aspirin- or salicylate-containing medications
- People with a weakened immune system due to disease or medication (such as people with HIV or AIDS, or some cancers such as leukemia) or medications (such as those receiving chemotherapy or radiation treatment for cancer, or persons with chronic conditions requiring chronic corticosteroids or other drugs that suppress the immune system)

Other people at high risk from the flu:

- Adults 65 years and older
- Children younger than 2 years old¹
- Pregnant women and women up to 2 weeks after the end of pregnancy
- American Indians and Alaska Natives
- People who live in nursing homes and other long-term-care facilities

¹ Although all children younger than 5 years old are considered at high risk for serious flu complications, the highest risk is for those younger than 2 years old, with the highest hospitalization and death rates among infants younger than 6 months old, younger than 6 months old.

What are the possible side effects of antiviral drugs?

Side effects vary for each medication. For example, the most common side effects for oseltamivir are nausea and vomiting, zanamivir can cause wheezing and difficulty breathing (bronchospasm), and peramivir can cause diarrhea.

Other less common side effects also have been reported. Your health care provider can give you more information about these drugs, or you can check the Food and Drug Administration (FDA) website for specific information about antiviral drugs, including the manufacturer's package insert.

When should antiviral drugs be taken for treatment?

Studies show that flu antiviral drugs work best for treatment when started within two days of getting sick. However, starting them later can still be helpful, especially if the sick person is in a group at high risk for serious complications (see list in sidebar) or is very sick from flu (for example, hospitalized from flu). Follow your health care provider's instructions for taking these drugs. These antiviral drugs are given in different ways and are approved for different ages.

How long should antiviral drugs be taken?

To treat flu, oseltamivir and zanamivir are usually taken for 5 days, although people hospitalized with flu may need the medicine for longer than 5 days. Peramivir is given once intravenously. Baloxavir is given as a single dose.

Can children take antiviral drugs?

Yes. Oseltamivir is recommended by CDC and the American Academy of Pediatrics (AAP) for early treatment of flu in people of any age, and is approved for the prevention of flu (i.e., prophylaxis) in people 3 months and older. Zanamivir is recommended for early treatment of flu in people 7 years and older. Peramivir is recommended for early treatment of flu in people 6 months and older. Baloxavir is recommended for early treatment of flu in children aged 5 to less than 12 years without chronic medical conditions and in all persons aged 12 years and older.

Can pregnant and breastfeeding women take antiviral drugs?

Oral oseltamivir is recommended for treatment of pregnant women it has the most studies available to suggest that it is safe and beneficial during pregnancy. Baloxavir is not recommended for pregnant women or breastfeeding mothers.

Who should take antiviral drugs?

It's very important that antiviral drugs be used early to treat flu in people who are very sick with flu (for example, people who are in the hospital).

People who are sick with flu and have a high-risk factor related to a health condition like asthma, diabetes or chronic heart disease or their age. (See the full list of high-risk factors).

For more information, visit: www.cdc.gov/flu
or call 1-800-CDC-INFO

INTER-FACILITY INFECTION PREVENTION TRANSFER FORM

Affix patient label here or complete patient information below.

Patient Name:

DOB:

MRN:

This form must be completed for transfer of a patient to the receiving facility. Information should be communicated prior to and during the transfer.

TRANSFER INFORMATION

Transfer Date: Sending Facility Name, City/State:

Sending Facility Point of Contact and Phone Number (for follow up questions):

Receiving Facility Name, City/State:

ISOLATION STATUS

Currently in Isolation? ☐ Yes ☐ No (standard precautions only)

If Yes, Check Type(s) of Isolation:

☐ Contact

☐ Contact plus Hand Hygiene with Soap/Water

☐ Droplet

☐ Airborne



SIGNIFICANT INFECTIOUS DISEASE HISTORY

Does the patient have a history of any known MDRO or infectious disease? ☐ Yes ☐ No

If Yes, check box(es) below and provide supporting lab reports and antimicrobial susceptibility results, if available.

☐ *Acinetobacter*, multidrug-resistant (MDR-A)

☐ *Candida auris*

☐ Carbapenem-resistant Enterobacteriaceae (CRE)

☐ Carbapenem-resistant *Pseudomonas aeruginosa* (CRPA)

☐ *Clostridoides difficile* (C. diff.)

☐ Extended Spectrum β -lactamase (ESBL)

☐ Influenza or Influenza-like illness (ILI)

☐ Methicillin-resistant *Staphylococcus aureus* (MRSA)

☐ *Mycobacterium tuberculosis* (TB)

☐ Vancomycin-resistant *Enterococcus* (VRE)

☐ Other: (example: pertussis)

SIGNS AND SYMPTOMS

Check all that **currently** apply:

☐ Incontinent of urine

☐ Draining wounds

☐ Vomiting

☐ Rash (e.g., vesicular)

☐ Acute diarrhea or incontinent of stool

☐ Cough/uncontrolled respiratory secretions

☐ Other uncontained body fluids/drainage

☐ Other (specify):

OTHER RISK FACTORS

Is the patient currently on antibiotics? ☐ Yes (complete table below or attach medication list) ☐ No

Antibiotic	Start Date	Stop Date

Does the patient currently have any of the following devices? ☐ Yes (check all that apply) ☐ No

☐ Central line/PICC

☐ Hemodialysis Catheter

☐ Urinary Catheter

☐ Suprapubic catheter

☐ Nasogastric/PEG tube

☐ Tracheostomy

☐ Fecal management system

☐ Ventilator/Intubated

☐ Other (specify):

Cultures pending? ☐ Yes, date collected:

☐ No

Additional Comments:



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ANTIMICROBIAL RESISTANCE TESTING

CURRENTLY ACCEPTING **ISOLATES & SWABS**

Testing and expedited shipping to our lab provided free of charge.

- *Candida auris** or unknown *Candida* spp.
- Carbapenem-Resistant Enterobacterales
- Carbapenem-Resistant *Pseudomonas aeruginosa*
- Carbapenem-Resistant *Acinetobacter baumannii*
- Antimicrobial Resistant *Neisseria gonorrhoeae* (AR GC)

REQUEST SUPPLIES **COLONIZATION SCREENING**

Coordinate with a DSHS HAI Epidemiologist for colonization screening or to investigate potential outbreaks. Testing kits, shipping containers, and expedited delivery are provided free of charge.

Colonization Screenings can be performed for:

- Carbapenemase-producing Organism Screening
- *Candida auris* screening

QUESTIONS?

For more information on isolate submission or general inquiries, contact:

- TexasARLN@dshs.texas.gov

For Colonization Screenings:

- HAIOutbreak@dshs.texas.gov

*It is mandatory to submit isolates for positive cases of *C.auris* per Texas Administrative Code Rule §97.3.





SUBMITTING AR SAMPLES



1 BECOME A SUBMITTER

Establish a Submitter ID, or update submitter information.

Contact LabInfo@dshs.texas.gov for a Submitter ID Request Form

2 PREPARE YOUR SHIPMENT

Each specimen submitted should be paired with one form. Use the G-2B for GC and the G-2E for Candida and Carbapenem Resistant organisms. Complete all required sections of the form. The specimen must be labeled with two unique identifiers that match the form.

1 SAMPLE



1 FORM



SAMPLE LABEL IDENTIFIERS
MUST MATCH FORM!

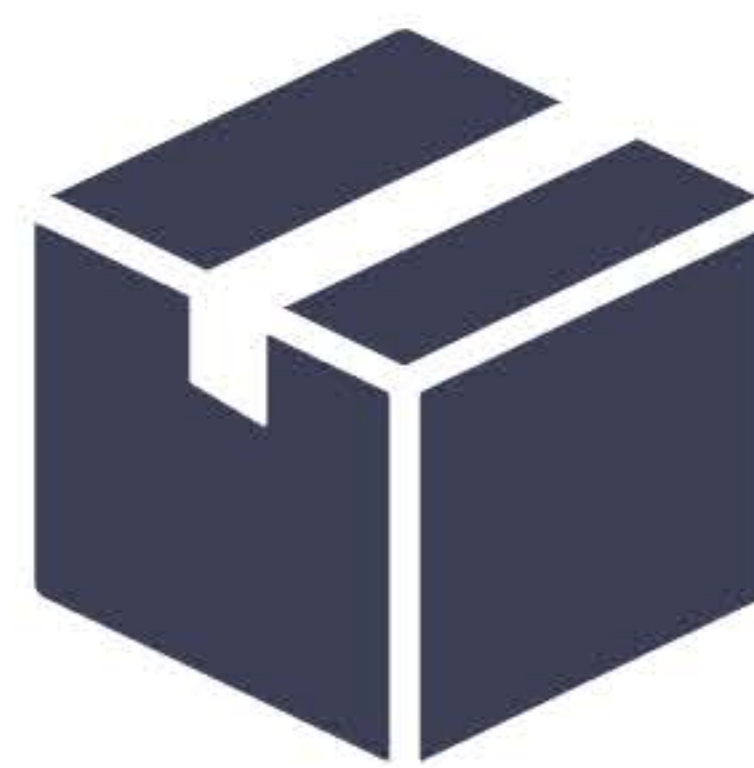


ACCEPTED
FOR
TESTING

3 SHIP TO THE DSHS LABORATORY

Shipping is free of charge using the ARLN FedEx account. **Please contact the DSHS Laboratory for ARLN FedEx instructions and to confirm shipment dates.** Shipments cannot be accepted on holidays or weekends.

- Isolates - Ship within 7 days of collection (preferred)
- CPO Swabs - Ship within 1 day of collection (required)
- C.auris Swabs - Ship within 1 day of collection (required)



Questions?

For support submitting samples, contact the DSHS Laboratory:

• TexasARLN@dshs.texas.gov

For epidemiology investigation support, contact a DSHS HAI Epidemiologist:

• HAIOutbreak@dshs.texas.gov



FIGHT ANTIMICROBIAL RESISTANCE WITH INFECTION CONTROL

Antimicrobial resistance happens when germs like bacteria and fungi develop the ability to defeat the drugs designed to kill them. That means the germs are not killed and continue to grow and spread.

As a frontline healthcare worker, you play an important role in fighting antimicrobial resistance.

When you practice infection control, you stop resistant germs from:



Entering the body and causing infections through procedures and medical devices



Spreading to people from surfaces like bedrails or the hands of healthcare workers



Moving with patients when they are transferred between facilities



Spreading into the community, making them harder to control

Infection control fights resistance by:



Infection control also protects you from getting sick and decreases the risk of spreading germs to patients.

Check out Project Firstline resources to learn more about how you can protect your patients, yourself, and your community from antimicrobial resistance.

www.cdc.gov/ProjectFirstline

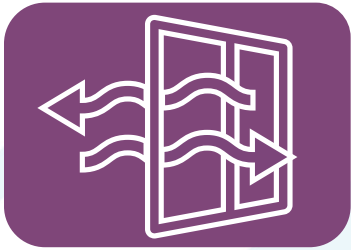
WE HAVE THE POWER
TO STOP RESISTANT
INFECTIONS. **TOGETHER**



VENTILATION IN HEALTHCARE SETTINGS

In healthcare settings, ventilation is important because it helps remove things from the air that we don't want to breathe in – like small virus particles. Good ventilation improves air quality and reduces the risk of germs spreading.

WHAT TO KNOW



Understand what an air change is and why recommended air changes per hour are important in healthcare.

- An air change means the air in a room is replaced with new air.
- Air changes are usually measured by the hour – air changes per hour (ACH).
- In healthcare facilities, nearly every type of room has a recommended number of ACHs to help reduce the risk of germs spreading among patients and staff.



Respect wait times to allow the air in rooms to clear.

- The infection prevention or clinical leaders in your area, like your nurse manager, will use the ACH to figure out how long a room should sit empty after a patient with a possible or confirmed respiratory infection has left.
- It is okay to enter a room before the air is completely cleared, including while the patient is still there, if you use the recommended personal protective equipment (PPE).



Ask before making changes to the ventilation in a room.

- Rooms are often connected in healthcare facilities.
- Making a change to the ventilation in one room – like opening a window or closing vents to adjust temperature – can change the ventilation in other places, too.
- **That's why it's important to talk to the person or team at your facility that is responsible for maintaining air filtration and ventilation if you have concerns about the ventilation in a room.**



Make sure vents are not blocked.

- A blocked vent could prevent the ventilation system from functioning like it is supposed to.



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**PROJECT
FIRSTLINE**
CDC's National Training Collaborative
for Healthcare Infection Prevention & Control

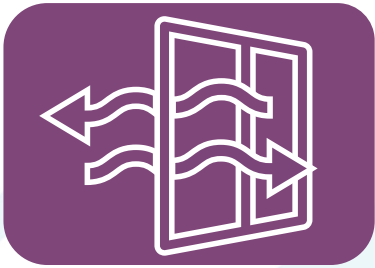
cdc.gov/ProjectFirstline

NCEZID-PFL-TT-9/9/21

LA VENTILACIÓN EN LOS ENTORNOS DE ATENCIÓN MÉDICA

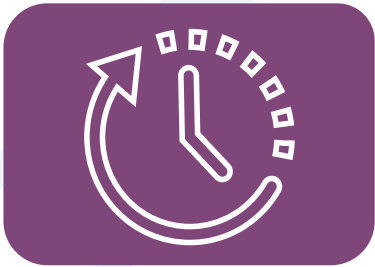
En los entornos de atención médica, la ventilación es importante porque ayuda a eliminar del aire elementos que no queremos respirar, como pequeñas partículas de virus. Una buena ventilación mejora la calidad del aire y reduce el riesgo de propagación de microbios.

LO QUE DEBE SABER



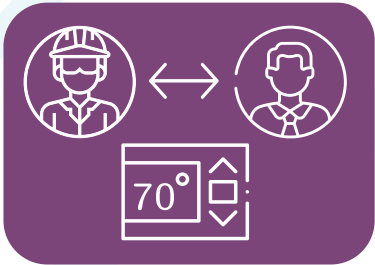
Entienda lo que es un cambio de aire y por qué los cambios de aire recomendados cada hora son importantes en la atención médica.

- Un cambio de aire significa que el aire de una habitación se reemplaza con aire nuevo.
- Los cambios de aire generalmente se miden por horas: cambios de aire por hora (ACH, por sus siglas en inglés).
- En los centros de atención médica, casi todos los tipos de habitaciones tienen una cantidad recomendada de ACH para ayudar a reducir el riesgo de propagación de microbios entre los pacientes y el personal.



Respete los tiempos de espera para permitir que el aire de las habitaciones se despeje.

- Los líderes clínicos o de prevención de infecciones de su área, como su gerente de enfermería, utilizarán el ACH para calcular cuánto tiempo debe permanecer vacía una habitación después de que se haya ido un paciente con una infección respiratoria posible o confirmada.
- Está bien entrar en una habitación antes de que el aire se haya despejado por completo, incluso mientras el paciente todavía está allí, si utiliza el equipo de protección personal (EPP) recomendado.



Pregunte antes de realizar cambios en la ventilación de una habitación.

- Las habitaciones suelen estar conectadas en los centros de atención médica.
- Hacer un cambio en la ventilación de una habitación, como abrir una ventana o cerrar las rejillas de ventilación para ajustar la temperatura, también puede cambiar la ventilación en otros lugares.
- **Por eso, si tiene preguntas sobre la ventilación de una habitación en su centro médico, es importante hablar con la persona o el equipo responsable de mantener la filtración del aire y la ventilación.**



Asegúrese de que las rejillas de ventilación no estén bloqueadas.

- Una rejilla de ventilación bloqueada podría impedir que el sistema de ventilación funcione como debería.

Meningococcal Disease Outbreaks: Information for Teens, Young Adults, and Their Parents

Meningococcal disease is a rare, but very serious bacterial illness. The best way to protect yourself or your child during an outbreak is to make sure they get vaccinated. Even if treated quickly, meningococcal disease can cause long-term problems or be deadly.

Outbreaks are rare and unpredictable

Outbreaks can occur in many settings, including

- Communities
- Schools and colleges
- Detention and correctional facilities
- Other populations

Since meningococcal disease is rare, just two cases in a setting over a few months might be considered an outbreak.

State and local health departments investigate outbreaks and determine

- Who is at increased risk during an outbreak
- How to best protect people's health and control the outbreak

Certain people are at increased risk

Anyone can get meningococcal disease, no matter their gender, age, race, ethnicity, or sexual orientation. However, being in an outbreak setting can increase someone's risk of getting meningococcal disease.



In addition, people of some ages have a higher risk than people of other ages:

- Babies
- Teens and young adults (16 to 23 year olds)
- Adults 65 years or older

Having certain medical conditions, going to college, or traveling to certain countries can increase someone's risk for getting this disease.

Vaccines, antibiotics offer protection during outbreaks

State and local health departments make sure all close contacts of someone with meningococcal disease get antibiotics. They may also recommend people at increased risk get vaccinated.

There are two types of vaccines that help protect against meningococcal disease: **MenACWY** and **MenB** vaccines. Each vaccine protects against different serotypes (strains), so it's important that the recommended vaccine matches the strain causing the outbreak.

Contact your state or local health department to learn about their vaccine recommendations during an outbreak.



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Vaccine side effects are usually mild

Meningococcal vaccines are safe. Most people who get a meningococcal vaccine do not have any serious problems with it. Side effects are usually mild and go away on their own within a few days. Serious reactions are possible, but rare.

Meningococcal bacteria are spread from person to person

People spread the bacteria that cause meningococcal disease to others through respiratory droplets and throat secretions (saliva or spit). Generally, it takes close (kissing) or lengthy (living together) contact to spread them.

Meningitis and bloodstream infection are common outcomes

With **meningococcal meningitis**, the lining of the brain and spinal cord becomes infected and swells. Symptoms include sudden onset of **fever, headache, and stiff neck**. There can be additional symptoms, such as

- Nausea and vomiting
- Eyes being more sensitive to light
- Confusion

In babies, these symptoms can be difficult to notice or may not be there at all. Instead, a baby may appear slow or inactive, be irritable, vomit, or feed poorly.

With a **meningococcal bloodstream infection**, the bacteria damage the walls of the blood vessels and cause bleeding into the skin and organs. Symptoms may include:

- Fever and chills
- Feeling tired
- Vomiting or diarrhea
- Cold hands and feet
- Severe aches or pain in the muscles, joints, chest, or belly
- Rapid breathing
- A dark purple rash

Seek medical care right away if you or your child has symptoms of meningococcal disease.

Meningococcal disease is very serious but treatable

Meningococcal disease can be treated with antibiotics. It's important that treatment be started as soon as possible. Meningococcal disease can be deadly in a matter of hours.

Vaccines are the best way to prevent meningococcal disease

Even when there isn't an outbreak, CDC recommends preteens, teens, and others get vaccinated.

Preteens, teens, and young adults

Preteens should get 1 dose of **MenACWY** vaccine at 11 or 12 years old. Teens should get a **MenACWY** booster dose at 16 years old. Teens and young adults may also be vaccinated with a **MenB** vaccine, preferably when they are between 16 and 18 years old.

Younger children and other adults

Younger children and other adults usually do not need meningococcal vaccines. However, CDC recommends one or both types of vaccines for people with

- Certain medical conditions that affect the immune system
- Travel plans to areas where the disease is common
- Laboratory jobs working with the bacteria

Talk to a doctor about which vaccines you or your child may need.

cdc.gov/meningococcal/





Increase in Pertussis Cases

November 12, 2024

Summary

The Texas Department of State Health Services (DSHS) is reporting an increase in pertussis cases in 2024 with about triple the number of cases reported so far this year compared with the same period in 2023. This follows a national trend, which has seen a more than fivefold increase in 2024 cases based on preliminary data.

DSHS advises clinicians to follow the recommendations below and report any cases to your local health department within one workday.

Background

Pertussis is highly contagious illness caused by the bacteria *Bordetella pertussis*. Early symptoms are very similar to the common cold. One to two weeks after the first symptoms start, people may develop paroxysms (coughing fits). The cough generally gets worse and becomes more common as the illness continues and can cause people to vomit or make a “whoop” sound when breathing in.

Coughing fits may continue for several weeks or even months. Many infants with pertussis may not have coughing fits; instead, they may gag, gasp, vomit, stop breathing, or turn blue. The best way to prevent pertussis is to get vaccinated. The specifics of the vaccine recommendations can be found [here](#). However, immunized children and adults can still get pertussis, so a history of immunization should not preclude a pertussis diagnosis. Immunized children, adolescents and adults may not present with the classic “whoop” symptom.

Pertussis can cause serious and potentially life-threatening complications in infants and young children who are not fully immunized. Infants under one year old are at greatest risk for serious disease and death because their immune systems are still developing. About a third of babies younger than 12 months old with pertussis need treatment in a hospital. Early recognition of cases, effective treatment and prophylaxis, and appropriate vaccination are vital to limiting the spread of pertussis.

