ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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TO: Illinois Long Term Care Facilities and Assisted Living Facilities, Local Health Departments, Local Health Department Administrators, Illinois Department of Public Health Long Term Care Regional Contacts

FROM: Becky Dragoo, MSN, RN, Deputy Director of Office of Health Care Regulation
Arti Barnes, MD, MPH, Medical Director/Chief Medical Officer

RE: Guidelines for the Prevention and Control of Influenza Outbreaks in Illinois Long Term Care Facilities

DATE: October 5, 2022

The purpose of this memorandum is to provide long-term care facilities (LTCF)[1] and other residential health and living facilities with current guidance for preventing and controlling influenza cases and outbreaks and with information on the reporting requirements in the event of a suspected or confirmed ***influenza outbreak.*** Specific guidance pertaining to COVID-19 can be found on the Illinois Department of Public Health (IDPH) or Centers for Disease Control & Prevention (CDC) websites. While notes specific to COVID-19 are mentioned in some sections of this document, the primary intent of this memorandum is to provide guidance for influenza. In certain situations, COVID-19 guidance may be more restrictive than the influenza guidance mentioned in this document. Facilities should refer to the appropriate guidance for the situation currently occurring in the community and the state, as the more restrictive guidance may be recommended.

Influenza (flu) and COVID-19 are highly contagious respiratory illnesses caused by different viruses. Because some of the symptoms of flu and COVID-19 are similar, it may be hard to tell the difference between them based on symptoms alone, and testing may be needed to help confirm a diagnosis. Facilities should evaluate respiratory symptoms and consider the appropriate test following CDC guidance. The most current information comparing COVID-19 to flu can be found here.

While it's not possible to say with certainty what will happen during the 2022-2023 influenza season, CDC believes it's likely that flu viruses and SARS-CoV-2 will be co-circulating. When SARS-CoV-2 and influenza viruses are found to be co-circulating based on local public health surveillance data and testing, additional practices should be considered. Influenza and COVID-19 viruses can cause substantial sickness

[1] LTCF includes an assisted living facility, a shared housing establishment, or a board and care home, as defined in the Assisted Living and Shared Housing Act [210 ILCS 9]; a community living facility, as defined in the Community Living Facilities Licensing Act]210 ILCS 35]; a life care facility, as defined in the Life Care Facilities Act [210 ILCS 40]; a long-term care facility, as defined in the Nursing Home Care Act [210 ILCS 45]; a long-term care facility as defined in the ID/DD Community Care Act [210 ILCS 47]; a long-term care facility, as defined in the MC/DD Act [210 ILCS 46]; a specialized mental health rehabilitation facility, as defined in the Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 48]; and a supportive residence, as defined in the Supportive Residences Licensing Act [210 ILCS 65].

and death among long-term care facility residents and personnel. Influenza and COVID-19 usually enter LTCFs via newly admitted residents, health care workers, and/or visitors. In addition, CDC also monitors circulation patterns of other types of respiratory viruses which may be responsible for major LTCF outbreaks, that should be considered along with influenza and COVID-19.

Vaccination is the most effective way to prevent influenza, limit transmission, and prevent complications from influenza in LTCFs. To address the importance of influenza vaccination, especially during the COVID-19 pandemic, CDC will maximize flu vaccination by increasing availability of vaccine, by emphasizing the importance of flu vaccination for the entire flu season and by conducting targeted communication outreach to specific groups at higher risk of complications from the flu. These same groups are often at higher risk for COVID-19 as well, so protecting them from influenza is important to decrease their risk of co-infection. It is recommended that influenza testing occur year-round (not just during flu season) whenever a resident has an influenza-like illness, regardless of whether the affected resident has been vaccinated.

Significant changes to the 2022-2023 LTCF influenza outbreak guidance include:

- Updates to recommendations for influenza vaccinations in those ages 65 years and older
- Updates indicating Baloxavir is no longer approved for chemoprophylaxis

Other small changes may have been made to the previous year's guidance documents such as improving clarity, updating links or removing outdated guidance.

