

TO: Illinois Long Term Care Facilities and Assisted Living Facilities, and Local Health Departments

FROM: William Moran, Chief, Immunization Section
Fred Echols, M.D., Chief, Communicable Disease Control Section

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

DATE: September 29, 2014

- Influenza in the community enters long-term care facilities via newly admitted residents, healthcare workers, and by visitors.
- Vaccination is the primary measure to prevent influenza, limit transmission, and prevent complications from influenza in long-term care facilities.
- Even if it is not influenza season, influenza testing should occur when any resident has signs and symptoms of influenza-like illness, regardless of whether the affected resident has been vaccinated.

Influenza (also known as the flu) is a contagious respiratory illness that can cause substantial sickness and death among long-term care facility (LTCF) residents and among personnel.

The purpose of this memorandum is to provide facilities with current guidance from the Illinois Department of Public Health (IDPH) for the prevention and control of influenza as well as the reporting requirements in the event of a suspected or confirmed influenza outbreak.

In this memorandum, LTCF includes Assisted Living Facilities, Community Living Facilities (i.e., [77 Illinois Administrative Code 370](#)), Illinois Veterans Homes, Intermediate Care Facilities for the Developmentally Disabled, Intermediate Care Nursing Facilities, Long Term Care for Under Age 22 Facilities, Shared Housing Establishments (i.e., [77 Illinois Administrative Code 295](#)), Shelter Care Facilities, Skilled Nursing Facilities, Supportive Residences (i.e., [77 Illinois Administrative Code 385](#)), and Supportive Living Facilities (i.e., [89 Illinois Administrative Code 146](#)).

This memorandum is also intended for use by inpatient rehabilitation facilities, long-term psychiatric hospitals, and senior living residential facilities. “Local Health Department” refers to the Certified Local Health Department in whose jurisdiction the LTCF is located. If there is no local health department for a jurisdiction, IDPH will assume the local health department role in the influenza outbreak investigation.

This memorandum contains the following 9 sections:

- I. Influenza Overview
- II. Definitions
- III. Reporting
- IV. General Prevention and Control Measures
- V. Control of Influenza in Long-Term Care Facilities
- VI. References
- VII. IDPH Influenza Outbreak Report Form For Congregate Settings
- VIII. Sample Influenza Surveillance for Congregate Setting Outbreak Log
- IX. Sample Employee Influenza Vaccination Tracking Form

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 LTCF residents. Adults 65 years of age and older are at high risk for developing influenza-related complications. Influenza symptoms usually occur abruptly and include some or all of the following: fever, myalgia, headache, malaise, nonproductive cough, sore throat, and rhinitis.

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 a susceptible person). Transmission via large-particle droplets requires close contact between 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 1 meter).

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 for influenza is 1-4 days (average 2 days). Infected adults shed influenza virus from the day before symptoms begin through 5 to 7 days after illness onset. Young children and persons with weakened immune systems may be infectious for 10 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 100° F [37.8° C] or higher orally) AND new onset cough or sore throat.
- **Influenza-like illness Outbreak:** Two or more cases of ILI occurring within 72 hours among residents in a unit of the facility.
- **Influenza Outbreak – Confirmed:** 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. Some ill residents may not have fever but may develop prostration (extreme exhaustion) with new onset cough or sore throat.

III. Reporting

PLEASE REPORT ALL OUTBREAKS OF INFLUENZA AND ILI to the **Local Health Department** AND to the IDPH LTC Division or applicable State agency within 24 hours (i.e., within 8 regularly scheduled business hours) by telephone or fax. [Pursuant to the Control of Communicable Diseases Code Section 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. A suspected or confirmed outbreak of influenza and ILI are reportable under this definition (see the Influenza Outbreak Report Form in section VII included with this memorandum).

IV. General Prevention and Control Measures

Strategies for the prevention and control of influenza in long-term care facilities include the following:

- Annual influenza vaccination of all residents and health-care personnel (e.g., all paid and unpaid workers who have contact with residents and visitors, including volunteer workers),
- Implementation of Standard Precautions (including respiratory hygiene/cough etiquette) and Droplet Precautions,
- Active surveillance and influenza testing for new cases,
- Restriction of ill visitors and personnel, and
- Administration of antiviral treatment and antiviral chemoprophylaxis.

A. Vaccination

Health-care personnel and persons at high risk for complications from influenza (including all residents of long-term care), are recommended to receive annual influenza vaccination according to current national recommendations. Immunization policies should include annual influenza vaccination for all residents and staff, and pneumococcal vaccine as recommended by the Advisory Committee on Immunization Practices.

1. Vaccination of Residents

- Standing orders for influenza vaccine should be in effect for all residents ≥ 6 months of age.
- Residents should be vaccinated on an annual basis, unless medically contraindicated, as soon as influenza vaccine is available. 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. Consider residents with uncertain immunization histories NOT immunized and vaccinate accordingly. Persons known to have anaphylactic hypersensitivity to eggs or to other components of the influenza vaccine should not receive the vaccine without first consulting a physician or health care provider.
 - Flublok® is a trivalent influenza vaccine that has been FDA approved for use in adults ages 18 to 49 years with severe egg allergies since it does not use the influenza virus or chicken eggs in its manufacturing process.
- Pneumococcal vaccine should be given on admission to all unvaccinated residents ≥ 2 years of age. Previously vaccinated residents who are ≥ 65 years of age should receive a second dose of pneumococcal vaccine if: a) it has been more than 5 years since their first dose and b) they were younger than 65 years of age when they received the first dose.
- Medicare reimburses both for the cost of influenza and pneumococcal vaccines and for administration of vaccines. For more information go to: <http://www.cms.hhs.gov/AdultImmunizations/>, or call (312)886-6432.