Recent Pertussis Data Trends

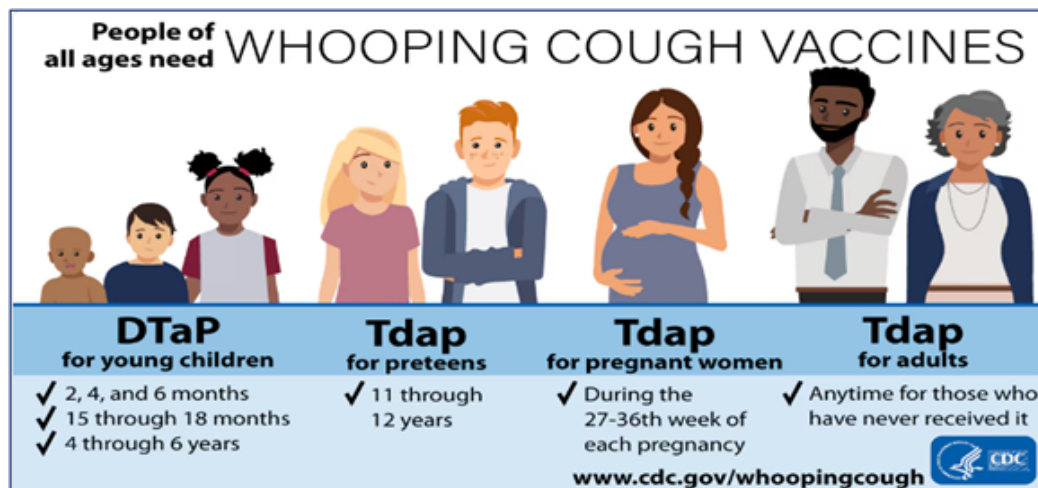
Reports of pertussis cases in Texas and nationally were lower than usual over the past few years, during and following the COVID-19 pandemic. However, nationally and in Texas, pertussis cases are beginning to return to pre-pandemic patterns when, on average, more than 1,400 cases were reported in Texas each year. In 2024, reported cases of pertussis increased across the United States and in Texas. Preliminary data show more than three times as many cases reported this year in Texas as compared to the same time in 2023.



Recommendations for Clinicians:

Vaccination

- The best way to protect against pertussis is vaccination. Centers for Disease Control and Prevention recommends pertussis vaccines for people of all ages.
- Pertussis infection may occur in vaccinated people since protection from vaccination fades over time. Thus, all individuals should be kept current with pertussis vaccination. Check the vaccination history of all individuals and offer vaccine to anyone that is not up to date.
- Ensure infants get the DTaP series on time and that pregnant women are vaccinated every pregnancy with Tdap to help prevent infant hospitalization and death.



Testing Symptomatic Patients

- Collect the test specimen prior to the patient starting any treatment. Test patients via culture and/or PCR assay, which are the preferred methods of pertussis testing. PCR assays are quick and widely available at hospital and commercial laboratories.
- **Consider beginning treatment prior to receiving test results, especially if clinical history is strongly suggestive of pertussis** (such as a long cough illness), the patient is at risk for severe or complicated disease (e.g., infants), or the patient has a known pertussis exposure and has not received prophylaxis.

Treatment for Cases

- Early treatment is critical to reduce illness severity and decrease risk of spread to others. Treat patients within three weeks after cough onset, except for infants aged <1 year and pregnant women (especially near term) who should be treated within six weeks after cough onset.
- Consider prescribing antibiotics effective for pertussis treatment and prevention, which include azithromycin, erythromycin, clarithromycin, or trimethoprim sulfamethoxazole (TMP-SMX).



- Treat patients regardless of vaccination history. According to provisional Texas Department of State Health Services data, more than half of 2024 cases (53%) have occurred in persons with one or more doses of pertussis vaccine and 33% have had five or more doses.
 - Note: The Texas Medical Board changed its rules (Texas Administrative Code, Title 22, Part 9, Chapter 190, Subchapter B, §190.8) regarding the prescribing of prophylaxis for close contacts to infectious disease. Physicians may now prescribe pertussis antibiotics to contacts of pertussis cases without first medically evaluating the contact.

Infection Control Precautions in Healthcare Settings

- Droplet precautions should be used for any suspected or confirmed pertussis cases until the patient has received at least five full days of an appropriate antibiotic.
- Healthcare workers should wear a mask and face protection, including, but not limited to, performing a physical examination on, feeding, or bathing a patient; bronchoscopy; intubation; or administration of bronchodilators.

Exclusion Guidelines

- People suspected of having pertussis should be told to stay home from work, school, daycare, and any public outings (e.g., church, grocery store) until they have completed five days of appropriate antibiotic therapy. School and childcare exclusion are mandated by the Texas Administrative Code, Title 25, Chapter 97, Subchapter A, Rule §97.7.

Disease Reporting Requirements/Statute

- Several Texas laws (Health & Safety Code Chapters 81 and 84) require specific information regarding notifiable conditions be provided to DSHS. Health care providers, hospitals, laboratories, schools, childcare facilities and others are required to report patients who are suspected of having pertussis within one workday (Texas Administrative Code, Title 25, Chapter 97, Subchapter A).
- Pertussis reports should be made to your local health department (contacts by county at www.dshs.texas.gov/idcu/investigation/conditions/contacts).

Post Exposure Prophylaxis (PEP) Recommendations for Contacts

Contact Group*	Description	PEP Recommended?**	PEP Administration Timeframe
Household contacts	Persons who spend many hours together or sleep under the same roof	Yes	within 21 days of onset of cough in the index patient



Infants	Aged <12 months	Yes; high-risk for developing severe illness	within 21 days of the last exposure to an infectious pertussis case
All persons with pre-existing health conditions that may be exacerbated by a pertussis infection	EX: immunocompromised persons or those with a chronic lung disease	Yes; high-risk for developing severe illness	
People in contact with people at high risk of severe illness	▪ Women in their third trimester of pregnancy ▪ All people in high-risk settings⁺	Yes	
Other relatives, coworkers, classmates, acquaintances, etc.	Persons who do not fit into any of the above descriptions	No; recommend evaluation for symptoms and educated about pertussis	-

*Some contacts may fall into more than one group. Base PEP recommendations on the group with the longest timeframe for administering PEP.

**Provide PEP regardless of vaccination history

^ Infectious period: from the beginning of symptom onset through the third week after the onset of paroxysms, or until 5 days after the start of effective antimicrobial treatment

+High-risk setting: settings that infants aged <12 months or women in their third trimester of pregnancy. These include, but are not limited to neonatal intensive care units, childcare settings, and maternity wards.

Recommendations for Public Health:

Lab Confirmation Tests

- Culture and PCR assay are the preferred methods of pertussis testing. PCR assays are quick and widely available at hospital and commercial laboratories.
- For PCR assays, a nasopharyngeal swab should be done using a synthetic swab. Check with the testing laboratory to determine what transport media, if any, is needed.
- Direct Fluorescent Antibody (DFA) and serological assays are not considered confirmatory tests for pertussis.
- More information on PCR testing is available at <https://www.cdc.gov/pertussis/php/pcr-bestpractices/index.html>.



Controlling Outbreaks in Group Settings

- Even in an outbreak, antibiotic prophylaxis is only recommended for household and high-risk contacts.
- Active screening for symptomatic patients with suspected pertussis can be considered during outbreaks in settings such as schools, daycare centers, and hospitals.
 - The asymptomatic contacts may remain in group settings if they comply with prophylaxis and lack respiratory symptoms.
 - They should be monitored for 21 days past their last known exposure.
- A broader use of PEP may be appropriate in limited closed settings when the number of identified cases is small and when a community-wide outbreak is not ongoing. However, when continued transmission of pertussis is evident, multiple rounds of antibiotics would not be recommended. Rather than repeating a course of antibiotics, public health should monitor people exposed to pertussis for onset of pertussis signs and symptoms for 21 days.
- During an outbreak, people without documented immunity from vaccination or previous pertussis infection should be isolated from anyone with pertussis to protect those without immunity and control the outbreak. Additional information on school exclusion and readmission can be found at dshs.texas.gov/idps-home/school-communicable-disease-chart.

Recommendations for the Public:

If you think you have pertussis, isolate yourself from others and call your healthcare provider before arriving so they can prepare for your arrival without exposing other people.

Routine prevention steps including hand washing and covering your mouth and nose while sneezing or coughing are essential to prevent the spread of bacteria. Avoid close contact with people who are sick, and don't share food, utensils, toothbrushes, cigarettes, or similar personal items.

Review your and your child's immunization history to see if you are up to date on your pertussis containing vaccines. Additionally, discuss with your provider your immunization history and any questions about these vaccines.

If you think you've been exposed to someone with pertussis, contact your healthcare provider about medication that can keep you from getting sick.

MEASLES

Measles can be dangerous, especially for babies and young children.

It can cause serious health complications like **pneumonia, swelling of the brain** and even **death**.

Measles symptoms can include:

- **High fever** (may spike to more than 104°F)
- **Rash** breaks out 3-5 days after symptoms begin
- **White spots inside the mouth**
- **Cough**
- **Runny nose**
- **Red, watery eyes**

Measles spreads easily.

- **Measles spreads through the air when an infected person coughs or sneezes.**
- **A person can spread measles to others even before knowing they have the disease.**
 - You can get measles just by **being in a room** where a person with measles has been.
 - This can happen even up to **2 hours** after that person has left the room.
 - If one person has it, up to **9 out of 10** people nearby will become infected if they are not protected.
 - You can spread measles to others from **4 days before** through **4 days after** the rash appears.



The best way to protect against measles is with the measles, mumps, and rubella (MMR) vaccine.

MMR is safe and effective.

Two doses of MMR vaccine are about **97% effective** at preventing measles.



Possible exposure:



If you think that you have measles or have been exposed to someone with measles, **ISOLATE YOURSELF FROM OTHERS** and call your healthcare provider or urgent care before arriving to be tested.



Do not arrive at a health care facility without giving advance notice.



TEXAS
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SARAMPIÓN

El sarampión puede ser peligroso, especialmente para los bebés y los niños pequeños.

Puede causar graves complicaciones de salud, como **pulmonía, inflamación del cerebro e incluso la muerte.**

Los síntomas del sarampión pueden incluir:

- **Fiebre alta** (puede subir a más de 104 °F)
- **Sarpullido** que aparece entre 3 y 5 días después del inicio de los síntomas
- **Manchas blancas dentro de la boca**
- **Tos**
- **Secreción nasal**
- **Ojos rojos y llorosos**

El sarampión se propaga fácilmente.

- **Se transmite de una persona a otra a través de las gotitas que la persona infectada expulsa al aire cuando tose o estornuda.**
- **Una persona puede transmitir el sarampión a otras incluso antes de saber que tiene la enfermedad.**
 - Se puede contraer el sarampión simplemente por estar en una habitación donde haya estado una persona con sarampión.
 - Esto puede ocurrir incluso hasta 2 horas después de que esa persona haya abandonado la habitación.
 - Si una persona lo tiene, hasta 9 de cada 10 personas cercanas se infectarán si no están protegidas.
 - Se puede transmitir el sarampión a otras personas desde 4 días antes hasta 4 días después de que aparezca la erupción cutánea.



La mejor forma de protegerse contra el sarampión es con la vacuna contra el sarampión, las paperas y la rubéola (MMR).

La vacuna MMR es segura y eficaz. Dos dosis de la vacuna tienen un **97% de eficacia** en la prevención del sarampión.



Posible exposición:



Si cree que tiene sarampión o ha estado expuesto a alguien con sarampión, **AÍSELE DE LOS DEMÁS** y llame a su proveedor de atención médica o a un centro de urgencias antes de llegar para someterse a pruebas.



No llegue a un centro médico sin previo aviso.



TEXAS
Health and Human
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THERE'S A CURRENT OUTBREAK OF MEASLES

Measles is a very contagious disease caused by a virus. It can be dangerous, especially for babies and young children. Protect your family and your community.



Measles spreads through the air when a sick person coughs or sneezes. The virus can stay in the air for 2 hours after a person with measles leaves the space. It is so contagious that about 9 out of 10 people who come near a person with measles and are not protected by vaccination will also become infected.

Measles symptoms appear 7 to 14 days after contact with the virus. Common measles symptoms include:



High fever
(may spike to more than 104°F)



Cough



Runny nose



Red and/or watery eyes



Rash
(breaks out 3-5 days after symptoms begin)

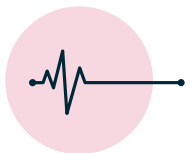
Measles can cause severe health problems, including:



Pneumonia



Swelling of the brain
(encephalitis)



Possibly even death

The best way to protect against measles ...

is with the measles, mumps, and rubella (MMR) vaccine. It's never too late to get vaccinated. Vaccination helps protect you, the people around you, and your community. If you are not vaccinated, consider staying at home or away from crowded areas until measles cases in the area decrease, especially to protect people in your family that could get very sick.

If you think that you or someone in your family have measles, stay away from others and call a healthcare provider, urgent care, or emergency room.



BE READY FOR MEASLES
cdc.gov/measles



HAY UN BROTE ACTUAL DE SARAMPIÓN

El sarampión es una enfermedad muy contagiosa causada por un virus. Puede ser peligroso, especialmente para los bebés y los niños pequeños. Proteja a su familia y a su comunidad.



El sarampión se propaga por el aire cuando una persona enferma tose o estornuda. El virus puede permanecer en el aire durante 2 horas después de que la persona con sarampión se vaya del lugar. Es tan contagioso que aproximadamente 9 de cada 10 personas que se acercan a una persona con sarampión y no están protegidas por la vacuna también se infectarán.

Los síntomas del sarampión aparecen entre 7 y 14 días después del contacto con el virus. Los síntomas comunes del sarampión incluyen:



Fiebre alta
(puede alcanzar más de 40 °C)



Tos



Moqueo



Ojos rojos y/o llorosos



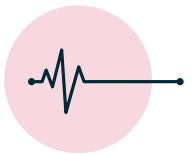
Sarpullido
(aparece de 3 a 5 días después del inicio de los síntomas)



Neumonía



Inflamación del cerebro
(encefalitis)



Incluso la muerte



La mejor manera de protegerse contra el sarampión...

es con la vacuna contra el sarampión, las paperas y la rubéola (MMR por sus siglas en inglés). Nunca es demasiado tarde para vacunarse. La vacunación ayuda a protegerle a usted, a quienes le rodean y a su comunidad. Si no está vacunado, considere quedarse en casa o lejos de lugares donde este mucha gente, hasta que disminuyan los casos de sarampión en el área, especialmente para proteger a los miembros de su familia que podrían enfermar gravemente.

Si cree que usted o algún familiar tiene sarampión, manténgase alejado de otras personas y llame a un médico, a un centro de atención de urgencias o a una sala de emergencias.

PREPÁRESE PARA EL SARAMPIÓN
cdc.gov/measles



DO YOU THINK YOUR CHILD HAS MEASLES?

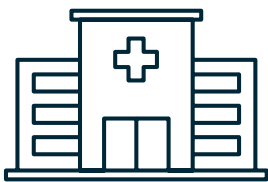
What to do if you think your child has measles

Measles usually starts with a fever, cough, runny nose, and red eyes that leads to a rash. If someone in your family has measles symptoms:

Keep them away from family members that are not sick.

Everyone in the house should stay home to not get your neighbors or people outside of your home sick.

Call a doctor or hospital right away to let them know someone in your home is sick with measles. They will give you instructions.



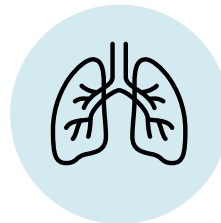
When to go to the emergency room

If the person who is sick gets rapidly worse or has any of symptoms below take them to the emergency department of a hospital immediately.

DO NOT WAIT.



Trouble breathing
(or breathing faster than normal)



Pain when breathing or coughing



Dehydration
(dry nose and mouth, urinating less, crying without making tears)



Fever or headache will not stop



Confusion, decreased alertness, or severe weakness



Blue color around the mouth, low energy, or difficulty feeding
(for young children)

Have someone call before you arrive. Let the hospital know a person with measles is coming.

BE READY FOR MEASLES
[cdc.gov/measles](https://www.cdc.gov/measles)



¿CREE QUE SU HIJO TIENE SARAMPIÓN?

Qué hacer si cree que su hijo tiene sarampión

El sarampión suele empezar con fiebre, tos, moqueo y ojos rojos que provocan un sarpullido. Si alguien de su familia tiene síntomas de sarampión:

Manténgalo alejado de los miembros de la familia que no están enfermos.

Todos los miembros de la familia deben quedarse en casa para no contagiar a los vecinos o a otras personas.

Llame inmediatamente al médico o al hospital para informarles de que alguien en su casa está enfermo de sarampión. Le darán instrucciones.



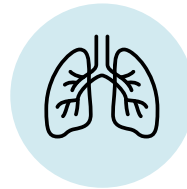
Cuándo acudir a un centro de atención de urgencias

Si empeora rápidamente, o presenta alguno de estos síntomas, vaya inmediatamente a la sala de urgencias de un hospital.

NO ESPERE.



Dificultad para respirar (o respiración más rápida de lo normal)



Dolor al respirar o toser



Deshidratación (sequedad de la nariz o boca, orinar menos, llorar sin lágrimas)



Fiebre o dolor de cabeza que no para



Confusión, disminución del estado de alerta o debilidad severa



Color azul alrededor de la boca, poca energía, o dificultad para alimentar (en niños pequeños)

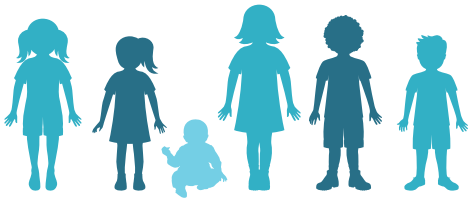
Pida que alguien llame antes de llegar. Avise al hospital de que viene una persona con sarampión.

PREPÁRESE PARA EL SARAMPIÓN
cdc.gov/measles



MEASLES

IT ISN'T JUST A LITTLE RASH



Measles can be dangerous, especially for babies and young children.

Measles symptoms typically include:



High fever
(may spike to more than 104°F)



Cough



Runny nose



Red and/or watery eyes



Rash
(breaks out 3-5 days after symptoms begin)

Measles can be serious.

Measles can cause severe health complications, including pneumonia, swelling of the brain (encephalitis) and death.



1 out of 5 people who get measles will be hospitalized.



1 out of every 20 children with measles will get pneumonia, the most common cause of death from measles in young children.



1 out of every 1,000 people with measles will develop brain swelling, which may lead to brain damage.



1 to 3 out of 1,000 people with measles will die.

Long-term complications

A very rare, but deadly disease called subacute sclerosing panencephalitis can develop 7 to 10 years after a person has recovered from measles.



You have the power to protect your child.

Provide your children with safe and long-lasting protection against measles by making sure they get the measles-mumps-rubella (MMR) vaccine. Talk to your healthcare provider.



www.cdc.gov/measles

EL SARAMPIÓN

NO ES SIMPLEMENTE UN SARPULLIDO LEVE



El sarampión puede ser peligroso, especialmente para los bebés y los niños pequeños.

Los síntomas del sarampión incluyen los siguientes:



Fiebre alta
(puede subir hasta más de 104 °F)



Tos



Moqueo



Ojos enrojecidos y llorosos



Sarpullido
(aparece de 3 a 5 días después del inicio de los síntomas)

El sarampión puede ser grave.

El sarampión puede causar complicaciones graves de salud, como neumonía, inflamación del cerebro (encefalitis) e incluso la muerte.



Cerca de 1 de cada 5 personas que contraen sarampión será hospitalizada.



1 de cada 20 niños con sarampión contraerá neumonía, la causa más frecuente de muerte por sarampión en niños pequeños.



1 de cada 1000 personas con sarampión presentará inflamación del cerebro por la infección (encefalitis), lo cual puede causar daño cerebral.



De 1 a 3 de cada 1000 personas con sarampión morirán.

Complicaciones a largo plazo

Una enfermedad muy rara, pero mortal, llamada panencefalitis esclerosante subaguda, puede desarrollarse entre 7 a 10 años después de que una persona se haya recuperado del sarampión.



Usted tiene el poder de proteger a su hijo.

Dele a su hijo una protección segura y duradera contra el sarampión al asegurarse de que reciba la vacuna contra el sarampión, las paperas y la rubéola (MMR, por sus siglas en español). Consulte con su médico.



www.cdc.gov/measles

Measles, Mumps, and Rubella (MMR) Vaccine Recommendations for Children (0 to 6 years of age) For Communities with Measles Transmission¹

Age Group	Number of Previous MMR Vaccine Doses	Recommended MMR Vaccine ² Doses (if otherwise not contraindicated)
0 - 6 months	0 doses	MMR vaccine is <u>NOT</u> recommended
6 - 11 months	0 doses	- Should receive an early (zero) dose of MMR vaccine immediately - The child should receive two additional doses of MMR vaccine: ➤ 1st dose at 12 to 15 months ➤ 2nd dose at 4 to 6 years of age - Each dose of MMR vaccine must be given at minimum 28 days apart
12 months - 6 years	0 doses	- Should receive a 1st dose of MMR vaccine <u>immediately</u> - Should receive a 2nd dose of MMR vaccine, <u>minimum 28 days after the 1st dose</u>.
	1 dose	Should receive the 2nd dose of MMR vaccine, <u>minimum 28 days after the 1st dose</u> of MMR vaccine.
	2 doses	- No additional MMR vaccination is recommended. - Child is considered <u>fully vaccinated</u> and does <u>not</u> need any additional doses of MMR vaccine.