Local health departments (LHDs)[2] and LTCFs are strongly encouraged to print the attached document for use during the upcoming influenza season. The guidance is also intended for use by inpatient rehabilitation facilities, long-term psychiatric hospitals, and senior living residential facilities. In addition to this guidance, the CDC has an online Toolkit for Long-Term Care Employers, located on CDC's Influenza Webpage, that may also assist your facility during the influenza season.

[2] "Local Health Department" refers to the certified local health department in the jurisdiction where the LTCF is located. In Edwards and Richland counties, IDPH will assume the LHD role during an influenza outbreak investigation.

Influenza

Disease and Outbreak Management for Long-term Care Facilities

CONTENTS

I. Influenza Overview

Influenza (also known as the flu) is a contagious respiratory illness caused by influenza viruses. It can cause mild illness in some persons but can cause substantial illness and death among residents of LTCF. Adults 65 years of age and older are at higher risk for developing influenza-related complications. Influenza symptoms usually occur abruptly and include some or all the following: fever, myalgia (muscle pain), headache, malaise, nonproductive cough, sore throat, and rhinitis (stuffy or runny nose, sneezing and post-nasal drip).

Influenza viruses are spread from person to person primarily through large-particle respiratory droplet transmission (e.g., when an infected person coughs or sneezes near another person). Transmission via large-particle droplets requires close contact between the source and recipient persons, because droplets do not remain suspended in the air and generally travel only a short distance (less than or equal to one meter or just over three feet).

Another possible source of transmission is contact with respiratory droplet-contaminated surfaces (e.g., the susceptible person touches contaminated surface and then touches his eyes, nose, or mouth). Contact with respiratory droplet-contaminated surfaces is another possible source of transmission (e.g., the susceptible person touches contaminated surface and then touches his eyes, nose, or mouth). The typical incubation period (time between exposure and infection) for influenza is one to four days, with an average of two days. Infected adults shed influenza virus from the day before symptoms begin through five to seven days after illness onset. Young children and persons with weakened immune systems may be infectious for ten or more days after onset of symptoms.

II. Definitions

The following definitions will assist you in determining how to respond to influenza-like illness and influenza outbreaks within your facility:

- **Influenza-like illness (ILI):** Fever (a temperature of 100º F [37.8º C] or higher orally) AND new onset of cough and/or sore throat.
- **Confirmed influenza outbreak:** Two or more cases of ILI occurring within 72 hours among residents in a unit of the facility with at least one of the ill residents having laboratory-confirmed influenza (i.e., reverse transcription polymerase chain reaction [RT-PCR], viral culture, or rapid test).

Note: When influenza is circulating in the surrounding community, a high index of suspicion should be maintained. Fever may be difficult to determine among elderly residents. Therefore, the definition of fever used for ILI can be a temperature two degrees (2°F) above the established baseline for that resident. Some ill residents may develop prostration (extreme exhaustion) with new onset of cough and/or sore throat.

III. Reporting

PLEASE REPORT ALL OUTBREAKS OF INFLUENZA to the LHD **AND** to your respective IDPH Long-term Care Regional Office within 24 hours (within eight regularly scheduled business hours) by telephone or fax. Pursuant to the Control of Communicable Diseases Code Section [77 ILCS 45 690.565], any pattern of cases or increased incidence of any illness beyond the expected number of cases in a given period that may indicate an outbreak shall be reported to the local health authority within 24 hours. Clusters or outbreaks determined to be confirmed as influenza should then be reported by the LHD to the IDPH influenza surveillance program via the Outbreak Reporting System (ORS). Facilities should use the attached Influenza Outbreak Report Form to assist in collecting and disseminating information to the LHD.

After seven days from the latest case onset have passed without a new case of ILI in the facility, the outbreak can be considered resolved and will be finalized and closed by the LHD in the Outbreak Reporting System (ORS).

IV. Prevention and Control of Influenza Outbreaks in LTCF

Strategies for preventing and controlling influenza in long-term care facilities include the following:

A. Vaccination
B. Testing
C. Infection Control Measures
D. Antiviral Treatment
E. Antiviral Chemoprophylaxis

A. Vaccination Recommendations

1. Anyone ≥6 months of age and older without contraindications, including health care personnel and persons at high risk for complications from influenza (including all residents of LTCFs), should receive annual influenza vaccination according to current national recommendations. Immunization policies should include annual influenza vaccination for all residents and staff, and the pneumococcal vaccine as recommended by the Advisory Committee on Immunization Practices (ACIP). Although vaccination by the end of October is recommended, influenza vaccine administered in December or later, even if influenza

activity has already begun, is likely to be beneficial in the majority of influenza seasons because the duration of the season is variable. **To review the 2022-2023 season recommendations, please view the MMWR article and CDC FAQ link.**

2. **Please note that the flu and Covid 19 vaccines can be administered at the same time.**

3. **Vaccination of Residents**
   LTC facilities should implement the following guidelines for vaccinating residents:
   a. Standing orders for influenza vaccine should be in effect for all residents ≥6 months of age.
   b. Residents should be vaccinated on an annual basis as soon as influenza vaccine becomes available, unless medically contraindicated (Nursing Home Care Act [210 ILCS 45/2-213]). It is important to continue to administer influenza vaccine throughout the influenza season. New residents should be vaccinated as soon as possible after admission to the facility. Residents with uncertain immunization histories should be considered NOT immunized and vaccinated accordingly.
      - For more information about vaccination recommendations and specifically for information on persons with a history of egg allergy, review the 2022-2023 Influenza Vaccine Recommendations.
   c. A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the CDC, who has not received this immunization prior to or upon admission to the facility, unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, arranged, refused, or medically contraindicated. For specific recommendations, visit the CDC website where this topic is discussed in detail.
   d. For the 2022-2023 influenza season, recommendations for vaccination of adults aged ≥65 have been modified. ACIP recommends that adults aged ≥65 years preferentially receive any one of the following higher dose adjuvanted influenza vaccines: quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated influenza vaccine (aIIV4). If none of these three vaccines is available at an opportunity for vaccine administration, then any other age-appropriate influenza vaccine should be used.
   e. For specific details on administration of influenza vaccines with other vaccines, visit the 2022-23 ACIP summary.

4. **Vaccination of Health Care Personnel**
   Pursuant to Section 30 of the Health Care Employee Vaccination Code [77 Ill. Adm. Code 956], "Each health care setting shall ensure that all health care employees are provided education on influenza and are offered the opportunity to receive seasonal, novel and pandemic influenza vaccine, in accordance with this section, during the influenza season (between September 1 and March 1 of each year) unless the vaccine is unavailable."

   Effective July 1, 2018, P.A. 100-1029 amended Section 2310-650 of the Department of Public Health Powers and Duties Law (20ILCS 2310/2310-650) to modify the instances in which a health care employee may decline an influenza vaccine offer. P.A. 100-1029 provides that 'A health care employee may decline the offer of vaccination if the vaccine is medically contraindicated, if the vaccine is against the employee's religious beliefs, or if the employee has already been vaccinated. General philosophical or moral reluctance to influenza vaccinations does not provide a sufficient basis for an exemption'. The

Department has adopted revised rules to the Health Care Employee Vaccination Code, [77 Ill. Adm. Code 956], effective February 6, 2019, to implement and adopt P.A. 100-1029.

Each health care setting is also required to maintain a system for tracking and documenting influenza vaccine offered and administered to health care employees. Documentation shall be kept for three years. Health care employees who decline vaccination for any reason indicated in the Code shall sign a statement declining vaccination and certifying that he or she received education about the benefits of influenza vaccine. Many health care facilities have chosen to implement more stringent influenza vaccination policies to improve employee vaccination rates.

Influenza vaccination of all persons who provide care and services in LTC facilities may help reduce transmission of influenza, staff illness and absenteeism, and influenza-related illness and death, especially among people at increased risk for severe influenza complications such as residents 65 and older. All LTC staff, including housekeeping and dietary staff, consultants, and volunteers should receive flu vaccine every year, unless contraindicated. (Note: Some studies have shown that approximately 25% of all health care workers are infected with influenza every flu season.)

5. **Vaccination of Family Members and Visitors**
   Family members and visitors should be informed about their role in the transmission of influenza to LTCF residents and they should be encouraged to receive influenza vaccine. To find out where to get their influenza vaccine, family members can call their health care provider, LHD, or visit the Department of Health and Human Services (HHS) Health Map Vaccine Finder.