1. Only in counties designated as part of the outbreak with ongoing community transmission. All other counties follow the CDC's routine MMR vaccination recommendations ([Routine MMR](#))

[Vaccination Recommendations: For Providers | CDC](#)

2. MMR vaccine refers to the current live-attenuated MMR vaccine

Measles, Mumps, and Rubella (MMR) Vaccine Recommendations for Children ≥6 years of age and Adults³ For Communities with Measles Transmission¹

If you were born	Number of Previous MMR Vaccine Doses	Recommended MMR Vaccine ² Doses (if otherwise not contraindicated)
Before 1957	-----	People born before 1957 are presumptively immune to measles, and MMR vaccine is not recommended
Between 1957-1968	0 dose	- Should <u>Immediately</u> get 1st dose of MMR vaccine - Should receive a 2nd dose of MMR vaccine, <u>minimum 28 days</u> after 1 dose of MMR vaccine.
	1 dose of the inactivated MMR Vaccine	
	1 dose of the live-attenuated MMR Vaccine	Should receive a 2nd dose of MMR vaccine.
After 1968	0 doses	- Should <u>immediately</u> get 1st dose of MMR vaccine - Should receive a 2nd dose of MMR vaccine, <u>minimum 28 days</u> after 1 dose of MMR vaccine.
	1 dose	Should receive a 2nd dose of MMR vaccine, <u>minimum 28 days</u> after 1 dose of MMR vaccine.
	2 doses	- No additional MMR vaccination is recommended - You are <u>fully</u> vaccinated and <u>do not</u> need any additional doses of MMR vaccine.

- Only in counties designated as part of the outbreak with ongoing community transmission. All other counties follow the CDC's routine MMR vaccination recommendations ([Routine MMR Vaccination Recommendations: For Providers | CDC](#))
- MMR vaccine refers to the live-attenuated MMR vaccine
- Currently, there are no recommendations to receive a third dose or a booster dose of MMR vaccine for adults during measles community transmission or outbreaks



TEXAS
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Texas Department of State
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March 6, 2025

Measles, Mumps, and Rubella (MMR) Vaccine Recommendations for Specific Populations*	
Pregnant Women	MMR vaccines are not recommended during pregnancy.
Severely Immunocompromised Individuals	- MMR vaccine is not recommended for individuals with severe immunodeficiency - Severe immunodeficiency includes hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with human immunodeficiency virus [HIV] infection who are severely immunocompromised.
Healthcare Personnel	Healthcare personnel without presumptive evidence of immunity should get two doses of MMR vaccine, minimum 28 days apart.
* Measles Vaccination for Specific Groups Measles (Rubeola) CDC March 6, 2025	
 TEXAS Health and Human Services Texas Department of State Health Services	

Summary of Measles Postexposure Prophylaxis*

Risk Population	Time from First Exposure	
	< 72 hours	Through 6 days
Infant < 6 months old	IG	IG
Infant 6 through 12 months	IG or MMR vaccine preferred	IG
Age > 12 months, no risk factor	MMR vaccine dose 1 or MMR vaccine dose 2, if ≥ 28 days from MMR dose 1	IG**
Pregnant woman	IG	IG
Severely immunocompromised	IG	IG

*The following patient groups are at risk for severe disease and complications from measles and should receive IG: infants aged <12 months, pregnant women without evidence of measles immunity, and severely immunocompromised persons. IGIM can be administered to other persons who do not have evidence of measles immunity, but priority should be given to persons exposed in settings with intense, prolonged, close contact (e.g., household, daycare, and classroom). For exposed persons without evidence of measles immunity, a rapid IgG antibody test can be used to inform immune status, provided that administration of IG is not delayed.

**IG is not often used for this age group given the volume of product required to achieve therapeutic doses <https://www.cdc.gov/surv-manual/php/table-of-contents/chapter-7-measles.html>

March 6, 2025

Measles-Mumps-Rubella (MMR) Vaccine Recommendations for Adults

People born after 1957 who have not received two doses of MMR, and have not had the measles, should get the vaccine. If both doses are needed for catch-up, they should be given at least 28 days apart.

If you do not have documentation of your MMR vaccination status, you should receive one dose of the vaccine followed by a second dose at least 28 days apart.

Born Before 1957

- People born before 1957 are presumptively immune to measles, and MMR vaccine is not recommended.

Born Between 1958 and 1968

- Should receive first dose if previously received inactivated ("killed") vaccine followed by a second dose at least 28 days apart.
- Should receive a second dose if previously received only one dose of live-attenuated vaccine, at least 28 days apart.

Born After 1968

- Should receive first dose if vaccination status is unknown, followed by a second dose at least 28 days apart.
- Should receive a second dose if previously received only one dose.

The MMR Vaccine is Safe and Effective

Two doses prevent more than 97% of measles infections.

Getting vaccinated is much safer than getting measles, mumps, or rubella.

The MMR Vaccine is NOT recommended if you are pregnant or immunocompromised.

Talk to Your Doctor

If you have questions about whether the vaccine is right for you, talk to your health care provider.

Measles Outbreak Vaccine Recommendations

for those who live in or visit counties* with measles spread

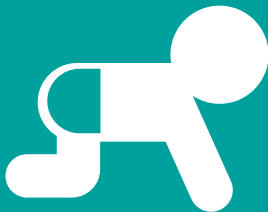
*As of April 7: Cochran, Dallam, Dawson, Gaines, Garza, Lamar, Lubbock, Lynn, Terry and Yoakum

0 to 6 months



Vaccine is NOT recommended

6 to 11 months

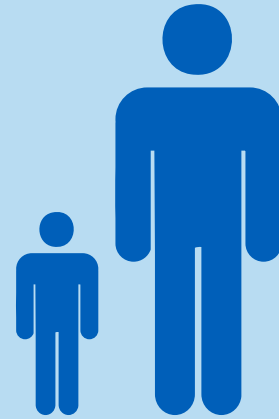


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Previous Vaccine Doses

- Should receive an early dose of vaccine immediately
- Should receive two additional doses of MMR vaccine:
 - First dose at 12- 15 months
 - Second dose at 4- 6 years
- Give each dose at least 28 days apart

1 year to adult



0

Previous Vaccine Doses

- Should receive first dose immediately.
- Should receive second dose at least 28 days later.

1

Previous Vaccine Doses

- Should receive a second dose of MMR vaccine, at least 28 days after first dose.

2

Previous Vaccine Doses

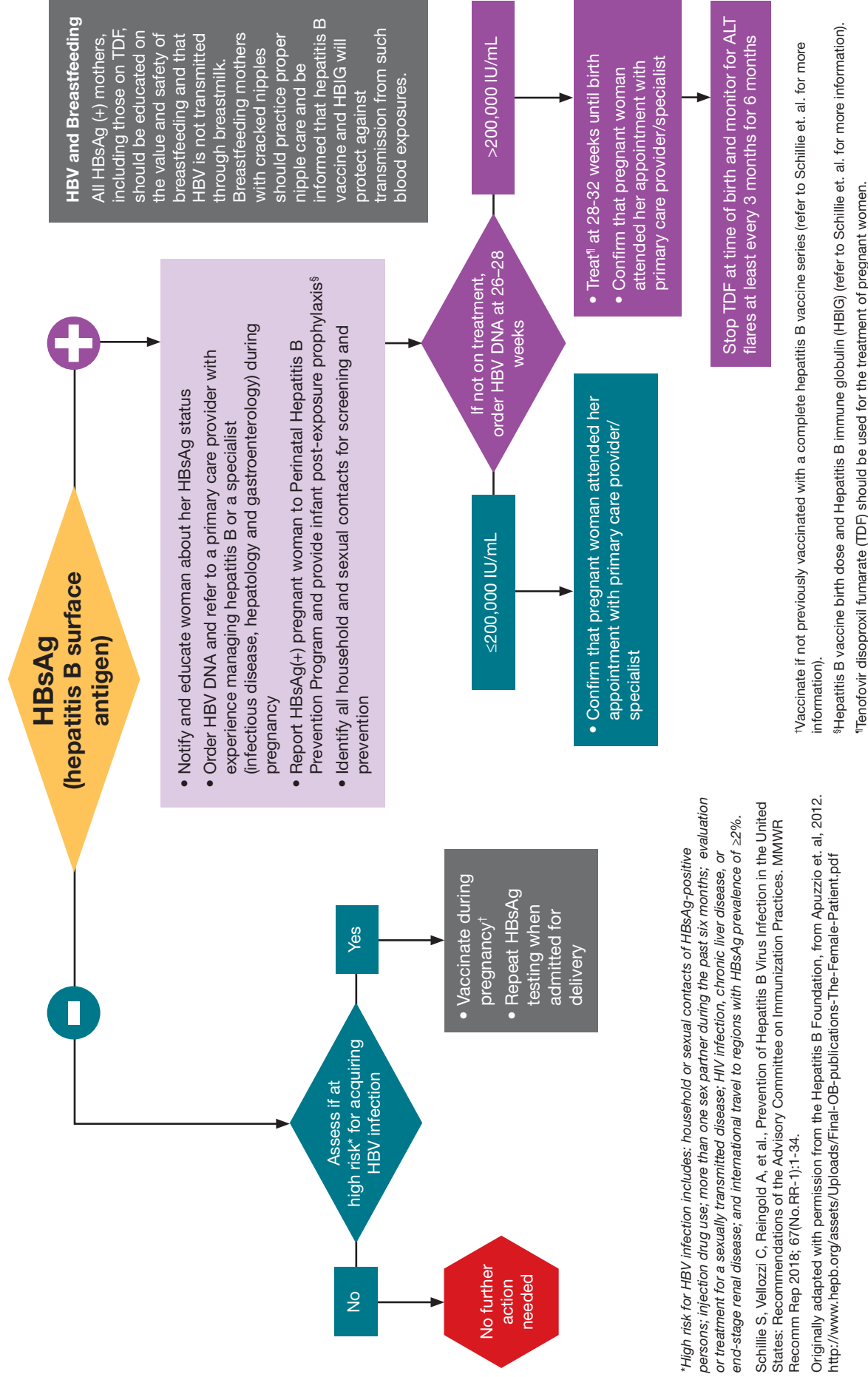
- Fully vaccinated.



TEXAS
Health and Human
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Texas Department of State
Health Services

Screening and Referral Algorithm for Hepatitis B Virus (HBV) Infection Among Pregnant Women



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Your child needs vaccines as they grow!

2025 Recommended Immunizations for Birth Through 6 Years Old



Want to learn more?
Scan this QR code to find out which
vaccines your child might need. Or visit
www2.cdc.gov/vaccines/childquiz/

VACCINE OR PREVENTIVE ANTIBODY	BIRTH	1 MONTH	2 MONTHS	4 MONTHS	6 MONTHS	7 MONTHS	8 MONTHS	12 MONTHS	15 MONTHS	18 MONTHS	19 MONTHS	20-23 MONTHS	2-3 YEARS	4-6 YEARS
RSV antibody		Depends on mother's RSV vaccine status						Depends on child's health status						
Hepatitis B	Dose 1	Dose 2						Dose 3						
Rotavirus		Dose 1	Dose 2	Dose 3										
DTaP		Dose 1	Dose 2	Dose 3				Dose 4						Dose 5
Hib		Dose 1	Dose 2	Dose 3				Dose 4						
Pneumococcal		Dose 1	Dose 2	Dose 3				Dose 4						
Polio		Dose 1	Dose 2	Dose 3				Dose 4						Dose 5
COVID-19								At least 1 dose of the current COVID-19 vaccine						
Influenza/Flu								Every year. Two doses for some children						
MMR								Dose 1						Dose 2
Chickenpox								Dose 1						Dose 2
Hepatitis A								2 doses separated by 6 months						

KEY

ALL children should be immunized at this age

SOME children should get this dose of vaccine or preventive antibody at this age

Talk to your child's health care provider for more guidance if:

1. Your child has any medical condition that puts them at higher risk for infection.
2. Your child is traveling outside the United States. Visit www2.cdc.gov/travel for more information.
3. Your child misses a vaccine recommended for their age.



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American Academy
of Pediatrics

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FOR MORE INFORMATION

Call toll-free: 1-800-CDC-INFO (1-800-232-4636)
Or visit: www2.cdc.gov/vaccines/childquiz/

What diseases do these vaccines protect against?

BIRTH–6 YEARS OLD

VACCINE-PREVENTABLE DISEASE	DISEASE COMPLICATIONS
RSV (<i>Respiratory syncytial virus</i>) Contagious viral infection of the nose, throat, and sometimes lungs; spread through air and direct contact	Infection of the lungs (pneumonia) and small airways of the lungs; especially dangerous for infants and young children
Hepatitis B Contagious viral infection of the liver; spread through contact with infected body fluids such as blood or semen	Chronic liver infection, liver failure, liver cancer, death
Rotavirus Contagious viral infection of the gut; spread through the mouth from hands and food contaminated with stool	Severe diarrhea, dehydration, death
Diphtheria* Illness caused by a toxin produced by bacteria that infects the nose, throat, and sometimes skin	Swelling of the heart muscle, heart failure, coma, paralysis, death
Pertussis (<i>Whooping Cough</i>)* Contagious bacterial infection of the lungs and airway; spread through air and direct contact	Infection of the lungs (pneumonia), death; especially dangerous for babies
Tetanus (<i>Lockjaw</i>)* Bacterial infection of brain and nerves caused by spores found in soil and dust everywhere; spores enter the body through wounds or broken skin	Seizures, broken bones, difficulty breathing, death
Hib (<i>Haemophilus influenzae type b</i>) Contagious bacterial infection of the lungs, brain and spinal cord, or bloodstream; spread through air and direct contact	Depends on the part of the body infected, but can include brain damage, hearing loss, loss of arm or leg, death
Pneumococcal Bacterial infections of ears, sinuses, lungs, or bloodstream; spread through direct contact with respiratory droplets like saliva or mucus	Depends on the part of the body infected, but can include infection of the lungs (pneumonia), blood poisoning, infection of the lining of the brain and spinal cord, death
Polio Contagious viral infection of nerves and brain; spread through the mouth from stool on contaminated hands, food or liquid, and by air and direct contact	Paralysis, death
COVID-19 Contagious viral infection of the nose, throat, or lungs; may feel like a cold or flu. Spread through air and direct contact	Infection of the lungs (pneumonia); blood clots; liver, heart or kidney damage; long COVID; death
Influenza (<i>Flu</i>) Contagious viral infection of the nose, throat, and sometimes lungs; spread through air and direct contact	Infection of the lungs (pneumonia), sinus and ear infections, worsening of underlying heart or lung conditions, death
Measles (<i>Rubeola</i>)* Contagious viral infection that causes high fever, cough, red eyes, runny nose, and rash; spread through air and direct contact	Brain swelling, infection of the lungs (pneumonia), death
Mumps * Contagious viral infection that causes fever, tiredness, swollen cheeks, and tender swollen jaw; spread through air and direct contact	Brain swelling, painful and swollen testicles or ovaries, deafness, death
Rubella (<i>German Measles</i>)* Contagious viral infection that causes low-grade fever, sore throat, and rash; spread through air and direct contact	Very dangerous in pregnant women; can cause miscarriage or stillbirth, premature delivery, severe birth defects
Chickenpox (<i>Varicella</i>) Contagious viral infection that causes fever, headache, and an itchy, blistering rash; spread through air and direct contact	Infected sores, brain swelling, infection of the lungs (pneumonia), death
Hepatitis A Contagious viral infection of the liver; spread by contaminated food or drink or close contact with an infected person	Liver failure, death

***D**Ta**P** protects against tetanus, diphtheria, and pertussis

***M**M**R** protects against measles, mumps, and rubella

Older children and teens need vaccines too!

2025 Recommended Immunizations for Children 7–18 Years Old



Want to learn more?
Scan this QR code to find out which
vaccines your child might need. Or visit
www2.cdc.gov/vaccines/childquiz/

RECOMMENDED VACCINES	7 YEARS	8 YEARS	9 YEARS	10 YEARS	11 YEARS	12 YEARS	13 YEARS	14 YEARS	15 YEARS	16 YEARS	17 YEARS	18 YEARS
HPV												
Tdap												
Meningococcal ACWY												
Meningococcal B												
Influenza/Flu												
COVID-19												
Mpox												
Dengue												

KEY

- ALL children in age group should get the vaccine
- ALL children in age group can get the vaccine

- SOME children in age group should get the vaccine
- Parents/caregivers should talk to their health care provider to decide if this vaccine is right for their child

Talk to your child's health care provider for more guidance if:

1. Your child has any medical condition that puts them at higher risk for infection or is pregnant.
2. Your child is traveling outside the United States. Visit www2.cdc.gov/travel for more information.
3. Your child misses any vaccine recommended for their age or for babies and young children.



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FOR MORE INFORMATION
Call toll-free: 1-800-CDC-INFO (1-800-232-4636)
Or visit: www2.cdc.gov/vaccines/childquiz/

What diseases do these vaccines protect against?

7-18 YEARS OLD

VACCINE-PREVENTABLE DISEASE	DISEASE COMPLICATIONS	NUMBER OF VACCINE DOSES
HPV (Human papillomavirus) Contagious viral infection spread by close skin-to-skin touching, including during sex	Genital warts and many types of cancers later in life, including cancers of the cervix, vagina, penis, anus, and throat	2 or 3 doses
Tetanus (Lockjaw)* Infection caused by bacterial spores found in soil and dust everywhere; spores enter the body through wounds or broken skin	Seizures, broken bones, difficulty breathing, death	1 dose at age 11-12 years Additional doses if missed childhood doses 1 dose for dirty wounds
Diphtheria* Illness caused by a toxin produced by bacteria that infects the nose, throat, and sometimes skin	Swelling of the heart muscle, heart failure, coma, paralysis, death	1 dose at age 11-12 years Additional doses if missed childhood doses
Pertussis (Whooping Cough)* Contagious bacterial infection of the lungs and airway; spread through air and direct contact	Infection of the lungs (pneumonia), death; especially dangerous for babies	1 dose at age 11-12 years Additional doses if missed childhood doses 1 dose every pregnancy
Meningococcal** Contagious bacterial infection of the lining of the brain and spinal cord or the bloodstream; spread through air and direct contact	Loss of arm or leg, deafness, seizures, death	2 doses. Additional doses may be needed depending on medical condition or vaccine used.
Influenza (Flu) Contagious viral infection of the nose, throat, and sometimes lungs; spread through air and direct contact	Infection of the lungs (pneumonia), sinus and ear infections, worsening of underlying heart or lung conditions, death	1 dose each year 2 doses in some children aged 6 months through 8 years
COVID-19 Contagious viral infection of the nose, throat, or lungs; may feel like a cold or flu. Spread through air and direct contact	Infection of the lungs (pneumonia); blood clots; liver, heart or kidney damage; long COVID; death	1 or more doses of the current COVID-19 vaccine depending on health status. For more information: www.cdc.gov/covidschedule
Mpox Contagious viral infection spread through close, often skin-to-skin contact, including sex; causes a painful rash, fever, headache, tiredness, cough, runny nose, sore throat, swollen lymph nodes	Infected sores, brain swelling, infection of the lungs (pneumonia), eye infection, blindness, death	2 doses
Dengue Viral infection spread by bite from infected mosquito; causes fever, headache, pain behind the eyes, rash, joint pain, body ache, nausea, loss of appetite, feeling tired, abdominal pain	Severe bleeding, seizures, shock, damage to the liver, heart, and lungs, death	3 doses

***Tdap** protects against tetanus, diphtheria, and pertussis

****Healthy adolescents:** Meningococcal ACWY vaccine (2 doses); Meningococcal B vaccine (2 doses if needed).

You need vaccines throughout your life!

2025 Recommended Immunizations for Adults Aged 19 Years and Older

Want to learn more?
Scan this QR code to find out which
vaccines you may need. Or visit:
www2.cdc.gov/nip/adultimmsched/



Staying **up to date** on your vaccines is one of the best things you can do to protect your health.

If you are pregnant or have a medical condition that puts you at higher risk for infections, talk to your health care provider about which vaccines are right for you.

KEY

- ALL adults in age group should get the vaccine.
- SOME adults in age group should get the vaccine.
- ▨ Adults should talk to their health care provider to decide if this vaccine is right for them.

VACCINE	19–26 YEARS	27–49 YEARS	50–64 YEARS	65+ YEARS
COVID-19	Aged 64 and younger: At least 1 dose of the current COVID-19 vaccine.			65+: At least 2 doses.
Influenza/Flu		Every Year		
RSV		If pregnant during RSV season	If aged 60 through 74 years	If aged 75 years or older
Tdap/Td		Tdap every pregnancy. Td/Tdap every 10 years for all adults.		
MMR		If aged 68 years or younger		
Chickenpox		If U.S. born and aged 45 years or younger		
Shingles				
HPV		Aged 27–45 years		
Pneumococcal				
Hepatitis A				
Hepatitis B		Through 59 years		
Meningococcal				
Hib				
Mpox				

What diseases do these vaccines protect against?