B. Testing

If influenza is suspected in any resident, influenza testing should be performed promptly. LTC facilities should develop a plan for collecting respiratory specimens and performing influenza testing when influenza is suspected in a resident. LTC facilities should work with their laboratory providers to identify a facility that can perform influenza testing. If possible, samples from any influenza outbreak should be sent to the IDPH laboratory. For more information regarding influenza testing, please visit CDC's website.

1. **Influenza Testing During Outbreaks**
   a. Facilities should be prepared to perform diagnostic testing if the index of suspicion is high. Facilities should develop a plan for collecting respiratory specimens and performing influenza testing (e.g., Real-Time PCR, and rapid molecular or nucleic acid based diagnostic test) when influenza-like illness (ILI) clusters occur or when influenza is suspected in a resident.
   b. If your facility is experiencing an outbreak, institute the facility's plan for collection and handling of specimens to identify influenza virus as the causal agent early in the outbreak (within one to two days of symptom onset) by performing rapid influenza virus testing of multiple residents with recent onset of symptoms suggestive of influenza. However, it is important to note that rapid antigen or immunofluorescence tests (not rapid molecular tests) are not as sensitive in detecting influenza and a negative test may warrant confirmation with PCR/NAAT testing. In addition, consult with your LHD regarding the shipment of specimens for RT-PCR testing to IDPH laboratory in order to determine the influenza virus type and subtype. For collection, shipping, and submission

details, please contact your LHD. If testing through a hospital or private laboratory, ensure that the laboratory performing the tests notifies the facility of results promptly.

2. **COVID-19 testing and Respiratory Viral Panels (RVP) during outbreaks**
    a. When SARS-CoV-2 and influenza are found to be co-circulating, test any resident with symptoms of COVID-19 or influenza for both viruses. Because SARS-CoV-2 and influenza virus co-circulation can occur, a positive influenza test result without SARS-CoV-2 testing does not exclude SARS-CoV-2 infection, and a positive SARS-CoV-2 test result without influenza testing does not exclude influenza virus infection.
    b. Respiratory viral panels (RVP) are used to determine the cause of respiratory illness when influenza and COVID-19 are either not suspected or have been ruled out, when there are concerns about co-infection, or when multiple viruses are circulating. There are multiple seasonal coronaviruses included in RVP that are not SARS-CoV-2. These coronaviruses cause milder upper respiratory infections and do not cause COVID-19.

C. Infection Control Measures

The following infection control measures are recommended to prevent person-to-person transmission of influenza and to control influenza outbreaks in LTCFs:

1. **Respiratory Hygiene/Cough Etiquette**
   It is important to ensure that all people *with symptoms of a respiratory infection* adhere to respiratory hygiene/cough etiquette. For more information regarding respiratory hygiene/cough etiquette visit the CDC website. LTC facilities should ensure the availability of supplies for hand and respiratory hygiene in resident and visitor areas, including tissues and no-touch receptacles for used tissue disposal, alcohol-based hand rub dispensers, hand washing supplies (soap, disposable towels), and surgical/procedure masks for symptomatic residents and visitors.

2. **Standard Precautions**
   During the care of any patient, all health care providers in every healthcare setting should adhere to standard precautions, which are the foundation for preventing transmission of infectious agents in all healthcare settings. Use standard precautions during the care of all residents in the facility. During the care of any resident with symptoms of a respiratory infection, health care personnel should adhere to the following standard precautions:
    a. Wear gloves if hand contact with respiratory secretions or potentially contaminated surfaces is anticipated.
    b. Wear a gown if soiling of clothes with a resident's respiratory secretions is anticipated. Do not reuse gowns, even for repeated contacts with the same resident.
    c. Change gloves and gowns after each resident encounter and perform hand hygiene.
    d. Perform hand hygiene before and after touching the resident, after touching the resident's environment, and/or after touching the resident's respiratory secretions, regardless of whether gloves are worn.
    e. When hands are visibly soiled or contaminated with respiratory secretions, wash hands with soap (either plain or antimicrobial) and water. The lather from the soap should remain on the hands for at least 20 seconds.

f. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands. Alternatively, wash hands with soap (either plain or antimicrobial) and water.
g. Eye and mucus membrane protection are part of standard precautions when possible exposure to secretions is anticipated: Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. For more information visit CDC's website.

3. **Droplet Precautions**
In addition to Standard Precautions, health care personnel should adhere to the Droplet Precautions, which should be followed during the care of a resident with suspected or confirmed influenza for at least seven days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a resident is in a healthcare facility. In some cases, facilities may choose to apply Droplet Precautions for longer periods based on clinical judgment, such as in the case of young children or severely immunocompromised patients, who may shed influenza virus for longer periods of time.
a. Place ill residents requiring precautions in private rooms. If a private room is unavailable, a room may be cohorted by residents with confirmed influenza OR a room may be cohorted by residents with suspected influenza. Wear facemasks (e.g., a surgical or procedure mask) upon entering residents' rooms or when working within six feet of residents on droplet precautions. Additional precautions have been recommended by CDC during aerosol generating procedures. Remove facemasks when leaving residents' rooms, dispose of masks in waste container inside the resident's room and perform hand hygiene before leaving the resident's room.
b. If resident movement or transport is necessary, residents must wear facemasks.
c. Communicate information about residents with suspected or confirmed influenza to appropriate personnel before transferring them to other departments or healthcare facilities. For more information on isolation precautions visit CDC's website.

NOTE: Droplet and Contact Precautions with eye/face protection should be followed when caring for a resident with confirmed or suspected COVID-19. If a resident is being tested for both viruses, caregivers must wear full COVID-19 personal protective equipment (PPE) while providing care to these residents. Full COVID-19 PPE includes the use of an N95 mask, gown, eye protection, and gloves.

4. **Restrictions for Ill Visitors and Health-care Personnel**
Health care personnel with influenza-like illness should be excluded from work for at least 24 hours after fever has subsided (without the use of fever-reducing medicines). If symptoms such as cough and sneezing are still present when they return to work, they should wear facemasks during patient care activities. Those with ongoing respiratory symptoms should be considered for evaluation by occupational health or the facility's Director of Nursing/Nursing Supervisor to determine appropriateness of contact with patients. Adherence to respiratory hygiene/cough etiquette and the importance of performing frequent hand hygiene (especially before and after each resident contact) should be reinforced.

LTC facilities should monitor the Illinois Weekly Influenza Surveillance Report for information about influenza activity in Illinois during the season. It can be found on the influenza surveillance page on the IDPH website.

Please note that the following guidance for visitors utilizing influenza activity levels during flu season may be superseded by COVID-19 visiting guidance:

a. ***If minimal or low levels of influenza activity are occurring in the surrounding community:***
   - Discourage persons with symptoms of a respiratory infection from visiting residents. Implement this measure through educational activities.
   - Monitor healthcare personnel absenteeism due to respiratory symptoms and exclude those with influenza-like symptoms from work until at least 24 hours after they no longer have a fever
   - Monitor residents for symptoms of respiratory illness.

b. ***If moderate or high levels of influenza are occurring in the surrounding community:***
   - Notify visitors (e.g., via posted notices) that adults with respiratory symptoms should not visit the facility for seven days, and children with symptoms for ten days following the onset of illness or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.
   - Evaluate health care personnel with influenza-like illness, perform rapid influenza testing to confirm the causal agent is influenza, and exclude ill persons as recommended above.
   - Monitor residents for symptoms of respiratory illness to determine need for Droplet Precautions.

NOTE: Facilities should regularly monitor IDPH website for COVID-19 and Influenza data.

5. **Surveillance**

LTC facilities should implement daily active surveillance for respiratory illness among all residents and health-care personnel. Respiratory testing should be used to identify any increased incidence of ILI among residents, so that infection control measures can be promptly initiated to prevent the spread of disease in the facility.

When influenza activity is occurring in the local community, implement daily active surveillance and continue through the end of the influenza season. Examples of conducting surveillance include:

a. Monitoring for symptoms of respiratory illness among residents, health care personnel, and visitors to the facility.
b. Maintaining a line listing of those ill, including both staff and residents.
c. Maintaining a log of staff call-ins and reviewing daily for symptoms of respiratory illness; inquire if influenza testing was performed and request results if available.