ADULTS AGED 19 YEARS AND OLDER

VACCINE-PREVENTABLE DISEASE	DISEASE COMPLICATIONS	NUMBER OF VACCINE DOSES
COVID-19 Contagious viral infection of the nose, throat, or lungs; may feel like a cold or flu	Pneumonia, blood clots, liver, heart, or kidney damage, long COVID, death	1 or more doses of the current COVID-19 vaccine depending on age or health status. For more information: www.cdc.gov/covid/schedule
Influenza (Flu) Contagious viral infection of the nose, throat, and sometimes lungs	Pneumonia, sinus and ear infections, worsening of underlying health conditions like heart and lung disease, death	1 dose each year
RSV (Respiratory syncytial virus) Contagious viral infection of the nose, throat, and sometimes lungs	Pneumonia, inflammation of the small airways in the lung; especially dangerous for infants, young children, and older adults	1 dose
Tetanus (Lockjaw)* Infection caused by bacterial spores found in soil and dust everywhere; spores enter the body through wounds or broken skin	Sudden, involuntary muscle spasms, jaw cramping, seizures, broken bones, difficulty breathing, death	3 doses if not already vaccinated 1 booster every 10 years 1 dose for dirty wounds
Diphtheria* Illness caused by a toxin produced by bacteria that infects the nose, throat, and sometimes skin	Thick, gray, build up in throat or nose makes breathing and swallowing difficult; heart failure, brain injury, coma, death	3 doses if not already vaccinated 1 booster every 10 years
Pertussis (Whooping Cough)* Contagious bacterial infection of the lungs and airway	Severe coughing fits, life-threatening pause in breathing, pneumonia, death; especially dangerous for babies	3 doses if not already vaccinated 1 dose every pregnancy
Measles (Rubeola)† Contagious viral infection that causes high fever, cough, red eyes, runny nose, and rash	Brain swelling, pneumonia, death	1 or 2 doses
Mumps† Contagious viral infection that causes fever, tiredness, swollen cheeks, and tender swollen jaw	Brain swelling, painful and swollen testicles or ovaries, deafness, death	1 or 2 doses
Rubella (German Measles)† Contagious viral infection that causes low-grade fever, sore throat, and rash	Very dangerous in pregnant women; can cause miscarriage or stillbirth, premature delivery, severe birth defects	1 or 2 doses
Chickenpox (Varicella) Contagious viral infection that causes fever, headache, and an itchy, blistering rash	Infected sores, brain swelling, pneumonia, death	2 doses
Shingles (Zoster) Caused by the chickenpox virus, which hides in the body and sometimes reactivates later in life	Severe blistering rash on one side of the face or body; long-term nerve pain, hearing damage, blindness, death	2 doses
HPV (Human papillomavirus) Contagious viral infection spread by sexual contact; sometimes causes genital warts	Many types of cancers including cancers of the cervix, vagina, penis, anus, and throat	2 or 3 doses
Pneumococcal Bacterial infections of ears, sinuses, lungs, or bloodstream	Depends on the part of the body infected, but can include pneumonia, blood poisoning, infection of the lining of the brain and spinal cord, death	1 or 2 doses
Hepatitis A Contagious viral infection of the liver spread by contaminated food or drink or close contact with an infected person	Liver failure, yellow skin or eyes, stomach pain, vomiting, fever, diarrhea, fatigue, death	2, 3, or 4 doses depending on vaccine used
Hepatitis B Contagious viral infection of the liver spread through contact with infected body fluids such as blood or semen	Liver failure, yellow skin or eyes, stomach pain, vomiting, fever, diarrhea, fatigue, death	2, 3, or 4 doses depending on vaccine used
Meningococcal Bacterial infection of the lining of the brain and spinal cord or the bloodstream	Fever, headache, stiff neck, light sensitivity, confusion, loss of arm or leg, deafness, seizures, death	1 or more doses depending on vaccine used, medical condition, where patient lives or works
Hib (<i>Haemophilus influenzae</i> type b) Bacterial infection that can attack the lungs, brain and spinal cord, or bloodstream	Brain damage, hearing loss, loss of arm or leg, death	1 or 3 doses depending on medical condition
Mpox Contagious viral infection spread by sexual contact; causes a painful rash, fever, headache, tiredness, cough, runny nose, sore throat, swollen lymph nodes	Infected sores, brain swelling, pneumonia, eye infection, blindness, death	2 doses

***Tdap** protects against tetanus, diphtheria, and pertussis

***Td** protects against tetanus and diphtheria

†MMR protects against measles, mumps, and rubella

Last updated April 2025

Free Immunization Resources

What is the DSHS Immunization Publication Order Form?

DSHS Immunization has created materials to help educate the public on the importance of vaccines.

These materials are available for free using the publication order form on our online portal.

What is Available in the Order Form?

- Brochures
- Flyers
- Posters
- Vaccine Information Statements (VIS)
- Immunization Schedules
- Children and Teen Activity Books
- Refrigerator Magnets

How to Access the Order Form

1. Go to immunizetexasorderform.com.
2. Create an account by clicking “click here to register.”
3. After registering, your email becomes your username.
4. You can browse by page or use keywords to look for specific materials in the search field in the top-right corner, next to the cart icon.

How to Place an Order

Once you find the items you want to order, add them to your cart and proceed to checkout. DSHS will ship the materials free to the address provided unless you request expedited shipping.

Please note: Products have a limit on the amount you can order at one time. Please contact PIET@dshs.texas.org for orders that exceed the online limits. Submitting multiple orders to bypass the maximum limit will delay your order.



Having issues?

If you receive an error message, please provide the error ID number and a screenshot of the error along with a brief description. We will work with our vendor to fix your cart.

If you have issues ordering, please contact PIET@dshs.texas.gov and someone will help you.



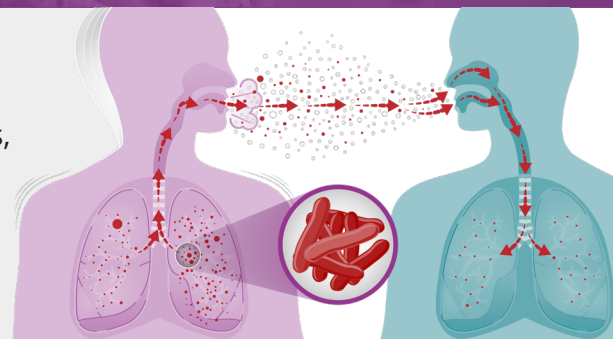
Texas Department of State
Health Services

Texas Department of State Health Services
Immunizations Section
Stock # 11-16791 Rev. 09/2024

What You Need to Know About Tuberculosis

Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine.

Not everyone infected with TB germs becomes sick. As a result, two TB-related conditions exist: latent TB infection (or inactive TB) and TB disease. If not treated properly, TB disease can be fatal.



The Difference Between Inactive TB and Active TB Disease

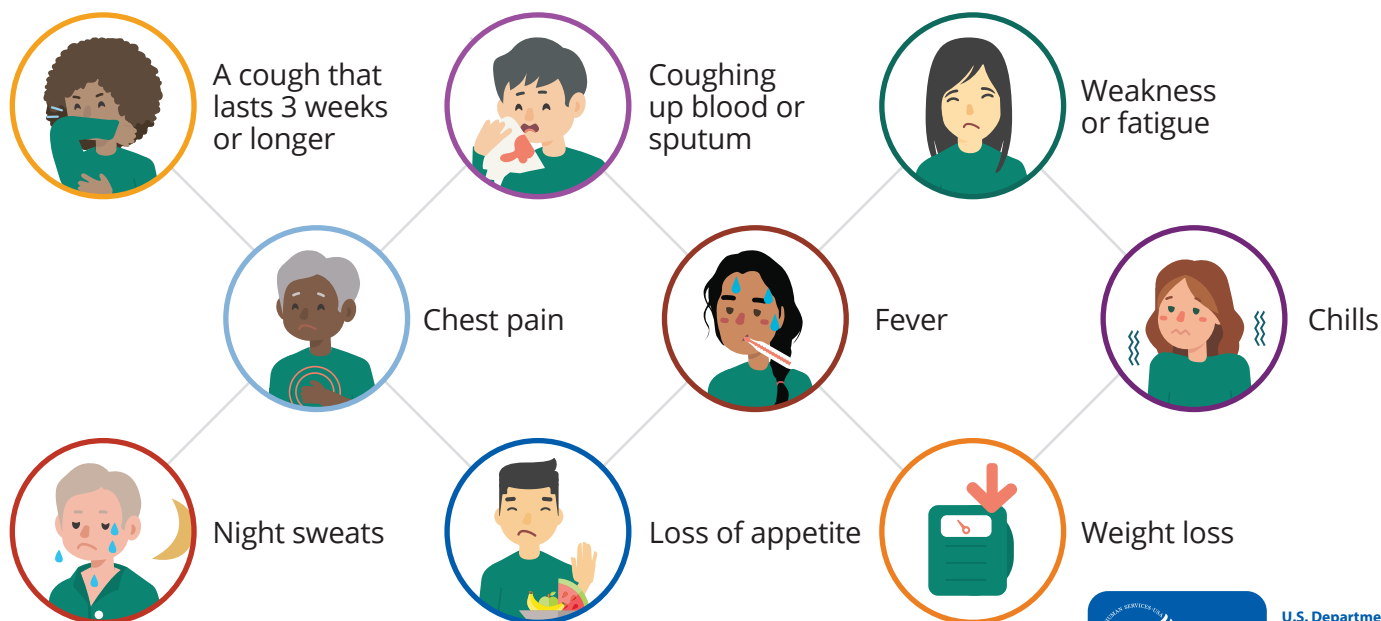
A Person With Inactive TB

- Has a small amount of TB germs in their body that are alive but inactive.
- Has no symptoms and does not feel sick.
- Cannot spread TB germs to others.
- Usually has a positive TB blood test or TB skin test indicating TB infection.
- Has a normal chest x-ray and a negative sputum smear.
- Needs treatment for inactive TB to prevent active TB disease.

A Person With Active TB Disease

- Has a large amount of active TB germs in their body.
- Has symptoms and feels sick.
- May spread TB germs to others.
- Usually has a positive TB blood test or TB skin test indicating TB infection.
- May have an abnormal chest x-ray, or positive sputum smear or culture.
- Needs treatment for active TB disease.

If your body cannot stop TB germs from growing, you develop active TB disease. Symptoms of active TB disease include:



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Control and Prevention

Testing for TB



Getting tested and treated for TB can protect yourself, your family and friends, and your community. There are two types of tests for TB infection: the **TB blood test** and the **TB skin test**.

A Positive Test For TB Infection

You have TB germs in your body. Your doctor will do other tests to determine if you have inactive TB or active TB disease. These tests may include a chest x-ray, and a test of the sputum you cough up.

A Negative Test For TB Infection

A negative test means you likely do not have inactive TB or active TB disease.

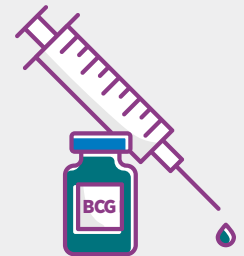
Your doctor may do more tests if:

- You have symptoms of active TB disease, like coughing, chest pain, fever, weight loss, or tiredness.
- You have HIV infection.
- Your exposure to TB germs was recent.

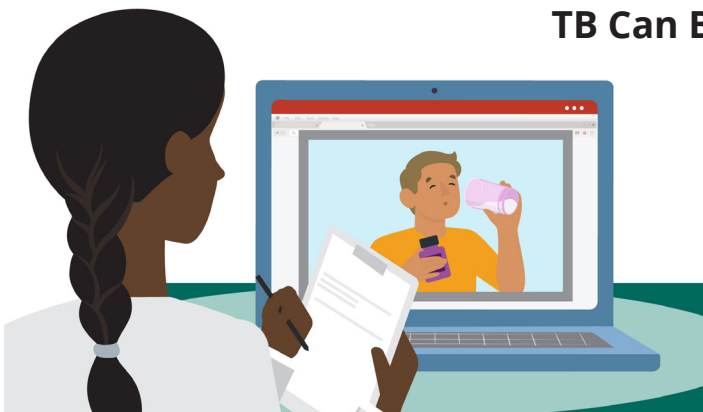
Tell Your Doctor if You Received a TB Vaccine

TB blood tests are the preferred test for people who have received the bacille Calmette-Guérin (BCG) TB vaccine. Unlike the TB skin test, TB blood tests are not affected by BCG vaccination.

Many people born outside of the United States have received the BCG TB vaccine. BCG vaccination does not completely prevent people from getting TB. A positive reaction to a TB skin test may be due to the BCG vaccine itself or due to infection with TB germs.



TB Can Be Treated



TB germs can live in your body for years without causing symptoms. If you have inactive TB, treating it is the best way to protect you from getting sick with active TB disease.

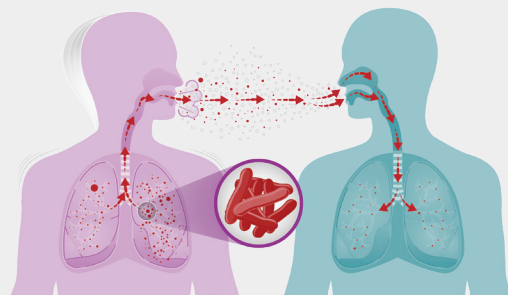
If you have been diagnosed with active TB disease, you can be treated with medicine. You will need to take and finish all of your TB medicine as directed by your doctor or nurse. This is to help you feel better and prevent other people from getting sick.

The best way to remember to take your medicines for active TB disease is by receiving directly observed therapy (DOT). Through DOT, you will meet with a health care worker every day or several times a week either in-person or virtually. The health care worker will make sure that the TB medicines are working as they should.

Lo que debe saber sobre la tuberculosis

La tuberculosis (TB) es una enfermedad causada por microbios que se propagan de persona a persona a través del aire. La TB generalmente afecta los pulmones, pero también puede afectar otras partes del cuerpo, como el cerebro, los riñones o la columna vertebral.

No todas las personas infectadas con microbios de TB se enferman. Como resultado, existen dos afecciones relacionadas con la TB: la infección de TB latente (o TB inactiva) y la enfermedad de TB. Si no se trata adecuadamente, la enfermedad de TB puede ser mortal.



Diferencias entre la TB inactiva y la enfermedad de TB activa

Las personas con TB inactiva

- Tienen una pequeña cantidad de microbios de TB en el cuerpo que están vivos pero inactivos.
- No tienen síntomas ni se sienten enfermas.
- No pueden transmitir los microbios de la TB a los demás.
- Suelen tener pruebas de sangre de la TB o pruebas cutáneas de la tuberculina positivas, lo cual indica infección de TB.
- Tienen radiografías de tórax normales y análisis de esputo con resultados negativos.
- Necesitan tratamiento para la TB inactiva para prevenir la enfermedad de TB activa.

Las personas con enfermedad de TB activa

- Tienen una gran cantidad de microbios de TB activos en el cuerpo.
- Tienen síntomas y se sienten enfermas.
- Pueden transmitir los microbios de la TB a los demás.
- Suelen tener pruebas de sangre de la TB o pruebas cutáneas de la tuberculina positivas, lo cual indica infección de TB.
- Pueden tener radiografías de tórax anormales, o cultivos o análisis de esputo con resultados positivos.
- Necesitan tratamiento para la enfermedad de TB activa.

Si su cuerpo no puede impedir que los microbios de la TB se multipliquen, usted presentará la enfermedad de TB activa. Los síntomas de la TB activa incluyen:



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Pruebas de detección de la TB

Hacerse una prueba de TB y recibir tratamiento puede protegerlo a usted y proteger a su familia, sus amigos y su comunidad. Hay dos tipos de pruebas para detectar la infección de TB: la **prueba de sangre de la TB** y la **prueba cutánea de la tuberculina**.



+ Resultado positivo de infección de TB

Usted tiene microbios de la TB en el cuerpo. Su médico hará otras pruebas para determinar si tiene la TB inactiva o la enfermedad de TB activa. Estas pruebas podrían incluir una radiografía de tórax y un análisis del esputo que expulsa al toser.

- Resultado negativo de infección de TB

Un resultado negativo significa que es probable que usted no tenga la TB inactiva ni la enfermedad de TB activa.

Su médico podría hacer más pruebas si usted:

- Tiene síntomas de la enfermedad de TB activa, como tos, dolor en el pecho, fiebre, pérdida de peso o cansancio.
- Tiene la infección por el VIH.
- Su exposición a los microbios de la TB fue reciente.

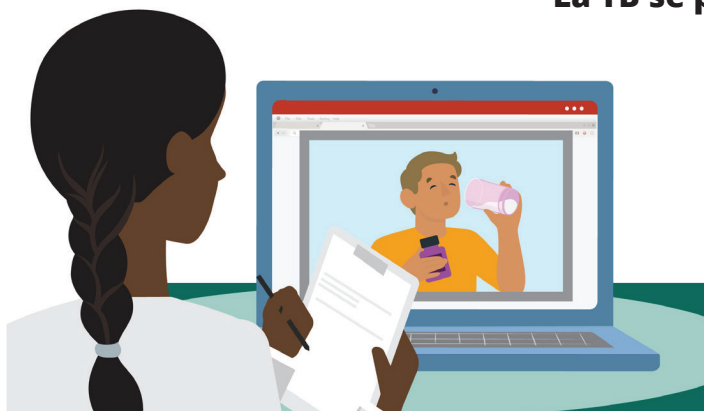
Dígale a su médico si recibió una vacuna contra la TB

Las pruebas de sangre de la TB son las que se prefieren para las personas que se han puesto la vacuna de bacilo de Calmette y Guérin (BCG) contra la tuberculosis. A diferencia de las pruebas cutáneas de la tuberculina, las pruebas de sangre no se ven afectadas por la BCG.

Muchas personas nacidas fuera de los Estados Unidos están vacunadas con la BCG. Esta vacuna no previene completamente que las personas contraigan la TB. La causa de una reacción positiva a la prueba cutánea de la tuberculina puede ser la vacuna BCG misma o una infección de microbios de TB.



La TB se puede tratar



Los microbios de la TB pueden permanecer en su cuerpo durante años sin causarle síntomas. Si usted tiene la TB inactiva, tratarla es la mejor forma de protegerse para que no le cause la enfermedad de TB activa.

Si le han diagnosticado enfermedad de TB activa, puede recibir tratamiento con medicamentos. Deberá tomar y terminar todos sus medicamentos según las indicaciones de su médico o enfermero. Esto es para ayudarlo a sentirse mejor y prevenir que se enfermen otras personas.

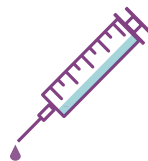
La mejor forma de acordarse de tomar sus medicamentos para la enfermedad de TB activa es mediante el tratamiento de observación directa (DOT, por sus siglas en inglés). Con la DOT, se reunirá con un trabajador de la salud todos los días o varias veces a la semana, ya sea en persona o de manera virtual. El trabajador de la salud se asegurará de que los medicamentos contra la TB estén funcionando del modo esperado.

What You Need to Know About the TB Skin Test

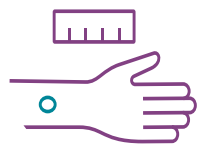
Getting tested and treated for **tuberculosis (TB)** can protect yourself, your family and friends, and your community. There are two types of tests for TB infection: the TB blood test and the TB skin test. This fact sheet provides information on the TB skin test.

TB Skin Test

The TB skin test, also known as the tuberculin skin test, may be used to find out if you are infected with TB germs. A health care worker will use a small needle to inject testing fluid (called tuberculin) under the skin on the lower part of your inner arm.



After Receiving the TB Skin Test



After the test, you should avoid using bandages, putting on lotion, or scratching the test area because it may affect the results. You can wash the area with water, but do not wipe or scrub. If the area itches, put an ice cube or cold cloth on it.

After 2 or 3 days, you must return to have a health care worker read your skin test. You may have swelling or a bump where the testing fluid was injected. The health care worker will measure the bump or swelling and will tell you if your skin test reaction is positive or negative.

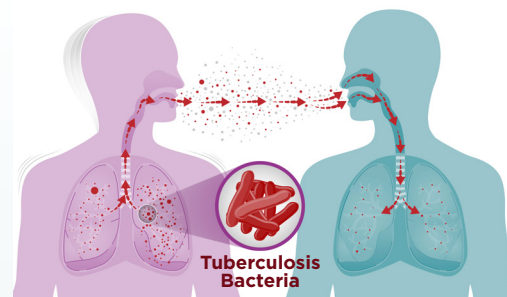
If you are not able to return within 2 to 3 days, you will need to repeat the skin test again.

Return to have your skin test read

Date: _____

Time: _____

Location: _____



TB germs spread through the air from one person to another. Anyone can get TB. TB germs usually attack the lungs but can move to any part of your body.

The bacteria responsible for causing TB can live in the body for years without symptoms. This is called latent TB infection or inactive TB. People with inactive TB do not have signs and symptoms of active TB disease and cannot spread TB bacteria to others.

Without treatment, inactive TB can become active TB disease at any time and make you sick. If not treated properly, active TB disease can be fatal.



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If your skin test is **POSITIVE**:

- You have TB germs in your body.
- The test does **not** tell whether you have inactive TB or active TB disease. You will need other tests, such as a physical examination, chest x-ray, and lab work to determine if you have active TB disease.
- Once you test positive for TB, you will always have a positive skin test even if you complete treatment for TB. Ask your health care provider for a written record of your positive TB skin test result. This will be helpful if you are asked to have another test in the future.



If your TB skin test is **NEGATIVE**:

- Your body did not react to the test. You likely do not have inactive TB or active TB disease.
- You may need to have more tests if:
 - » You have symptoms of active TB disease, like coughing, chest pain, fever, weight loss, or tiredness.
 - » You have HIV infection.
 - » Your exposure to TB germs was recent. You may need a second skin test 8 to 10 weeks after the last time you spent time with someone with active TB disease. This is because it can take several weeks after infection for your immune system to react to the TB skin test. If your reaction to the second test is negative, you likely do not have inactive TB or active TB disease.