NOTE: Facilities should continue to track COVID-19 and influenza outbreaks separately.

6. **Education**

Annually educate health care personnel about the importance of vaccination, signs and symptoms of influenza, control measures, and indications for obtaining influenza testing. Posting signage about influenza in your facility is one way to educate the visitors, staff, and residents about influenza, especially during peak influenza season. You may utilize the Contact Precautions and Droplet Precautions signs. Adherence to respiratory hygiene/cough etiquette and the importance of performing frequent hand hygiene (especially before and after each resident contact) should be reinforced.

7. **Other Considerations**
   In addition to the above, the following procedures also may be considered to reduce transmission among residents and healthcare personnel:
   a. Have symptomatic residents stay in their own rooms as much as possible, including restricting them from common activities, and have their meals served in their rooms when possible
   b. Limit or suspend the number of large group activities in the facility and consider serving all meals in resident rooms if possible when the outbreak is widespread (involving multiple units of the facility
   c. If influenza is suspected in any resident, influenza testing should be performed promptly. Symptomatic residents with suspected or confirmed influenza and their exposed roommates should be confined to their rooms or grouped together in rooms or on one unit (i.e., cohorted) for seven days following onset of symptoms. Personnel should work on only one unit, if possible.
   d. Droplet Precautions and Standard Precautions should be maintained for residents receiving antiviral treatment for influenza as they may continue to shed influenza viruses while on antiviral treatment. Using Standard Precautions and Droplet Precautions also will reduce transmission of viruses that may have become resistant to antiviral drugs during therapy.
   e. Standard cleaning and disinfection procedures may be used during influenza season. Increased frequency of cleaning and disinfection of high touch surfaces is recommended. An Environmental Protection Agency (EPA) registered, hospital grade disinfectant labeled with an influenza or virucidal statement must be used in accordance with product instructions.
   f. If a novel influenza strain emerges, resulting in an epidemic or pandemic, IDPH may delegate orders for Isolation and Quarantine to the certified LHD(s). Please take time to review IDPH's statutes for Isolation and Quarantine, which are hyperlinked below:
      - Subpart I of the Control of Communicable Diseases Code [77 Ill Adm. Code 690, Subpart I]

D. Antiviral Treatment

The use of antiviral medications for influenza treatment is a key component of influenza outbreak control in LTCFs whose residents are at higher risk for influenza complications. **Antiviral medications have been shown to be most effective if administered within 48 hours after symptom onset; however, these medications can still help if given to the very ill after 48 hours.** Due to antiviral resistance identified during previous influenza seasons, it is currently recommended that neither amantadine nor rimantadine be used for the treatment or chemoprophylaxis of currently circulating influenza A viruses in the United States. Dosage recommendations vary by age group and medical condition. For more detailed information about the use of antiviral medication to control influenza, visit CDC's website. Pre-approved medication orders, or plans to obtain physicians' orders on short notice, should be in place to ensure that treatment can be started as soon as possible.

E. Antiviral Chemoprophylaxis

During a confirmed influenza outbreak, antiviral chemoprophylaxis should be given to residents and offered to health care personnel in accordance with current CDC recommendations. When influenza is identified as a cause of a respiratory disease outbreak among nursing home residents, use of antiviral medications for chemoprophylaxis within 48 hours of exposure, is recommended for all non-ill residents (regardless of whether they have received influenza vaccination) living on the same unit as the resident with the laboratory-confirmed influenza (outbreak affected units). Consideration may be given for extending antiviral chemoprophylaxis

to residents on other unaffected units or warns in the long-term care facility based upon other factors (e.g. unavoidable mixing of residents or healthcare personnel from affected units and unaffected units). Antiviral chemoprophylaxis is meant to prevent transmission for residents who are not exhibiting influenza-like illness but who may be exposed or who may have been exposed to an ill person with influenza.