Did You Receive the Bacille Calmette-Guérin (BCG) Vaccine?



BCG is a vaccine for TB. This vaccine is not widely used in the United States. Many people born outside of the United States have received the BCG TB vaccine.

It is often given to infants and small children in other countries where TB is more common. It protects children in those countries from getting severe forms of active TB disease, such as TB meningitis. Protection from TB goes away as people get older.

Let your health care provider know if you were previously vaccinated with the BCG TB vaccine.

In some people, the BCG TB vaccine may cause a positive TB skin test even if they are not infected with TB germs. Unlike the TB skin test, TB blood tests are not affected by prior BCG vaccination. Therefore, TB blood tests are the preferred test for people who have received the BCG TB vaccine.

TB Can Be Treated

If you have inactive TB, you can take medicine to prevent the development of active TB disease even if you do not feel sick.

TB germs can live in your body for years without causing symptoms. Without treatment, inactive TB can develop into active TB disease and make you sick.

If you have been diagnosed with active TB disease, you will need to take and finish all your TB medicine. This is to help you feel better and prevent other people from getting sick.

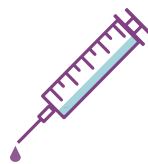


Lo que necesita saber sobre la prueba cutánea de la tuberculina

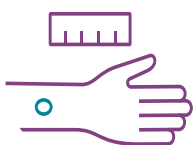
Hacerse la prueba de detección de la **tuberculosis** (llamada **TB en inglés**) y recibir tratamiento puede protegerlo a usted, a sus familiares y amigos, y a su comunidad. Hay dos tipos de prueba para detectar la infección de TB: la prueba de sangre y la prueba cutánea de la tuberculina. Esta hoja informativa proporciona información sobre la prueba cutánea de la tuberculina.

Prueba cutánea de la tuberculina

La prueba cutánea de la tuberculina se puede usar para determinar si usted se ha infectado con microbios de TB. Un trabajador de la salud usará una aguja pequeña para inyectarle un líquido para la prueba (llamado tuberculina) debajo de la piel, en el antebrazo.



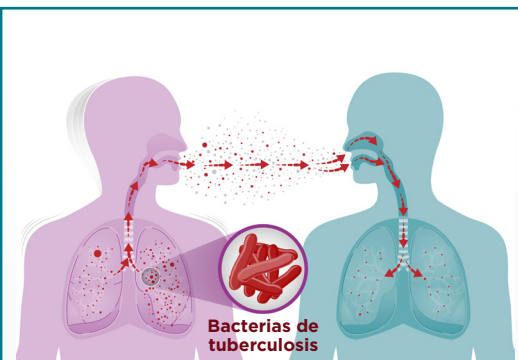
Después de que le hagan la prueba cutánea de la tuberculina



Después de la prueba, debe evitar usar vendajes, aplicarse lociones o rascarse el área de la piel usada para la prueba, ya que podría afectar los resultados. Puede lavarse el área con agua, pero no la limpie con una toallita ni la restriegue. Si le pica, aplique frío con un cubito de hielo o un paño frío.

Después de 2 o 3 días, deberá regresar para que un trabajador de la salud lea el resultado de su prueba cutánea. Es posible que tenga hinchazón o un bulto en donde se le inyectó el líquido. El trabajador de la salud medirá el bulto o la hinchazón y le dirá si la reacción a la prueba es positiva o negativa.

Si no puede regresar dentro de los 2 a 3 días, deberá repetir la prueba cutánea.



Los microbios de la TB se propagan por el aire de una persona a otra. Todas las personas pueden contraer TB. Los microbios de la TB por lo general atacan los pulmones, pero también pueden ir a cualquier parte del cuerpo.

Las bacterias que causan la TB pueden vivir en el cuerpo por años sin que se presenten síntomas. Esto se conoce como infección de TB latente o TB inactiva. Las personas con TB inactiva no presentan signos ni síntomas de la enfermedad de TB activa, ni pueden propagar las bacterias a otras personas.

Si no se trata, la TB inactiva puede volverse TB activa en cualquier momento y enfermarlo. Si no se trata adecuadamente, la enfermedad de TB activa puede ser mortal.

Regrese para la lectura de su prueba cutánea



Fecha: _____

Hora: _____

Lugar: _____



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Si su prueba cutánea da POSITIVO:

- Usted tiene los microbios de la TB en el cuerpo.
- La prueba **no** indica si usted tiene TB inactiva o la enfermedad de TB activa. Necesitará otras pruebas, como un examen físico, radiografía del tórax y pruebas de laboratorio para determinar si tiene la enfermedad de TB activa.
- Una vez que dé positivo en la prueba de TB, siempre tendrá un resultado positivo en la prueba cutánea, aunque complete el tratamiento. Pídale a su proveedor de atención médica un registro por escrito de su resultado positivo a la prueba cutánea de la tuberculina. Esto le servirá si se le pide que se haga otra prueba en el futuro.



Si la prueba de la tuberculina da NEGATIVO:

- Su cuerpo no reaccionó a la prueba. Probablemente no tiene TB inactiva ni la enfermedad de TB activa.
- Podría necesitar más pruebas si:
 - » Tiene síntomas de la enfermedad de TB activa, como tos, dolor en el pecho, fiebre, pérdida de peso o cansancio.
 - » Tiene infección por el VIH.
 - » Su exposición a los microbios de la TB fue reciente. Es posible que necesite una segunda prueba cutánea 8 a 10 semanas después de la última vez que haya pasado tiempo con alguien con enfermedad de TB activa. Esto se debe a que su sistema inmunitario puede tardar varias semanas en reaccionar a esta prueba después de la infección. Si su reacción a la segunda prueba es negativa, probablemente no tiene TB inactiva ni la enfermedad de TB activa.

¿Le pusieron la vacuna de bacilo de Calmette y Guérin (BCG)?



La BCG es una vacuna contra la TB. En los Estados Unidos su uso no es generalizado. Muchas personas nacidas fuera de este país están vacunadas con la BCG.

En otros países donde la TB es más común, se suele aplicar a los bebés y a los niños pequeños. Los protege contra las formas graves de la enfermedad de TB activa, como la TB meníngea. La protección contra la TB desaparece con la edad.

Dígale a su proveedor de atención médica si se vacunó previamente con la BCG.

En algunas personas la vacuna BCG puede causar una reacción positiva en la prueba cutánea de la tuberculina, aunque no estén infectadas por los microbios de la TB. A diferencia de las pruebas cutáneas de la tuberculina, las pruebas de sangre no se ven afectadas por la vacunación previa con la BCG. Por lo tanto, se prefieren las pruebas de sangre para las personas vacunadas con la BCG.

La TB puede ser tratada

Si usted tiene TB inactiva, puede tomar medicamentos para prevenir la aparición de la enfermedad de TB activa, aunque no se sienta enfermo.

Los microbios de la TB pueden permanecer en su cuerpo durante años sin causar síntomas. Si no se trata, la TB inactiva puede convertirse en la enfermedad de TB activa y enfermarlo.

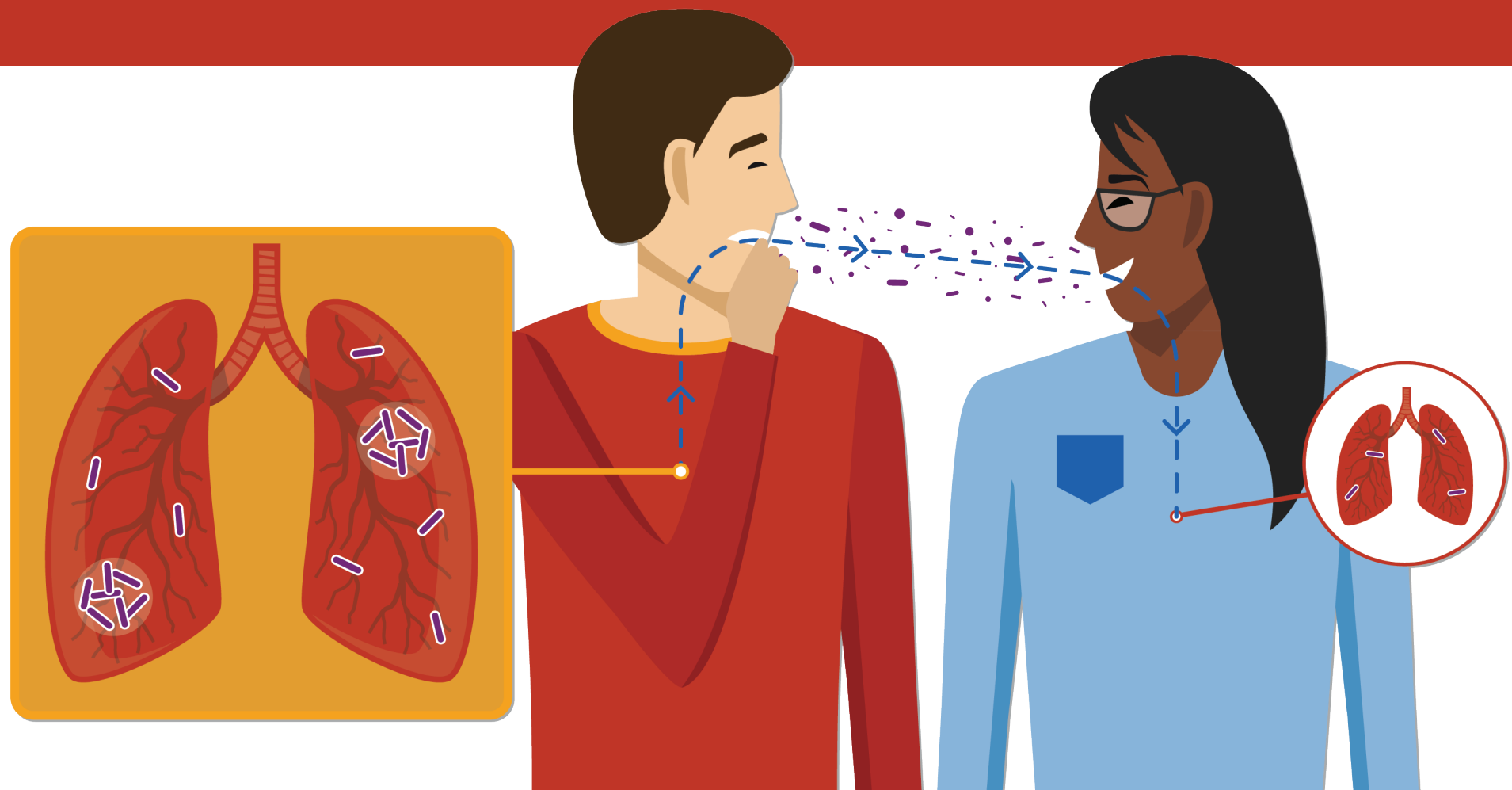
Si le han diagnosticado la enfermedad de TB activa, necesitará tomar y finalizar todos los medicamentos contra la TB. Esto es para ayudarlo a sentirse mejor y prevenir que otras personas se enfermen.



STOP TB

Tuberculosis (TB) **spreads through the air** from one person to another.

- TB germs spread when a person with infectious TB disease **coughs, speaks, or sings**.
- TB germs usually **attack the lungs** but can also move to any part of the body.



TB germs can live in the body **without making you sick**.

This is called **latent TB infection** or **inactive TB**.

- TB germs can live in your body for years without causing symptoms. Without treatment, **inactive TB can develop into active TB disease and make you sick**.
- If you have inactive TB, you can take TB medicine to **prevent the development of active TB disease** even if you do not feel sick.

If your body cannot stop TB germs from growing, **you develop active TB disease**.

- You may **feel sick** and **spread TB germs** to your family, friends, and others around you.
- You need to **take and finish all your TB medicine** to help you feel better and prevent other people from getting sick.

Symptoms of active TB disease:



Cough lasting 3+ weeks



Coughing up blood or sputum (phlegm from deep inside the lungs)



Chest pain



Weakness or fatigue



No appetite



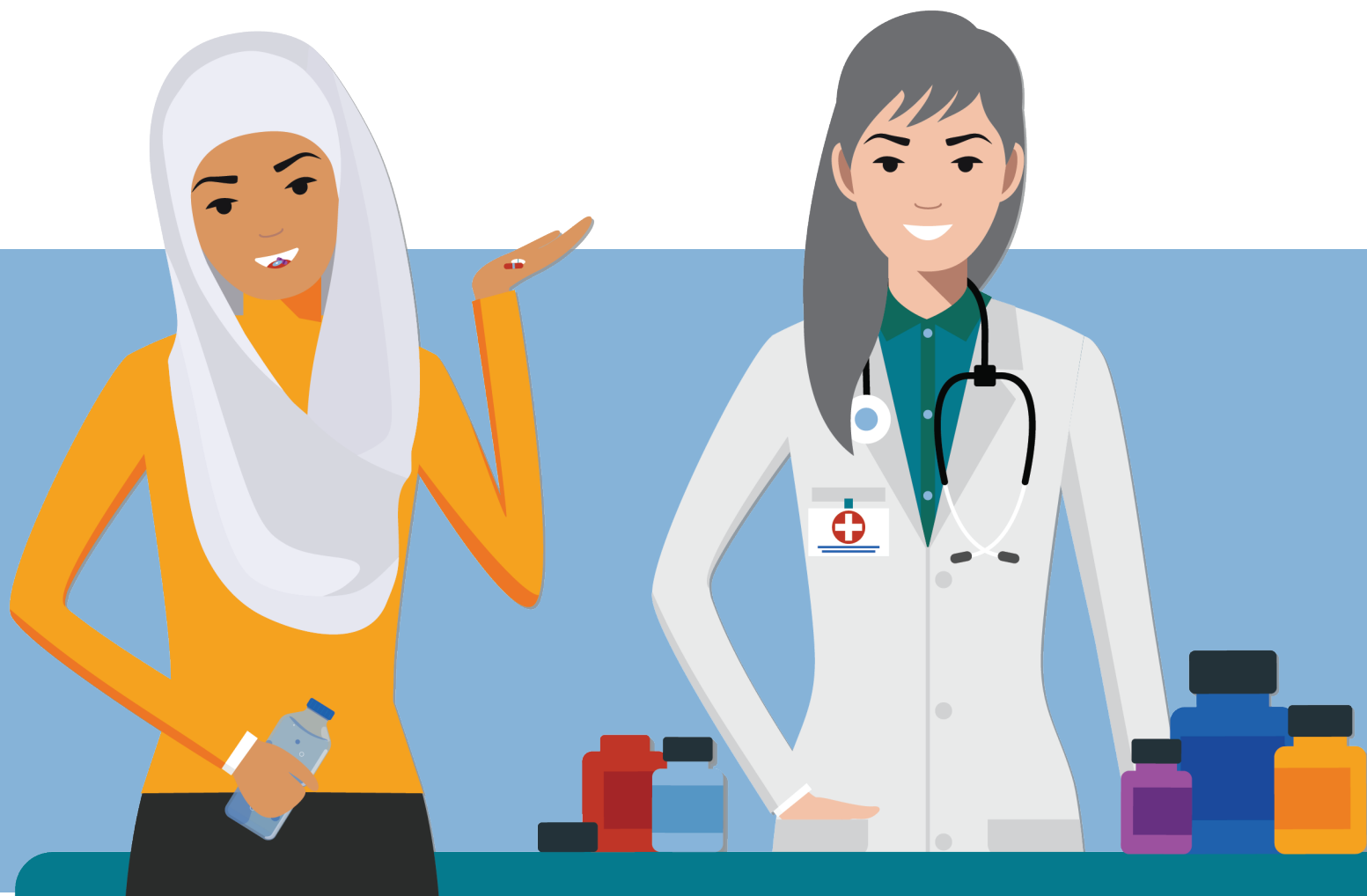
Weight loss



Fever and/or chills



Night sweats



Take and finish all of your TB medicine to **kill TB germs** and **STOP TB!**

What Clinicians Need to Know about LEGIONNAIRES' DISEASE

Legionnaires' disease is a sometimes fatal form of pneumonia that is on the rise in the United States. Unfortunately, this disease is also underrecognized and underdiagnosed. Clinicians are in a unique position to make sure cases are detected, allowing rapid investigation by public health officials and prevention of additional cases.

Diagnosis and Testing

Clinical features of Legionnaires' disease include cough, fever, and radiographic pneumonia. Signs and symptoms for Legionnaires' disease are similar to pneumonia caused by other pathogens; the only way to tell if a pneumonia patient has Legionnaires' disease is by getting a specific diagnostic test. Indications that warrant testing include:

- Patients who have failed outpatient antibiotic therapy for community-acquired pneumonia
- Patients with severe pneumonia, in particular those requiring intensive care
- Immunocompromised patients with pneumonia*
- Patients with a travel history (patients who have traveled away from their home within 14 days before the onset of illness)
- All patients with pneumonia in the setting of a Legionnaires' disease outbreak
- Patients at risk for Legionnaires' disease with healthcare-associated pneumonia (pneumonia with onset ≥ 48 hours after admission)

* Clinicians may also consider testing for Legionnaires' disease in patients with other risk factors for this infection (see page 2).

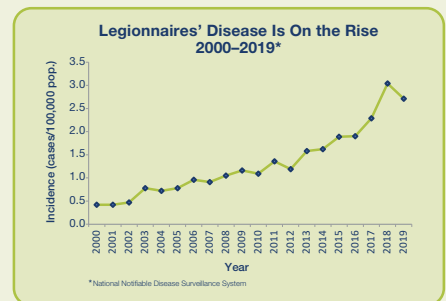
Testing for healthcare-associated Legionnaires' disease is especially important if any of the following are identified in your facility:

- Other patients with healthcare-associated Legionnaires' disease diagnosed in the past 12 months
- Positive environmental tests for *Legionella* in the past 2 months
- Current changes in water quality that may lead to *Legionella* growth (such as low chlorine levels)

Infection control staff may have more information about these situations in your facility.

The preferred diagnostic tests for Legionnaires' disease are culture of lower respiratory secretions (e.g., sputum, bronchoalveolar lavage) on selective media and the *Legionella* urinary antigen test. Serological assays can be nonspecific and are not recommended in most situations. Best practice is to obtain both sputum culture and a urinary antigen test concurrently. Sputum should ideally be obtained prior to antibiotic administration, but antibiotic treatment should not be delayed to facilitate this process. The urinary antigen test can detect *Legionella* infections in some cases for days to weeks after treatment. The urinary antigen test detects *Legionella pneumophila* serogroup 1, the most common cause of Legionnaires' disease; isolation of *Legionella* by culture is important for detection of other species and serogroups and for public health investigation. Molecular techniques can be used to compare clinical isolates to environmental isolates and confirm the outbreak source.

Order both a culture of a lower respiratory specimen and a urinary antigen test when testing patients for *Legionella*.



In the United States, reported cases of Legionnaires' disease have grown by nearly nine times since 2000. Nearly 10,000 cases of Legionnaires' disease were reported in 2018, but this number is likely an underestimate as the illness is thought to be underdiagnosed.

More illness occurs in the summer and early fall, but Legionnaires' disease can happen any time of year.



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Treatment

If your patient has Legionnaires' disease, see the most recent guidelines for treatment of community-acquired pneumonia (<http://bit.ly/CommunityPneumonia>) and hospital-acquired pneumonia (<http://bit.ly/HospitalPneumonia>). Macrolides and respiratory fluoroquinolones are currently the preferred agents for treating Legionnaires' disease.

Reporting

Make sure your infection control department or lab are promptly reporting cases of Legionnaires' disease to your local health department. Timely identification and reporting of cases is important, as this allows public health officials to quickly identify and stop potential clusters and outbreaks by linking new cases to previously reported ones.

Etiology

Legionnaires' disease is a severe form of pneumonia that often requires hospitalization and is fatal in about 10% of cases overall, and in 25% of healthcare-associated cases. Legionnaires' disease is caused by *Legionella* bacteria. There are at least 60 different species of *Legionella*, and most are considered capable of causing disease. However, most disease is caused by *L. pneumophila*, particularly serogroup 1.

Transmission

While *Legionella* is found in natural, freshwater environments, it can become a health concern in human-made water systems (e.g., plumbing system of large buildings, cooling towers, certain medical devices, decorative fountains, hot tubs) where conditions allow it to multiply and come in contact with vulnerable persons. People contract *Legionella* by inhaling aerosolized water droplets containing the bacteria, or, less commonly, by aspiration of contaminated drinking water. *Legionella* is usually not transmitted from person to person; however, a single episode of person-to-person transmission has been reported. Fortunately, most people exposed to the bacteria do not become ill.

Risk Factors

Risk factors for developing Legionnaires' disease include:

- Age ≥50 years
- Smoking (current or historical)
- Chronic lung disease, such as emphysema or COPD
- Immune system disorders due to disease or medication
- Systemic malignancy
- Underlying illness, such as diabetes, renal failure, or hepatic failure

Prevention

The key to preventing Legionnaires' disease is maintenance of the water systems in which *Legionella* may grow. If *Legionella* is found in a healthcare facility's water system, the facility should work to eliminate the bacteria. CDC encourages all building owners, and especially those in healthcare facilities, to develop comprehensive water management programs to reduce the risk of *Legionella* growth and spread. Learn more about how to develop a water management program at www.cdc.gov/legionella/WMPtoolkit.

Timely reporting of Legionnaires' disease cases is important for controlling clusters and outbreaks.

Common Sources of Infection

Outbreaks of Legionnaires' disease are most often associated with large or complex water systems, like those found in hospitals, long-term care facilities, hotels, and cruise ships.

The most likely sources of infection include:



Water used for showering (potable water)



Cooling towers (parts of large air conditioning systems)



Decorative fountains



Hot tubs

Figure 1. Routine *Legionella* testing: A multifactorial approach to performance indicator interpretation**^Δ

Concentration indicates that *Legionella* growth appears:

Uncontrolled	Poorly Controlled	Well Controlled
≥10 CFU/mL [†] in potable water	1.0–9.9 CFU/mL in potable water	Detectable to 0.9 CFU/mL in potable water
OR ≥100 CFU/mL in cooling towers	OR 10–99 CFU/mL in cooling towers	OR Detectable to 9 CFU/mL in cooling towers
		No <i>Legionella</i> detected in a single round of testing
		No <i>Legionella</i> detected in multiple rounds of testing
		No <i>Legionella</i> detected in multiple rounds of testing with methods that detect viable and non-viable bacteria of any <i>Legionella</i> species

Change in concentration over time indicates that *Legionella* growth appears:

Uncontrolled	Poorly Controlled	Well Controlled
100-fold or greater increase in concentration (e.g., 0.05 to 5 CFU/mL)	10-fold increase in concentration (e.g., 0.05 to 0.5 CFU/mL)	<i>Legionella</i> concentration steady (e.g., 0.5 CFU/mL for two consecutive sampling rounds)
		No <i>Legionella</i> detected in a single round of testing
		No <i>Legionella</i> detected in multiple rounds of testing
		No <i>Legionella</i> detected in multiple rounds of testing with methods that detect viable and non-viable bacteria of any <i>Legionella</i> species

Extent indicates that *Legionella* growth appears:

Uncontrolled	Poorly Controlled	Well Controlled
Detection in multiple locations AND a common source location [‡]	Detection in a common source location that serves multiple areas	Detection in a few of many tested locations within a water system
OR Detection across many locations within a water system	OR Detection in more than one location within a water system	
		No <i>Legionella</i> detected in multiple rounds of testing with methods that detect viable and non-viable bacteria of any <i>Legionella</i> species

Type* of *Legionella* (species and serogroup) associated with Legionnaires' disease:

Highly Associated	Less Associated
<i>L. pneumophila</i> serogroup 1; Non-Lp1 <i>L. pneumophila</i> ; Presence of multiple different <i>Legionella</i> species or serogroups	Any non- <i>pneumophila</i> <i>Legionella</i> species including "blue-white" fluorescent <i>Legionella</i>



* This figure is intended for use during routine testing of potable water and cooling towers only. Due to their ability to rapidly grow and spread *Legionella*, any detection of viable *Legionella* in a hot tub or decorative fountain should prompt a response, including a review of the water management program and corrective actions. Test results are performance indicators and are not a measure of risk of human illness. This figure is not intended for use if a building or device is associated with Legionnaires' disease (LD) cases or an outbreak.

° See "Routine testing for *Legionella*" for guidance regarding suggested response activities. Comparable results may lead to different suggested response activities when other factors are considered (e.g., if there is evidence of poorly controlled growth at a healthcare facility).

Δ Considering the type of *Legionella* identified along with other *Legionella* testing performance indicators provides a clearer picture of water system control than the results of any single indicator. For example, facility owners and operators may consider implementing immediate interventions for a healthcare facility with: A. detectable but <10 colony-forming units per milliliter (CFU/mL), B. non-Lp1 *Legionella pneumophila*, C. observed at steady concentrations, but D. detected at multiple distal locations including a central water heater.

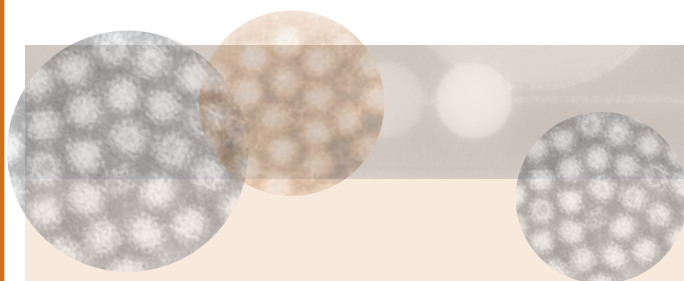
† Concentrations expressed as CFU/mL are for test results generated by traditional spread plate culture methods. If other test methods are used, consult testing lab or manufacturer instructions for appropriate interpretation.

‡ Common source location examples include water heaters, hot water returns, storage tanks, and cooling tower basins.

¶ If a facility has a history of associated LD cases, then sequencing isolates obtained during routine testing may provide performance indicators regarding outbreak strain persistence (if that strain is detected).

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Norovirus in Healthcare Facilities Fact Sheet



General Information

Virology

Noroviruses (genus *Norovirus*, family *Caliciviridae*) are a group of related, single-stranded RNA, non-enveloped viruses that cause acute gastroenteritis in humans. Norovirus is the official genus name for the group of viruses provisionally described as “Norwalk-like viruses”. Currently, human noroviruses belong to one of three norovirus genogroups (GI, GII, or GIV), which are further divided into >25 genetic clusters. Over 75% of confirmed human norovirus infections are associated with genotype GII.

Clinical manifestations

The average incubation period for norovirus-associated gastroenteritis is 12 to 48 hours, with a median period of approximately 33 hours. Illness is characterized by nausea, acute-onset vomiting, and watery, non-bloody diarrhea with abdominal cramps. In addition, myalgia, malaise, and headache are commonly reported. Low-grade fever is present in about half of cases. Dehydration is the most common complication and may require intravenous replacement fluids. Symptoms usually last 24 to 60 hours. Up to 30% of infections may be asymptomatic.

Epidemiology of transmission

Noroviruses are highly contagious, with as few as 18 virus particles thought to be sufficient to cause infection. This pathogen is estimated to be the causative agent in over 21 million gastroenteritis cases every year in the United States, representing approximately 60% of all acute gastroenteritis cases from known pathogens. Noroviruses are transmitted primarily through the fecal-oral route, either by direct person-to-person spread or fecally contaminated food or water. Noroviruses can also spread via a droplet route from vomitus. These viruses are relatively stable in the environment and can survive freezing and heating to 60°C (140°F). In healthcare facilities, transmission can also occur through

hand transfer of the virus to the oral mucosa via contact with materials, fomites, and environmental surfaces that have been contaminated with either feces or vomitus.

Norovirus infections are seen in all age groups, although severe outcomes and longer durations of illness are most likely to be reported among the elderly. Among hospitalized persons who are immunocompromised or have significant medical comorbidities, norovirus infection can directly result in prolonged hospital stays, additional medical complications, and, rarely, death. There is currently no vaccine available for norovirus and, generally, no specific medical treatment is offered for norovirus infection apart from oral or intravenous repletion of volume.

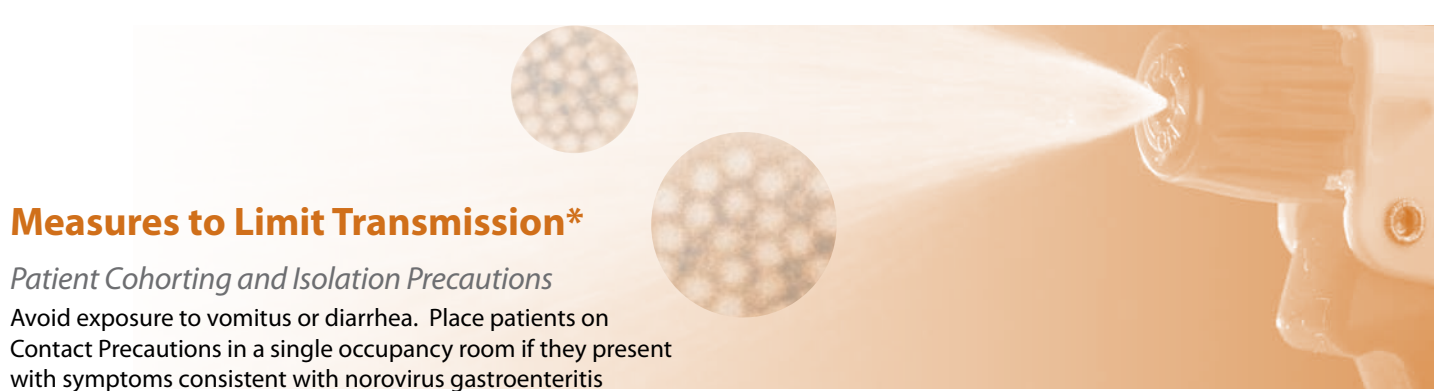
The ease of its transmission, a very low infectious dose, a short incubation period, environmental persistence, and lack of durable immunity following infection enables norovirus to spread rapidly through confined populations. Healthcare facilities and other institutional settings (e.g., daycare centers, schools, etc.) are particularly at-risk for outbreaks because of increased person-to-person contact. Healthcare facilities managing outbreaks of norovirus gastroenteritis may experience significant costs relating to isolation precautions and personal protective equipment, ward closures, supplemental environmental cleaning, staff cohorting or replacement, and sick time.

Diagnosis of norovirus infection

Diagnosis of norovirus infection relies on the detection of viral RNA in the stools of affected persons, by use of reverse transcription-polymerase chain reaction (RT-PCR) assays. This technology is available at CDC and most state public health laboratories and should be considered in the event of outbreaks of gastroenteritis in healthcare facilities. Enzyme immune-assays may also be used for identification of norovirus outbreak but are not recommended for diagnosis of individuals. Identification of the virus can be best made from stool specimens taken within 48 to 72 hours after onset of symptoms, although positive results can be obtained by using RT-PCR on samples taken as long as 7 days after symptom onset. Because of the limited availability of timely and routine laboratory diagnostic methods, a clinical diagnosis of norovirus infection is often used, especially when other agents of gastroenteritis have been ruled out.



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Measures to Limit Transmission*

Patient Cohorting and Isolation Precautions

Avoid exposure to vomitus or diarrhea. Place patients on Contact Precautions in a single occupancy room if they present with symptoms consistent with norovirus gastroenteritis.

Hand Hygiene

During outbreaks, use soap and water for hand hygiene after providing care or having contact with patients suspected or confirmed with norovirus gastroenteritis.

Patient Transfer and Ward Closure

Consider limiting transfers to those for which the receiving facility is able to maintain Contact Precautions; otherwise, it may be prudent to postpone transfers until patients no longer require Contact Precautions. During outbreaks, medically suitable individuals recovering from norovirus gastroenteritis can be discharged to their place of residence.

Diagnostics

In the absence of clinical laboratory diagnostics or in the case of delay in obtaining laboratory results, use Kaplan's clinical and epidemiologic criteria to identify a norovirus gastroenteritis outbreak.

Kaplan's Criteria

1. Vomiting in more than half of symptomatic cases and,
2. Mean (or median) incubation period of 24 to 48 hours and,
3. Mean (or median) duration of illness of 12 to 60 hours and,
4. No bacterial pathogen isolated in stool culture

Environmental Cleaning

Increase the frequency of cleaning and disinfection of patient care areas and frequently touched surfaces during outbreaks of norovirus gastroenteritis (e.g., increase ward/unit level cleaning to twice daily to maintain cleanliness, with frequently touched surfaces cleaned and disinfected three times daily using the US Environmental Protection Agency's list of approved products for healthcare settings (<http://www.epa.gov/oppad001/chemregindex.htm>).

Staff Leave and Policy

Develop and adhere to sick leave policies for healthcare personnel who have symptoms consistent with norovirus infection.

Exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms. Once personnel return to work, the importance of performing frequent hand hygiene should be reinforced, especially before and after each patient contact.

Establish protocols for staff cohorting in the event of an outbreak of norovirus gastroenteritis. Ensure staff care for one patient cohort on their ward and do not move between patient cohorts (e.g., patient cohorts may include symptomatic, asymptomatic exposed, or asymptomatic unexposed patient groups).

Communication and Notification

As with all outbreaks, notify appropriate local and state health departments, as required by state and local public health regulations, if an outbreak of norovirus gastroenteritis is suspected.

*Prevention and control recommendations taken from priority recommendations in the CDC HICPAC Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings (<http://www.cdc.gov/hicpac/pdf/norovirus/Norovirus-Guideline-2011.pdf>)

Date last modified: September 6, 2011

Content source: Division of Healthcare Quality Promotion (DHQP), National Center for Preparedness, Detection, and Control of Infectious Diseases (NCEID)

Contact Us: Centers for Disease Control and Prevention
1600 Clifton Road, Atlanta, GA 30333, USA

1-800-CDC-INFO (1-800-232-4636)

TTY:888-232-6348,

24 hours/everyday at cdcinfo@cdc.gov (TTY)



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Norovirus Illness: Key Facts

Norovirus—the stomach bug

Norovirus is a highly contagious virus. Norovirus infection causes gastroenteritis (inflammation of the stomach and intestines). This leads to diarrhea, vomiting, and stomach pain.

Norovirus illness is often called by other names, such as food poisoning and stomach flu. Noroviruses can cause food poisoning, as can other germs and chemicals. Norovirus illness is not related to the flu (influenza). Though they share some of the same symptoms, the flu is a respiratory illness caused by influenza virus.



Anyone can get norovirus illness

- Norovirus is the most common cause of acute gastroenteritis in the U.S.
- Each year, norovirus causes 19 to 21 million cases of acute gastroenteritis in the U.S.
- There are many types of norovirus and you can get it more than once.

Norovirus illness can be serious

- Norovirus illness can make you feel extremely sick with diarrhea and vomiting many times a day.
- Some people may get severely dehydrated, especially young children, the elderly, and people with other illnesses.
- Each year, norovirus causes 56,000 to 71,000 hospitalizations and 570 to 800 deaths, mostly in young children and the elderly.

Norovirus spreads very easily and quickly

- It only takes a very small amount of norovirus particles (fewer than 100) to make you sick.
- People with norovirus illness shed billions of virus particles in their stool and vomit and can easily infect others.
- You are contagious from the moment you begin feeling sick and for the first few days after you recover.
- Norovirus can spread quickly in enclosed places like daycare centers, nursing homes, schools, and cruise ships.
- Norovirus can stay on objects and surfaces and still infect people for days or weeks.
- Norovirus can survive some disinfectants, making it hard to get rid of.

Norovirus can spread in many ways

Norovirus can spread to others by—

- having direct contact with an infected person, for example, touching an infected person while caring for them,
- eating food or drinking liquids that are contaminated with norovirus,
- touching objects that have norovirus on them and then putting your fingers in your mouth, for example, touching a countertop that has vomit droplets on it and then putting your fingers in your mouth and
- sharing utensils or cups with people who are infected with norovirus.

There's no vaccine to prevent norovirus infection and no drug to treat it

- Antibiotics will not help with norovirus illness because antibiotics do not work on viruses.
- When you have norovirus illness, drink plenty of liquids to replace fluid loss and prevent dehydration.
- If you or someone you are caring for is dehydrated, call a doctor.



What is the Right Way to Wash Your Hands?

1. Wet your hands with clean, running water (warm or cold) and apply soap.
 2. Rub your hands together to make a lather and scrub them well; be sure to scrub the backs of your hands, between your fingers, and under your nails.
 3. Continue rubbing your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
 4. Rinse your hands well under running water.
 5. Dry your hands using a clean towel or air dry them.
- See Handwashing: Clean Hands Saves Lives (www.cdc.gov/handwashing/)

5 Tips to Prevent Norovirus From Spreading

1. Practice proper hand hygiene

Always wash your hands carefully with soap and water—

- after using the toilet and changing diapers, and
- before eating, preparing, or handling food.

Alcohol-based hand sanitizers can be used in addition to hand washing. But, they should not be used as a substitute for washing with soap and water.

2. Wash fruits and vegetables and cook seafood thoroughly

Carefully wash fruits and vegetables before preparing and eating them.

Cook oysters and other shellfish thoroughly before eating them.

Be aware that noroviruses are relatively resistant. They can survive temperatures as high as 140°F and quick steaming processes that are often used for cooking shellfish.

Food that might be contaminated with norovirus should be thrown out.

Keep sick infants and children out of areas where food is being handled and prepared.

3. When you are sick, do not prepare food or care for others

You should not prepare food for others or provide healthcare while you are sick and for at least 2 to 3 days after you recover. This also applies to sick workers in schools, daycares, and other places where they may expose people to norovirus.

4. Clean and disinfect contaminated surfaces

After throwing up or having diarrhea, immediately clean and disinfect contaminated surfaces. Use a chlorine bleach solution with a concentration of 1000–5000 ppm (5–25 tablespoons of household bleach [5.25%] per gallon of water) or other disinfectant registered as effective against norovirus by the Environmental Protection Agency (EPA).

5. Wash laundry thoroughly

Immediately remove and wash clothes or linens that may be contaminated with vomit or stool (feces).

You should—

- handle soiled items carefully without agitating them,
- wear rubber or disposable gloves while handling soiled items and wash your hands after, and wash the items with detergent at the maximum available cycle length then machine dry them.



Visit CDC's Norovirus Web site at www.cdc.gov/norovirus for more information.

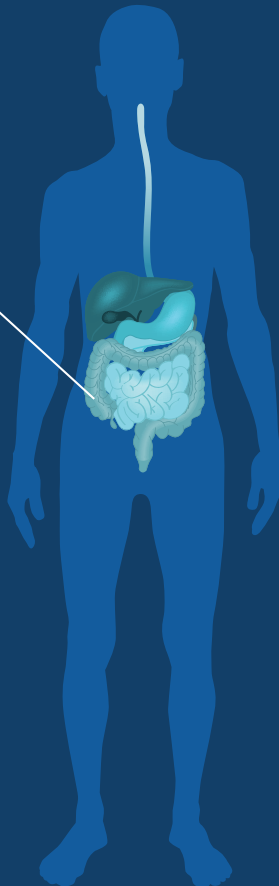
GERMS LIVE IN "THE GUT."

WHERE IS THE RISK?

Know where germs live to stop spread
and protect patients

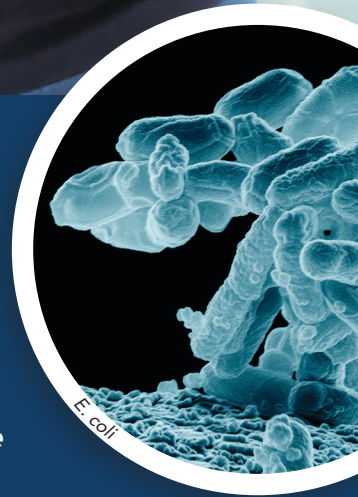


- The gut is filled with bacteria and some yeasts, which are part of a healthy immune system.
- Most gut germs don't cause problems in healthy people, but they can cause infection when they spread.
- Germs in stool can spread onto hands and skin when wiping or changing a diaper.



Germs That Live in the Gut

- *E. coli*
- *Klebsiella*
- *Candida*
- *Clostridioides difficile* (*C. diff*)



Healthcare Tasks Involving the Gut

- Toileting/changing diapers
- Bathing a patient
- Laundry

Infection Control Actions to Reduce Risk

- Hand hygiene
- Use of personal protective equipment (gloves and gowns)
- Cleaning and disinfection
- Textile management
- Waste management



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention



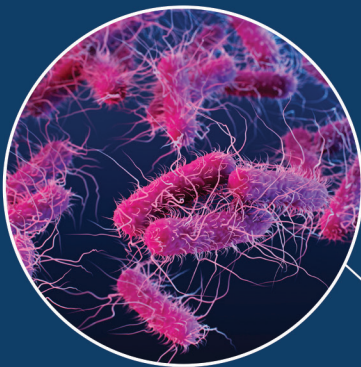
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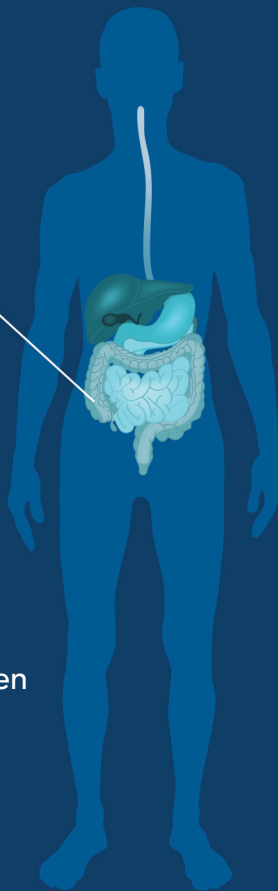
LOS MICROBIOS VIVEN EN "LOS INTESTINOS".

¿DÓNDE ESTÁ EL RIESGO?

Aprenda dónde viven los microbios
para detener la propagación
y proteger a los pacientes



- Los intestinos están llenos de bacterias y algunas levaduras, que forman parte de un sistema inmunitario sano.
- La mayoría de los microbios intestinales no causan problemas en las personas sanas, pero pueden provocar infecciones cuando se propagan.
- Los microbios presentes en las heces pueden extenderse a las manos y a la piel al limpiar o al cambiar un pañal.