Antiviral chemoprophylaxis can be considered or offered to unvaccinated personnel who provide care to persons at high risk of influenza complications. For newly vaccinated staff, antiviral chemoprophylaxis can be offered for up to two weeks (the time needed for antibody development) following influenza vaccination. Prophylaxis should be considered for all employees, regardless of their vaccination status, if the outbreak is caused by a variant strain of influenza that is not well-matched by the vaccine. For institutional outbreak management, antiviral chemoprophylaxis should be administered for a minimum of two weeks and continue for at least seven days after the last known case was identified. Oseltamivir is the recommended antiviral drug for chemoprophylaxis of influenza in long-term care settings. Baloxavir is not approved for chemoprophylaxis of influenza and is not recommended for chemoprophylaxis of influenza in long term care facility residents.

Persons receiving antiviral chemoprophylaxis should be actively monitored for potential adverse effects and for possible infection with influenza viruses that are resistant to antiviral medication. Dosage recommendations vary by age group and medical condition. Pre-approved medication orders or plans to obtain physicians' orders on short notice should be in place to ensure that chemoprophylaxis can be started as soon as possible. For more information about the use of antiviral medication to control influenza, visit CDC's website.

For additional information or questions about influenza outbreaks, please contact your local health department.

V. References

1. "Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities" from CDC http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm

2. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html

3. Clinical Description & Lab Diagnosis of Influenza
http://www.cdc.gov/flu/professionals/diagnosis/index.htm

4. State of Illinois Administrative Code Title 77: Public Health
http://www.ilga.gov/commission/jcar/admincode/077/077parts.html

5. State of Illinois Administrative Code Title 89: Social Services (Subpart B: Supportive Living Facilities)
http://www.ilga.gov/commission/jcar/admincode/089/08900146sections.html

6. Illinois Weekly Influenza Surveillance Reports and Updates
https://dph.illinois.gov/topics-services/diseases-and-conditions/influenza/influenza-surveillance.html

7. Prevention and Control of Seasonal Influenza with Vaccines; Recommendations of the Advisory Committee on Immunization Practices – United States, 2022-23 Influenza Season
https://www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm

List of Attachments:

1. Regional and Other LTC Contacts
2. Regional Counties List
3. IDPH Influenza Outbreak Report Form
4. Influenza Surveillance for Congregate Settings Outbreak Log
5. Employee Influenza Vaccination Tracking Form

IDPH LTC Regional and Other Long Term Care Contacts

REGION 1 – ROCKFORD 4302 North Main Street Rockford, IL 61103 815-987-7511 William Schubert	**REGION 2 – PEORIA** 5415 N. University Street Peoria, IL 61614 309-693-5497 Michelle Thompson
REGION 4 – EDWARDSVILLE 22 Kettle River Drive Glen Carbon, IL 62034 630-293-6900 William Schubert	**REGION 5 – MARION** 2309 W. Main Street Marion, IL 62959 309-693-5497 Michelle Thompson
REGION 6 – CHAMPAIGN 2125 S. 1st Street Champaign, IL 61820 217-278-5900 Michelle Thompson	**REGION 7 – WEST CHICAGO** 245 W. Roosevelt Road, Bldg. #5 West Chicago, IL 60185 630-293-6900 William Schubert
REGION 8/9 - BELLWOOD 4212 W. St. Charles Road Bellwood, IL 60104 708-544-5300 Ext 263 Janette Williams-Smith	**ICF/IID and Under 22 Facilities & SMHRF** 525 West Jefferson, 5th Floor Springfield, IL 62761-0001 217-782-2363 or 708-544-5300 Sheila Baker
Assisted Living Facilities 525 West Jefferson, 5th Floor Springfield, IL 62761-0001 217-782-2363 or 708-544-5300 Sheila Baker	**Illinois Department of Healthcare and Family Services-Supportive Living Facilities** 201 S. Grand Avenue, 3rd Floor Springfield, IL 62763 217-782-1868 Kara Helton

Regional Counties

REGION 1 – ROCKFORD

Boone	DeKalb	Lee	Stephenson	Whiteside
Carroll	Jo Davies	Ogle	Winnebago	

REGION 2 – PEORIA

Adams	Hancock	Logan	Mercer	Stark
Brown	Henderson	Marshall	Peoria	Tazewell
Bureau	Henry	Mason	Putnam	Warren
Cass	Knox	McDonough	Rock Island	Woodford
Fulton	LaSalle	Menard	Schuyler	

REGION 4 – EDWARDSVILLE

Bond	Greene	Monroe	Pike	Scott
Calhoun	Jersey	Montgomery	Randolph	St. Clair
Christian	Macoupin	Morgan	Sangamon	Washington
Clinton	Madison			

REGION 5 – MARION

Alexander	Franklin	Jefferson	Perry	Union
Clay	Gallatin	Johnson	Pope	Wabash
Crawford	Hamilton	Lawrence	Pulaski	Wayne
Edwards	Hardin	Marion	Richland	White
Effingham	Jackson	Massac	Saline	Williamson
Fayette	Jasper			

REGION 6 – CHAMPAIGN

Champaign	DeWitt	Ford	Macon	Piatt
Clark	Douglas	Iroquois	McLean	Shelby
Coles	Edgar	Livingston	Moultrie	Vermilion
Cumberland				

REGION 7 – WEST CHICAGO

DuPage	Kane	Kendall	McHenry
Grundy	Kankakee	Lake	Will

REGION 8/9 – BELLWOOD

Cook County – Outside of Chicago (Collar Counties)

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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IDPH INFLUENZA OUTBREAK REPORT FORM FOR CONGREGATE SETTINGS

(e.g. Long Term Care & Correctional Facilities)

Fax or secure email, along with the Outbreak Log, to your Local Public Health Department to report an outbreak

Facility Name		
Name of Reporter	**Title:**	
Date of Report		
Address:		
City	**County**	**Zip**
Phone #	**Fax #**	
FACILITY INFORMATION		
Total # of residents in the facility at the time of the outbreak (total exposed): _____	**Total number of staff: _____** **Number of staff currently with ILI:_____**	
Number of residents in the facility currently with influenza-like illness (ILI):_____	**% of residents vaccinated with seasonal flu vaccine:_____** **% of staff vaccinated with seasonal flu vaccine:_____** **% of outbreak cases vaccinated with flu vaccine:_____**	
(ILI) [Fever >100° F [37.8° C] or higher orally AND new onset cough or sore throat]		
(for those with ILI) **# Seen by Provider_____ # Hospitalized_____ # Fatalities_____**		
Date of symptom/onset detection for the first case of ILI during the outbreak:	**Dates of onset for most recent case of ILI during the outbreak:**	
Type of setting: ☐ Correctional Facility ☐ Long-Term Care Facility ☐ Group Home ☐ Other_____ **If long-term care facility, please specify (check only one):** **☐ Skilled Nursing ☐ Assisted Living ☐ Combined Care ☐ Other_____**		
Have specimens been sent to a laboratory for confirmation of influenza: ☐Yes ☐ No **If Yes, names of laboratories:_____**		
Influenza test results to date: **Name of test:** **Number of positive tests *(Include type/subtype)*:** **Number of negative tests:**	**Infection Control Actions Planned:**	

Reviewed 08/2019

Thank you for your assistance with influenza surveillance in Illinois.
Contact your local health department, or IDPH Communicable Disease Section 217-782-2016
(After hours: 1-800-782-7860 or 1-217-782-7860) if you have questions.

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

Influenza Surveillance for Congregate Setting Outbreak Log

Suspect outbreaks should be investigated and tested to confirm the etiology. Suspect outbreaks should be reported to your local health department who will then report confirmed influenza outbreaks in the Outbreak Reporting System (ORS) to IDPH.

Facility Name: _____

List all ill residents and employees. Designate employees with an "E" by their names.

Name	DOB	Unit or Wing	Onset Date	Symptoms/ Signs*	Influenza Specimen Collection Date	Lab Result	Seasonal Flu Vaccine Date	Hospitalized (Y/N)	Died (Y/N)

* Symptoms/Signs: e.g. cough(C), fever (F), sore throat (ST), or Other (O) {list: i.e., chills (CH), pneumonia (P), myalgias (M)}

Reviewed 08/2019

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Employee/Resident Influenza Vaccination Tracking Form

This form can be used to track employee and resident influenza vaccination status

Date	Last Name	First Name	Unit/Floor/Dept	Date Vaccine Received	Declined Vaccine (Y or N)	Declination Form Signed (Y or N)	Educational Information Received (Y or N)	Date Educational Information (VIS) Received

Reviewed 10/2022