Microbios que viven en los intestinos

- *E. coli*
- *Klebsiella*
- *Cándida*
- *Clostridiodes difficile* (*C. diff*)



Tareas de la atención médica relacionadas con los intestinos

- Aseo/cambio de pañales
- Bañar a un paciente
- Lavado de ropa

Acciones de control de infecciones para reducir los riesgos

- Higiene de las manos
- Uso de equipo de protección personal (guantes y batas)
- Limpieza y desinfección
- Gestión de artículos de tela
- Gestión de residuos



Departamento de Salud
y Servicios Humanos de
los Estados Unidos
Centros para el Control y la
Prevención de Enfermedades



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**When you see diarrhea,
there's often more than meets the eye.**



**Germ from diarrhea are everywhere and can be infectious.
Protect yourself and others:**



Use gloves when you're working with a patient or resident or in their environment. Clean your hands immediately afterwards.



Use a gown if there is risk you might get stool on your clothes, like if you're performing personal care tasks or leaning over the bed.



Clean and disinfect the patient's or resident's environment frequently with the correct products.

Learn More

Diarrhea Dilemma Interactive Scenario: <https://bit.ly/48SdFRz>

Germ Live in the Gut Infographic: <https://bit.ly/3s1cleg>

Hand Hygiene Training Module: <https://bit.ly/49B21KW>

Cuando vea diarrea, a menudo puede haber más de lo que aparece.



Los microbios de la diarrea están en todas partes y pueden ser infecciosos. Protégase a sí mismo y a los demás:



Use guantes cuando esté trabajando con un paciente o residente o en su entorno. Límpiese las manos inmediatamente después.



Use bata si hay riesgo que le caigan heces en la ropa, como cuando esté realizando tareas de cuidados personales o esté inclinado sobre la cama.



Limpie y desinfecte el entorno del paciente o residente frecuentemente con los productos correctos.

Aprenda más

Escenario interactivo del dilema de la diarrea: <https://bit.ly/3RhIBUI>
Infografía sobre los microbios que viven en los intestinos: <https://bit.ly/49QMhUi>
Hand Hygiene Training Module (English only): <https://bit.ly/49B21KW>

Bird Flu Guidance for Farm Workers

1. Infected animals can pass disease to people in their **milk, saliva (spit), feces (poop), and other body fluids.**

2. Signs and symptoms of infection may include:



- Eye redness (conjunctivitis)
- Fever (temperature of 100°F (37.8°C) or greater) or chills



- Cough
- Sore throat
- Runny or stuffy nose
- Headaches



- Fatigue
- Diarrhea
- Nausea
- Difficulty breathing/shortness of breath (**call 911 immediately**)

3. **Personal protective equipment (PPE)** should be put on and taken off in areas away from animals.



- Masks
- Safety glasses, goggles or face shields
- Disposable gloves
- Overalls/gown



4. **Do not drink unpasteurized milk.**
Do not take milk home.



5. **Wash your hands with soap and water** or use hand sanitizer after touching animals or their **milk, saliva (spit), feces (poop), or other body fluids.**

6. **Do not touch your face, eyes, mouth, phone, food, or other commonly used objects until after you've washed your hands.**

Even though it's rare for humans to get sick from bird flu, we want you to know how to monitor your health and the health of your family.



For questions and 24/7 support, contact 806-778-7391 to reach the Texas Department of State Health Services in Lubbock. Let them know you work with cattle.

Guía Sobre la Gripe Aviar para Trabajadores de Lecherías

1. Los animales infectados pueden transmitir enfermedades a las personas a través de la **leche, la saliva, el excremento, y otros fluidos.**
2. Los signos y síntomas de una infección pueden incluir:



- Enrojecimiento de los ojos (conjuntivitis)
- Fiebre (temperatura de 100°F (37.8°C) o más) o escalofríos
- Tos
- Dolor de garganta
- Secreción o congestión nasal
- Dolores de cabeza
- Fatiga
- Diarrea
- Náuseas
- Dificultad para respirar/falta de aire (llame al 911 de inmediato)



3. El **equipo de protección personal (PPE en inglés)** debe ponerse y quitarse en un área alejada de los animales.



- Máscaras
- Gafas, anteojos de seguridad o protectores faciales
- Guantes desechables
- Bata/delantal



4. **No tome leche no pasteurizada.**
No se lleve leche a casa.



5. **Lávese las manos** con agua y jabón o gel desinfectante después de tocar **animales o leche, saliva, excremento, y otros fluidos.**

6. **No se toque la cara, los ojos, la boca, su teléfono, la comida ni otros objetos** hasta después de lavarse las manos.

Aunque es raro que los humanos se enfermen a causa de la influenza aviar, queremos que sepa cómo controlar su salud y la de su familia.



Si tiene preguntas y necesita ayuda 24/7, comuníquese al 806-778-7391 para comunicarse con el Departamento de Servicios de Salud del Estado de Texas, Región 1 de Salud Pública. Hágales saber que trabaja con ganado.

Long-Term Care (LTC) Acute Gastroenteritis Surveillance Line List

Instructions for the Long-Term Care (LTC) Acute Gastroenteritis Surveillance Line List

The Acute Gastroenteritis Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected gastroenteritis cluster or outbreak at a nursing home or other LTC facility. Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness.

Each row represents an individual resident or staff member who may have been affected by the outbreak illness (i.e., case). The information in the columns of the worksheet capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results, and outcomes. While this template was developed to help with data collection for common gastroenteritis outbreaks, the data fields can be modified to reflect the needs of the individual facility during other outbreaks.

Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring.

LTC Acute Gastroenteritis Surveillance Line List

Instruction Sheet for Completion of the Long-Term Care (LTC) Acute Gastroenteritis Surveillance Line List

Section A: Case Demographics

In the space provided per column, fill in each line with name, age, and gender of each person affected by the current outbreak at your facility. Please differentiate residents (R) from staff (S).

***Staff includes** all healthcare personnel (e.g., nurses, physicians and other providers, therapists, food services, environmental services) whether employed, contracted, consulting, or volunteer.

For residents only: Short-stay (S) residents are often admitted directly from hospitals, require skilled nursing or rehabilitation care, and are expected to have a length of stay less than 100 days. Long-stay (L) residents are admitted to receive residential care or nursing support and are expected to have a length of stay that is 100 days or more. Indicate the stay type for each resident in this column.

Section B: Case Location

For residents only: Indicate the building (Bldg), unit, or floor where the resident is located and the room and bed number for each resident being monitored for outbreak illness. *Answers may vary by facility due to differences in the names of resident care locations.

For staff only: For each staff member listed, indicate the floor, unit, or location where that staff member had been primarily working at the time of illness onset. Fill in the box (Y or N) indicating whether that monitored or ill staff member was responsible for handling food at the beginning or during the outbreak period.

Section C: Signs and Symptoms (s/s)

Symptom onset date: Record the date (month/day) each person developed or reported signs/symptoms (e.g., abdominal cramps, diarrhea, vomiting) consistent with the outbreak illness.

Symptoms: Fill in the box (Y or N) indicating whether or not a resident or staff member experienced each of the signs/symptoms listed within this section (abdominal pain or tenderness; diarrhea; vomiting).

Additional documented s/s (select all codes that apply): In the space provided, record the code that corresponds to any additional s/s the resident or staff member experienced. If a resident or staff member experienced a s/s that is not listed, please use the space provided by "other" to specify the s/s.

N – nausea, F – fever, B – blood in stool, LA – loss of appetite, O – other: specify _____

Section D: Diagnostics

Type of specimen collected: (e.g., stool, blood): In the space provided, record the type of specimen collected for laboratory testing. If the type of specimen collected is not listed, please use the space provided by "other" to specify the specimen type.

S – stool, B – blood, O – other: specify _____

Date of collection: Record the date (month/day) of specimen collection.

Type of test ordered (select all codes that apply): In the space provided, record the code that corresponds to whether a diagnostic laboratory test was performed for each individual. If no test was performed, indicate "zero." If the laboratory test used to identify the pathogen is not listed, please use the space provided by "Other" to specify the type of test ordered.

0 – No test performed, 1 – Culture, 2 – Polymerase Chain Reaction (PCR), also called nucleic acid amplification testing (includes multiplex PCR tests for several organisms using a single specimen), 3 – Other: specify _____

Pathogen Detected (select all codes that apply): In the space provided, record the code that corresponds to the bacterial and/or viral organisms that were identified through laboratory testing. If the test performed was negative, indicate "zero." If a pathogen not listed was identified through laboratory testing, please use the space provided by "Other" to specify the organism.

0 – Negative results; Bacterial: 1 – *Salmonella*, 2 – *Campylobacter*, 3 – *Clostridium difficile*, 4 – *Shigella*; Viral: 5 – Norovirus, 6 – Rotavirus, 7 – Other: Specify _____

Section E: Outcome During Outbreak

Symptom Resolution Date: Record the date that each person recovered from the outbreak illness and was symptom free for 24 hours.

Hospitalized: Fill in the box (Y or N) indicating whether or not hospitalization was required for a resident or staff member during the outbreak period. *Note: The outbreak period is the time from the date of symptom onset for the first case to date of symptom resolution for the last case.*

Died: Fill in the box (Y or N) indicating whether or not a resident or staff member expired during the outbreak period.

Case (C) or Not a case (leave blank): Based on the clinical criteria and laboratory findings collected during the outbreak investigation, record whether or not each resident or staff member meets the case definition (C) or is not a case (leave space blank).

LTC Acute Gastroenteritis Surveillance Line List

Date: ____/____/____

This worksheet was created to help nursing homes and other LTC facilities detect, characterize, and investigate a possible outbreak of acute gastroenteritis.

A. Case Demographics					B. Case Location				C. Signs and Symptoms (s/s)				D. Diagnostics				E. Outcome During Outbreak ^A									
Name					Residents Only: Bldg/Floor/Unit	Residents Only: Room/Bed	Staff Only: Primary assignment (floor or location)	Staff Only: Food handler (Y/N)	Symptom onset date: (mm/dd)	Abdominal pain or tenderness (Y/N)	Diarrhea (Y/N)	Vomiting (Y/N)	Additional documented s/s (select all codes that apply)		Type of specimen collected (select all codes that apply)	Date of collection: (mm/dd)	Type of test ordered (select all codes that apply)	0 – No test performed, 1 – Culture, 2 – PCR, 3 – Other: Specify _____	Pathogen detected (select all codes that apply)	0 – Negative results Bacterial: 1 – <i>Salmonella</i> , 2 – <i>Campy</i> , 3 – <i>C. difficile</i> , 4 – <i>Shigella</i> Viral: 5 – Norovirus, 6 – Rotavirus 7 – Other: Specify _____	Symptom resolution date: (mm/dd)	Hospitalized (Y/N)	Died (Y/N)	Case (C) or Not a case (leave blank)		
1.																										
2.																										
3.																										
4.																										
5.																										
6.																										
7.																										
8.																										
9.																										
10.																										

If faxing to your local Public Health Department, please complete the following information:

Facility Name: _____

City, State: _____

County: _____

Contact Person: _____

Phone: _____

Email: _____

^A Note: Outbreak period defined as date of first case to resolution of last case.

Long-Term Care (LTC)

Acute Gastroenteritis Outbreak Summary

Instructions for the Long-Term Care (LTC) Acute Gastroenteritis Outbreak Summary Form

The Acute Gastroenteritis Outbreak Summary Form was created to help nursing homes and other LTC providers summarize the findings, actions, and outcomes of an outbreak investigation and response. Completing this outbreak form will provide LTC facilities and other public health partners with a record of a facility's outbreak experience and highlight areas for outbreak prevention and response.

Instructions for each section of the form are described below. This form should be filled out by the designated infection preventionist with support from other clinicians in your facility (e.g., front-line nursing staff, physicians or other practitioners, consultant pharmacist, laboratory).

A LTC facility can use this form for internal documentation and dissemination of outbreak response activities. Facilities are encouraged to share this information with the appropriate public health authority by contacting the local health department. Should a facility decide to share this form with the local/state public health officials, please include facility contact information at the bottom of the form.

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Section 3: Outbreak Period Information	2
Section 4: Staff Information	2
Section 5: Laboratory Tests.....	2
Section 6: Resident Outcome.....	3
Section 7: Facility Outbreak Control Interventions.....	3
Section 8: # of New Cases Per Day	3
For HD Use Only	3

LTC Acute Gastroenteritis Surveillance Outbreak Summary

Section 1: Facility Information

Health Dept. Contact Name and Phone Number: A LTC facility should have contact information (name or division, phone number) for the local and/or state health department for outbreak guidance and reporting purposes. Enter the health dept. contact information your facility used to request support during an outbreak.

Date First Notified Health Department: Record the date you first contacted local or state public health during this outbreak at your facility.

Total # of Residents at Facility: Document the total number of residents in the facility at the time of the outbreak.

Total # of Employees: Document the total number of staff working in the facility at the time of the outbreak. Staff includes all healthcare personnel (e.g., nurses, providers, consultants, therapists, food services, environmental services) whether employed, contracted, or volunteer.

Summary Form Status: Information in the summary form may be completed over the course of the outbreak. Record the dates your facility started collecting information on the form and completed the outbreak summary report.

Section 2: Case Definition

Provide a description of the criteria used to determine whether a resident should be considered a case in this outbreak. The description can include: signs/symptoms, presence of positive diagnostic tests, location within facility, and the timeframe during which individuals may have been involved in the outbreak (e.g., within the past 4 weeks).

Example: A gastroenteritis case includes any resident with the following symptoms: nausea, vomiting, abdominal pain, or diarrhea, residing on Units 2E or 2W, with onset of symptoms between Jan 15 and Feb 1 with or without a stool specimen positive for norovirus.

Section 3: Outbreak Period Information

Outbreak Start (Date of symptom onset of first case): Record the date the first person developed signs/symptoms (e.g., nausea, vomiting, diarrhea) consistent with the outbreak illness.

Average Length of Illness: Estimate the average number of days it takes for signs/symptoms to resolve, based on clinical course among residents/staff affected by the outbreak illness.

Outbreak End (Symptom resolution date of last case): Record the date the last person recovered from the outbreak illness and became symptom-free for 24 hours.

Total # of Cases: Document the number of residents and staff (if applicable) who were identified as having the outbreak illness.

Section 4: Staff Information

Were any ill staff delivering resident care? Check yes or no.

- If yes, try to estimate the number of ill staff involved in resident care based on date when a staff member reported symptoms compared with the date when/if staff member was excused from work.

Were any ill staff responsible for handling food at the start of the outbreak? Check yes or no.

- If yes, try to estimate the number of ill staff who handled food at the beginning or during the outbreak based on date when a food-handling staff member reported symptoms compared with the date when/if staff member was excused from work.

Did any staff seek medical attention for an acute gastroenteritis infection at any time during the outbreak? Check yes or no.

- If yes, try to estimate the number of staff who sought medical attention based on self-report.

If available, indicate whether ill staff received care at an emergency department (ED). Check yes or no and estimate number of staff.

If available, indicate whether ill staff were hospitalized as a result of the outbreak illness. Check yes or no and estimate number of staff.

LTC Acute Gastroenteritis Surveillance Outbreak Summary

Section 5: Laboratory Tests

List all bacterial (e.g., *C. difficile*, *Salmonella*, *Campylobacter*); viral (e.g., *Rotavirus*, *Norovirus*) organisms that were identified through laboratory testing; use the space provided by "Other" to specify whether a parasite or non-infectious cause of gastroenteritis was identified.

Diagnostic Testing Results: In the table, each row corresponds to an organism identified during the outbreak. Use the column to specify the type of testing used to identify each organism (either microbiologic culture, PCR (also known as nucleic acid amplification), or specify whether a different diagnostic test was used (e.g., *C. diff* toxin)). For each test type, document the total number of residents and staff that received laboratory confirmation by that test.

Section 6: Resident Outcome

Hospitalizations: During the outbreak, check the box (yes or no) indicating whether or not hospitalization was required for any residents. If yes, please record how many residents were hospitalized.

Deaths: During the outbreak, check the box (yes or no) indicating whether or not any residents died. If yes, please record how many residents died during the outbreak period (deaths should be recorded even if unable to determine whether outbreak illness was the cause).

Section 7: Facility Outbreak Control Interventions

In this section, check whether any of the infection control strategies listed were implemented at your facility in response to the outbreak. If a practice or policy change was implemented during the outbreak that is not listed (e.g., new cleaning/disinfecting products used, change to employee sick leave policy), specify in the space provided by "Other." For each strategy, record the date the change was implemented (if available).

Section 8: # of New Cases Per Day

Please fill in the chart with the number of new cases of residents and staff per day. Once each day is complete, add the number of new cases of residents and staff and place the sum in total column for that corresponding day.

In the space provided under the chart, record the date that corresponds to Day 1 on the outbreak period (i.e., date of outbreak start).

For HD Use Only

Facility Licensed by State: Check the box (yes or no) indicating whether or not the facility is licensed by the state.

Facility Certified by CMS: Check the box (yes or no) indicating whether or not the facility is certified by the Centers for Medicare & Medicaid Services (CMS).

Facility Type: Check the box that best describes the type of care the facility provides: Nursing Home, Intermediate Care Facility, Assisted Living Facility or Other (specify).

of Licensed Beds: Document the total number of licensed beds at the facility.

of Staff Employees: Document the total number of facility employed staff working in the facility at the time of the outbreak.

of Contract Employees: Document the total number of contract/consulting providers working in the facility at the time of the outbreak.

LTC Acute Gastroenteritis Outbreak Summary

1. Facility Information

Health Dept. Contact Name: _____ Health Dept. Contact Phone Number: _____
 Health Dept. Fax Number: _____ Date First Notified Health Dept.: ____/____/____
 Total # of Residents at facility: ____ Total # of Employees (staff and contract personnel): ____
 Summary Form Status: Date initiated: ____/____/____ Date completed: ____/____/____

2. Case Definition

Summarize the definition of a symptomatic case during the outbreak, including symptoms, time range, and location (if appropriate) within facility:

3. Outbreak Period Information

Outbreak Start (Date of symptom onset of first case): ____/____/____ **Total # of Cases**
 Average Length of Illness: ____ Residents: ____ Staff: ____
 Outbreak End (Symptom resolution date of last case): ____/____/____

4. Staff Information

Were any ill staff delivering resident care at the beginning or during the outbreak? ☐ Yes ☐ No If yes, how many: ____
 Were any of the ill staff responsible for handling food at the beginning or during the outbreak? ☐ Yes ☐ No If yes, how many: ____
 Did any ill staff seek outside medical care at the beginning or during the outbreak? ☐ Yes ☐ No If yes, how many: ____
 ED Visit: ☐ Yes ☐ No If yes, how many: ____ Hospitalization: ☐ Yes ☐ No If yes, how many: ____

5. Laboratory Tests

Which organisms were identified through laboratory testing?

Bacterial: Specify _____ Viral: Specify _____ Other: Specify _____

Diagnostic testing results	Microbiology Culture	PCR	Other Test: Specify
Organism 1	Residents: ____ Staff: ____	Residents: ____ Staff: ____	Residents: ____ Staff: ____
Organism 2	Residents: ____ Staff: ____	Residents: ____ Staff: ____	Residents: ____ Staff: ____
Organism 3	Residents: ____ Staff: ____	Residents: ____ Staff: ____	Residents: ____ Staff: ____

6. Resident Outcome

Hospitalizations: ☐ Yes ☐ No If yes, how many: ____ Deaths: ☐ Yes ☐ No If yes, how many: ____

7. Facility Outbreak Control Measures (Check if control measure used and provide date of implementation)

☐ Educated on hand hygiene (HH) practices: Date: ____/____/____ ☐ Monitored appropriate HH and PPE use by staff: Date: ____/____/____
☐ Implemented Transmission-Based Precautions: Date: ____/____/____ ☐ Cohorted ill residents within unit/building: Date: ____/____/____
☐ Dedicated staff to care for only affected residents: Date: ____/____/____ ☐ Placed ill staff on furlough: Date: ____/____/____
☐ Suspended activities on affected unit: Date: ____/____/____ ☐ Restricted new admissions to affected unit: Date: ____/____/____
☐ Notified family/visitors about outbreak: Date: ____/____/____ ☐ Educated family/visitors about outbreak: Date: ____/____/____
☐ Other: _____ ☐ Other: _____

8. # of New Cases Per Day

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Residents														
Staff														
Total														

Indicate Date of Day 1: ____/____/____ List units/floors involved in outbreaks: _____

If faxing to your local Public Health Department, please complete the following information:

Facility Name: _____ City, State: _____ County: _____
 Contact Person: _____ Phone: _____ Email: _____

For HD Use Only

Facility Licensed by State: ☐ Yes ☐ No Facility ID: _____
 Facility Certified by CMS: ☐ Yes ☐ No Facility Type: ☐ Nursing Home ☐ Assisted Living Other: Specify _____
 # of Licensed Beds: _____ # of Employed Staff: _____ # of Contract/Consultant providers: _____

Long-Term Care (LTC) Respiratory Surveillance Line List

Instructions for the Long-Term Care (LTC) Respiratory Surveillance Line List

The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a nursing home or other LTC facility. Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness.

Each row represents an individual resident or staff member who may have been affected by the outbreak illness (i.e., case). The information in the columns of the worksheet capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results and outcomes. While this template was developed to help with data collection for common respiratory illness outbreaks the data fields can be modified to reflect the needs of the individual facility during other outbreaks.

Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring.

LTC Respiratory Surveillance Line List

Instruction Sheet for Completion of the Long-Term Care (LTC) Respiratory Surveillance Line List

Section A: Case Demographics

In the space provided per column, fill in each line with name, age and gender of each person affected by the current outbreak at your facility. Please differentiate residents (R) from staff (S).

*Staff includes all healthcare personnel (e.g., nurses, physicians and other providers, therapists, food services, environmental services) whether employed, contracted, consulting or volunteer.

For residents only: Short stay (S) residents are often admitted directly from hospitals, require skilled nursing or rehabilitation care, and are expected to have a length of stay less than 100 days. Long stay (L) residents are admitted to receive residential care or nursing support and are expected to have a length of stay that is 100 days or more. Indicate the stay type for each resident in this column.

Section B: Case Location

For resident only: Indicate the building (Bldg), unit or floor where the resident is located and the room and bed number for each resident being monitored for outbreak illness. *Answers may vary by facility due to differences in the names of resident care locations.

For staff only: For each staff member listed, indicate the floor, unit or location where that staff member had been primarily working at the time of illness onset.

Section C: Signs and Symptoms (s/s)

Symptom onset date: Record the date (month/day) each person developed or reported signs/symptoms (e.g., fever, cough, shortness of breath) consistent with the outbreak illness.

Symptoms: Fill in the box (Y or N) indicating whether or not a resident or staff member experienced each of the signs/symptoms listed within this section.

Additional documented s/s (select all codes that apply): In the space provided, record the code that corresponds to any additional s/s the resident or staff member experienced. If a resident or staff member experienced a s/s that is not listed, please use the space provided by "Other" to specify the s/s.

H – headache, SB – shortness of breath, LA – loss of appetite, C – chills, ST – sore throat, O – other: Specify _____

Section D: Diagnostics

Chest x-ray: Fill in the box (Y or N) indicating whether or not a chest x-ray was performed.

Type of specimen collected: (Select all codes that apply): In the space provided, record the type of specimen collected for laboratory testing. If the type of specimen collected is not listed, please use the space provided by "Other" to specify the specimen type.

NP – nasopharyngeal swab, OP – oropharyngeal swab, S – sputum, U – urine, O – Other: Specify _____

Date of collection: Record the date (month/day) of specimen collection.

Type of test ordered (select all codes that apply): In the space provided, record the code that corresponds to whether a diagnostic laboratory test was performed for each individual. If no test was performed, indicate "zero". If the laboratory test used to identify the pathogen is not listed, please use the space provided by "Other" to specify the type of test ordered.

0 – No test performed, 1 – Culture, 2 – Polymerase Chain Reaction (PCR), also called nucleic acid amplification testing includes multiplex PCR tests for several organisms using a single specimen, 3 – Urine Antigen, 4 – Other: Specify _____

Pathogen detected (select all codes that apply): In the space provided, record the code that corresponds to the bacterial and/or viral organisms that were identified through laboratory testing. If the test performed was negative, indicate "zero". If a pathogen not listed was identified through laboratory testing, please use the space provided by "Other" to specify the organism.

0 – Negative results; Bacterial: 1 – *Streptococcus pneumoniae*, 2 – *Legionella*, 3 – *Mycoplasma*

Viral: 4 – Influenza, 5 – Respiratory syncytial virus (RSV), 6 – Human metapneumovirus (HMPV), 7 – Other: Specify _____

Section E: Outcome During Outbreak

Symptom Resolution Date: Record the date that each person recovered from the outbreak illness and was symptom free for 24 hours.

Hospitalized: Fill in the box (Y or N) indicating whether or not hospitalization was required for a resident or staff member during the outbreak period. **Note: The outbreak period is the time from the date of symptom onset for the first case to date of symptom resolution for the last case.**

Died: Fill in the box (Y or N) indicating whether or not a resident or staff member expired during the outbreak period.

Case (C) or Not a case (leave blank): Based on the clinical criteria and laboratory findings collected during the outbreak investigation, record whether or not each resident or staff member meets the case definition (C) or is not a case (leave space blank).

LTC Respiratory Surveillance Line List

Date: ____/____/____

This worksheet was created to help nursing homes and other LTC facilities detect, characterize and investigate a possible outbreak of respiratory illness.

A. Case Demographics				B. Case Location		C. Signs and Symptoms (s/s)				D. Diagnostics				E. Outcome During Outbreak ^A							
Name	Age	Gender (M/F)	Resident (R) or Staff (S)	Residents Only: Short stay (S) or Long stay (L)	Residents Only: Bldg/Floor	Residents Only: Room/Bed	Staff Only: Primary floor assignment	Symptom onset date: (mm/dd)	Fever ^B (Y/N)	Cough (Y/N)	Myalgia (body ache) (Y/N)	Additional documented s/s (select all codes that apply) H – headache, SB – shortness of breath, LA – loss of appetite, C – chills, ST – sore throat, O – other: Specify _____	Chest x-ray (Y/N)	Type of specimen collected (select all codes that apply) NP – nasopharyngeal swab, OP – oropharyngeal swab, U – urine, S – sputum, Other: Specify _____	Date of collection: (mm/dd)	Type of test ordered (Select all codes that apply) 0 – No test performed, 1 – Culture, 2 – PCR, 3 – Urine Antigen, 4 – Other: Specify _____	Pathogen Detected (Select all codes that apply) 0 – Negative results Bacterial: 1 – <i>S. pneumoniae</i> , 2 – <i>Legionella</i> , 3 – <i>Mycoplasma</i> Viral: 4 – Influenza, 5 – RSV, 6 – HMPV 7 – Other: Specify _____	Symptom resolution date: (mm/dd)	Hospitalized (Y/N)	Died (Y/N)	Case (C) or Not a case (leave blank)
1.																					
2.																					
3.																					
4.																					
5.																					
6.																					
7.																					
8.																					
9.																					
10.																					

If faxing to your local Public Health Department, please complete the following information:

Facility Name: _____ City, State: _____ Phone: _____ County: _____

Contact Person: _____ Email: _____

^A **Note:** Outbreak defined as date of first case to resolution of last case.

^B **Definition of Fever** (Stone N, Ashraf MS, Calder, J, et al. Surveillance Definitions in Long-Term Care Facilities: Revisiting the McGeer Criteria. Infect Control Hosp Epidemiol 2012; 33:965-977):

(1) a single oral temp > 37.8°C (100°F) or (2) repeated oral temps > 37.2°C (99°F) or rectal temps > 37.5°C (99.5°F) or (3) a single temp > 1.1°C (2°F) over baseline from any site (oral, tympanic, axillary).

Long-Term Care (LTC) Respiratory Surveillance Outbreak Summary

Instructions for the Long-Term Care (LTC) Respiratory Surveillance Outbreak Summary

The Respiratory Outbreak Summary Form was created to help nursing homes and other LTC providers summarize the findings, actions and outcomes of an outbreak investigation and response. Completing this outbreak form will provide LTC facilities and other public health partners with a record of a facility's outbreak experience and highlight areas for outbreak prevention and response.

Instructions for each section of the form are described below. This form should be filled out by the designated infection preventionist with support from other clinicians in your facility (e.g., front-line nursing staff, physicians or other practitioners, consultant pharmacist, laboratory).

A LTC facility can use this form for internal documentation and dissemination of outbreak response activities. Facilities are encouraged to share this information with the appropriate public health authority by contacting the local health department. Should a facility decide to share this form with the local/state public health officials, please include facility contact information at the bottom of the form.

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LTC Respiratory Surveillance Outbreak Summary

Section 1: Facility Information

Health Dept. Contact Name and Phone Number: A LTC facility should have contact information (name or division, phone number) for the local and/or state health department for outbreak guidance and reporting purposes. Enter the health dept. contact information your facility used to request support during an outbreak.

Date First Notified Local Health Dept: Record the date you first contacted local or state public health during this outbreak at your facility.

Total # of residents at facility: Document the total number of residents in the facility at the time of the outbreak.

Total # of employees: Document the total number of staff working in the facility at the time of the outbreak. Staff includes all healthcare personnel (e.g., nurses, providers, consultants, therapists, food services, environmental services) whether employed, contracted or volunteer.

Summary Form Status: Information in the summary form may be completed over the course of the outbreak. Record the dates your facility started collecting information on the form and completed the outbreak summary report.

Section 2: Influenza Vaccination Status

Total # of residents vaccinated: Record the total number of residents that received the Flu Vaccine within the past year.

Total # of staff vaccinated: Record the total number of staff that received the Flu Vaccine within the past year.

Section 3: Pneumococcal Vaccination Status

Total # of residents vaccinated: Record the total number of residents that received at least one dose of the Pneumococcal Vaccine (either polysaccharide or conjugate).

Section 4: Case Definition

Provide a description of the criteria used to determine whether a resident should be considered a case in this outbreak. The description can include: signs/symptoms, presence of positive diagnostic tests, location within facility, and the timeframe during which individuals may have been involved in the outbreak (e.g., within the past 4 weeks).

Example: A Respiratory illness case includes any resident with the following symptoms: cough, shortness of breath, sputum production and fever residing on Units 2E or 2W, with onset of symptoms between Jan 15th and Feb 1st with or without a sputum specimen positive for Streptococcus pneumoniae.

Section 5: Outbreak Period Information

Outbreak start: (Date of symptom onset of first case): Record the date the first person developed signs/symptoms (e.g., fever, cough, shortness of breath) consistent with the outbreak illness.

Average length of illness: Estimate the average number of days it takes for signs/symptoms to resolve, based on clinical course among residents/staff affected by the outbreak illness.

Outbreak end: (Symptom resolution date of last case): Record the date the last person recovered from the outbreak illness and became symptom free for 24 hours.

Total # of Cases: Document the number of residents and staff (if applicable) who were identified as having the outbreak illness.

LTC Respiratory Surveillance Outbreak Summary

Section 6: Staff Information

Were any ill staff delivering resident care? Check yes or no.

- If yes, try to estimate the number of ill staff involved in resident care based on date when a staff member reported symptoms compared with the date when/if staff member was excused from work.

Did any staff seek medical attention for an acute respiratory infection at any time during the outbreak? Check yes or no.

- If yes, try to estimate the number of staff that sought medical attention based on self-report.

If available, indicate if ill staff received care at an emergency department (ED). Check yes or no and estimate number of staff.

If available, indicate if ill staff was hospitalized as a result of the outbreak illness. Check yes or no and estimate number of staff.

Section 7: Diagnostic and Laboratory Tests

Chest x-ray: Fill in the box (yes or no) indicating whether or not residents and staff had an x-ray done as a part of the diagnosis of the outbreak illness. If yes, please record the # of individuals who received chest x-ray and the # of x-rays that had abnormal findings consistent with the outbreak illness.

List all bacterial (e.g., *S. pneumoniae*, *Mycoplasma*); viral (e.g., Influenza, RSV) organisms that were identified through laboratory testing; Use the space provided by "Other" to specify if a parasite or non-infectious cause of respiratory illness was identified.

Diagnostic testing results: In the table, each row corresponds to an organism identified during the outbreak. Use the column to specify the type of testing used to identify each organism (either microbiologic culture, PCR (also known as nucleic acid amplification) or specify if a different diagnostic test was used (e.g., Legionella urinary antigen). For each test type, document the total number of residents and staff that received laboratory confirmation by that test.

Section 8: If Influenza Identified During Outbreak:

Antiviral Treatment: Fill in the box (yes or no) indicating whether or not antiviral treatment was offered. If antiviral treatment was offered, please record the total number of residents and staff that received treatment.

Antiviral Prophylaxis Offered: Fill in the box (yes or no) indicating whether or not antiviral prophylaxis was offered to any additional residents, staff or family members at risk for infection due to the outbreak. If antiviral prophylaxis was offered, please record the total number of residents and staff that received prophylaxis.

Section 9: Resident Outcome

Hospitalizations: During the outbreak, fill in the box (yes or no) indicating whether or not hospitalization was required for any residents. If yes, please record how many residents were hospitalized.

Deaths: During the outbreak, fill in the box (yes or no) indicating whether or not any residents died. If yes, please record how many residents died during the outbreak period (deaths should be recorded even if unable to determine if outbreak illness was the cause).

Section 10: Facility Outbreak Control Interventions

In this section, check if any of the infection control strategies listed were implemented at your facility in response to the outbreak. If a practice or policy change was implemented during the outbreak that is not listed (e.g., new cleaning/disinfecting products used, change to employee sick leave policy), specify in the space provided by "Other". For each strategy, record the date the change was implemented (if available).

Section 11: # of New Cases Per Day

Please fill in the chart with the number of new cases that are residents and staff per day. Once each day is complete, add the number of new cases of residents and staff and place the sum in total column for that corresponding day.

In the space provided under the chart, record the date which corresponds to Day 1 on the outbreak period (i.e., date of outbreak start).

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Facility Licensed by State: Fill in the box (yes or no) indicating whether or not the facility is licensed by the state.	# of Licensed Beds: Document the total number of licensed beds at the facility.
Facility Certified by CMS: Fill in the box (yes or no) indicating whether or not the facility is certified by the Center for Medicare and Medicaid Services (CMS).	# of staff employees: Document the total number of facility employed staff working in the facility at the time of the outbreak.
Facility Type: Check that box that best describes the type of care the facility provides: Nursing home, Intermediate Care Facility, Assisted living Facility or Other (specify).	# of contract employees: Document the total number of contract/consulting providers working in the facility at the time of the outbreak.

LTC Respiratory Surveillance Outbreak Summary

1. Facility Information

Health Dept. Contact Name: _____ Health Dept. Contact Phone Number: _____
 Health Dept. Fax Number: _____ Date First Notified Local Health Dept.: ____/____/____
 Total # of residents at facility: _____ Total # of employees (staff and contract personnel): _____
 Summary Form Status: Date initiated: ____/____/____ Date completed: ____/____/____

2. Influenza Vaccination Status

Total # of residents vaccinated: _____ Total # of staff vaccinated: _____

3. Pneumococcal Vaccination Status

Total # of residents vaccinated: _____

4. Symptomatic Case Definition

Summarize the definition of a symptomatic case during the outbreak, including symptoms, time range and location (if appropriate) within facility:

5. Outbreak Period Information

Outbreak start: (Date of symptom onset of first case): ____/____/____
 Average length of illness: _____ days
 Outbreak end: (Symptom resolution date of last case): ____/____/____

Total # of Cases
 Residents: _____ Staff: _____

6. Staff Information

Were any ill staff delivering resident care at the beginning of the outbreak? ☐ Yes ☐ No If yes, how many: _____
 Did any ill staff seek outside medical care at the beginning or during the outbreak? ☐ Yes ☐ No If yes, how many: _____
 ED Visit: ☐ Yes ☐ No If yes, how many: _____ Hospitalization: ☐ Yes ☐ No If yes, how many: _____

7. Diagnostic and Laboratory Tests

Chest x-ray: ☐ Yes ☐ No # performed: _____ # abnormal: _____

Which organisms were identified through laboratory testing:

Bacterial: Specify _____ Viral: Specify _____ Other: Specify _____

Total # of Laboratory Confirmed Cases	Culture	PCR	Other Diagnostic Tests: Specify
Organism 1	Residents: _____ Staff: _____	Residents: _____ Staff: _____	Residents: _____ Staff: _____
Organism 2	Residents: _____ Staff: _____	Residents: _____ Staff: _____	Residents: _____ Staff: _____
Organism 3	Residents: _____ Staff: _____	Residents: _____ Staff: _____	Residents: _____ Staff: _____

8. If Influenza Identified During Outbreak:

Antiviral **treatment** offered: ☐ Yes ☐ No Antiviral **prophylaxis** offered: ☐ Yes ☐ No
 If yes, indicate total # : Residents _____ Staff _____ If yes, indicate total # : Residents _____ Staff _____

9. Resident Outcome

Hospitalizations: ☐ Yes ☐ No If yes, how many: _____ Deaths: ☐ Yes ☐ No If yes, how many: _____

10. Facility Outbreak Control Measures

☐ Educated on hand hygiene practices: Date: _____ ☐ Monitored appropriate HH and PPE use by staff: Date: _____
☐ Implemented transmission-based precautions: Date: _____ ☐ Cohorted ill residents within unit/building: Date: _____
☐ Dedicate staff to care for only affected residents: Date: _____ ☐ Placed ill staff on furlough: Date: _____
☐ Suspend activities on affected unit: Date: _____ ☐ Restricted new admissions to affected unit: Date: _____
☐ Notified family/visitors about outbreak: If yes, Date: _____ ☐ Educated family/visitors about outbreak: If yes, Date: _____
☐ Other: _____ ☐ Other: _____

11. # of New Cases Per Day

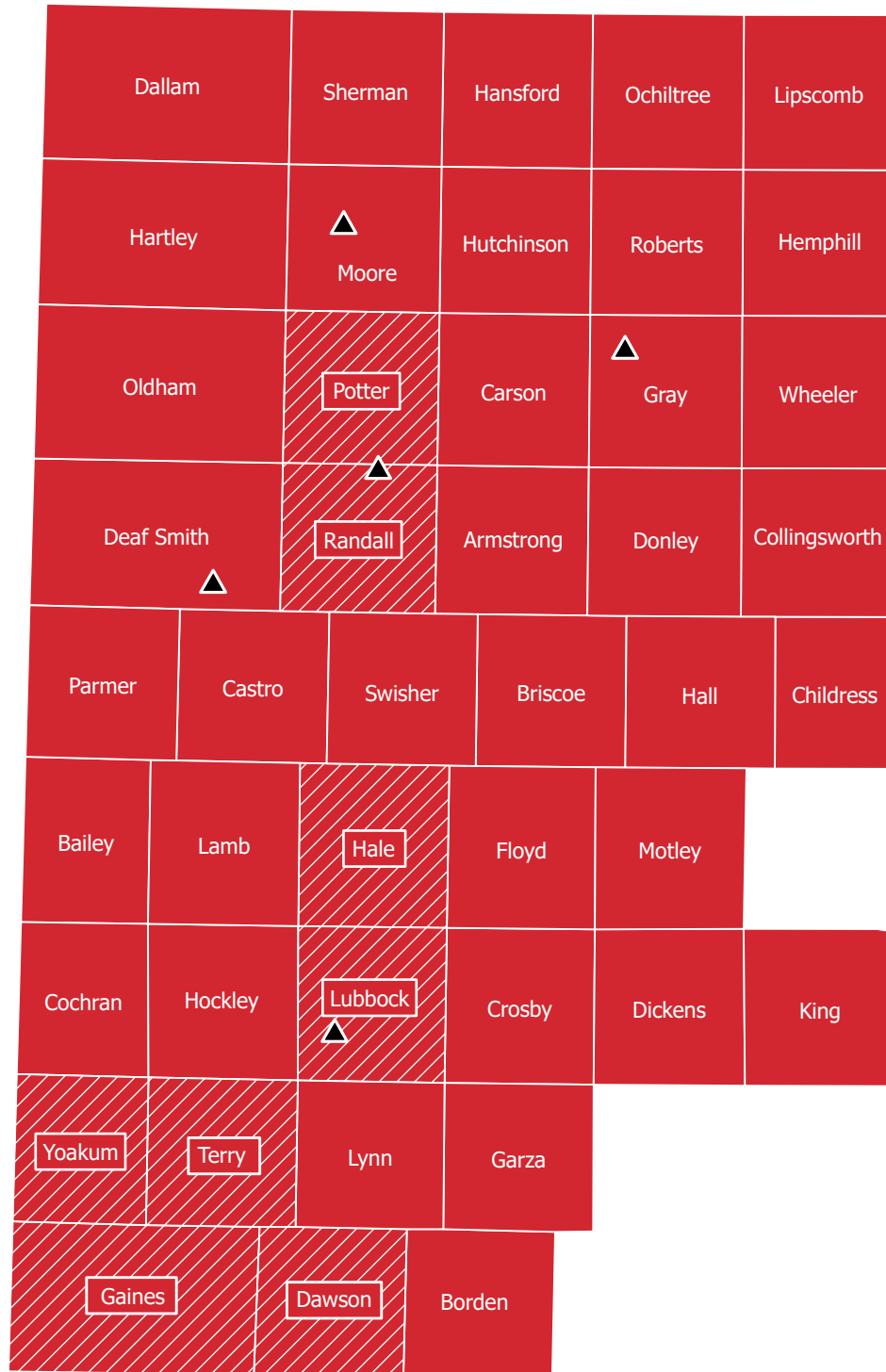
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Residents														
Staff														
Total														

Indicate Date of Day 1: ____/____/____ List units/floors involved in the outbreak: _____

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Facility Licensed by State: ☐ Yes ☐ No Facility ID: _____
 Facility Certified by CMS: ☐ Yes ☐ No Facility Type: ☐ Nursing home ☐ Assisted living ☐ Other (specify): _____
 # of Licensed Beds: _____ # of staff employees: _____ # of contract employees: _____

DSHS Northwest Texas



- ▲ DSHS Regional Office
- Local Health Department provides public health services to city only (not county)
- ▨ Local Health Department provides public health services



TEXAS
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Services

**Texas Department of State
Health Services**