- Influenza vaccine may be less effective in the very elderly, and although immunized, some LTCF residents may remain susceptible to influenza.
 - Fluzone High-Dose is an influenza vaccine, manufactured by Sanofi Pasteur Inc., that contains more antigen than regular IIV and is designed specifically for people 65 years and older. Fluzone High-Dose is *not* recommended for people who have had a severe reaction to the flu vaccine in the past.
 - Does the higher dose vaccine produce a better immune response in adults 65 years and older?
 - Data from clinical trials comparing Fluzone to Fluzone High-Dose among persons aged 65 years or older indicate that a stronger immune response (i.e., higher antibody levels) occurs after vaccination with Fluzone High-Dose. Whether or not the improved immune response leads to greater protection has been the topic on ongoing research. A [study published in the New England Journal of Medicine](#) indicated that the high-dose vaccine was 24.2% more effective in preventing flu in adults 65 years of age and older relative to a standard-dose vaccine. The confidence interval for this result was 9.7% to 36.5%).

2. Vaccination of Health-Care Personnel

Pursuant to Illinois Administrative [Code Title 77, Chapter 1, Subchapter U, Section 956.30](#), “Beginning with the 2010 to 2011 influenza season, 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). Each health care setting is also required to maintain a system to track the offer of vaccination to health care employees and documentation shall be kept for three years. Health care employees who decline vaccination for any reason shall sign a statement declining vaccination and certifying that he or she received education about the benefits of influenza vaccine. It is important to note that many health care facilities have chosen to implement more stringent influenza vaccination policies to improve employee vaccination rates.

(NOTE: Please refer to Section 956.10 for “health care setting” definition:
<http://www.ilga.gov/commission/jcar/admincode/077/077009560000100R.html>)

For more information regarding Section 956.30 visit
<http://www.ilga.gov/commission/jcar/admincode/077/077009560000300R.html>

Influenza vaccination of all staff reduces mortality in elderly residents. All staff, including housekeeping and dietary staff, consultants and volunteers in LTCFs should receive flu vaccine every year, unless contraindicated. (Note: Some studies have shown that ~ 25% of all healthcare workers are infected with influenza every flu season.)

- Inactivated influenza vaccine is preferred for vaccinating health-care personnel who are >50 years old and health-care personnel of any age who have close contact with severely immunosuppressed persons (e.g., patients who have recently had a hematopoietic stem cell transplant [HSCT] and require a protected environment).
- Live, attenuated influenza vaccine (LAIV) (FluMist®) may be given to health-care personnel <50 years old who do not have contraindications to receiving this

intranasal vaccine. A new quadrivalent formulation of FluMist was approved by the Food and Drug Administration in February 2012 and has replaced last season's trivalent LAIV formulation. Health-care personnel who provide care to HSCT patients who require a protected environment should not receive LAIV.

3. 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 flu shots, family members can call their health care provider, or local health department, or visit the Department of Health and Human Services (HHS) Health Map Vaccine Finder at <http://flushot.healthmap.org/>.

B. Control Measures Including Infection Control

1. In addition to influenza vaccination, the following infection control measures are recommended to prevent person-to-person transmission of influenza and to control influenza outbreaks in LTCFs:

a. Surveillance

Conduct surveillance for respiratory illness and use influenza testing to identify any increased incidence of ILI among residents, so that infection control measures can be promptly initiated to prevent the spread of influenza in the facility.

b. Education

Annually educate health-care personnel about the importance of vaccination, signs and symptoms of influenza, control measures, and indications for obtaining influenza testing.

c. Influenza Testing

If influenza is suspected in any resident, influenza testing should be done promptly. Develop a plan for collecting respiratory specimens and performing influenza testing and viral cultures for influenza when influenza is suspected in a resident. In order of priority, the following influenza tests are recommended by the Centers for Disease Control and Prevention (CDC): reverse transcription polymerase chain reaction (RT-PCR); immunofluorescence; rapid influenza diagnostic tests. LTCFs should work with their laboratory providers to identify a laboratory that can perform the recommended testing. If possible, samples from any influenza outbreak should be sent to the nearest IDPH laboratory. For collection, shipping and submission details, please contact your Local Health Department. For more information regarding influenza testing, please visit <http://www.cdc.gov/flu/professionals/diagnosis/index.htm>

2. Infection Control

a. Respiratory Hygiene/Cough Etiquette

Respiratory hygiene/cough etiquette is a component of Standard Precautions. It is important to ensure that all persons with symptoms of a respiratory infection adhere to respiratory hygiene/cough etiquette. For more information regarding respiratory hygiene/cough etiquette visit <http://www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm>

b. Standard Precautions

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:

- Wear gloves if hand contact with respiratory secretions or potentially contaminated surfaces is anticipated.
- 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.
- Change gloves and gowns after each resident encounter and perform hand hygiene.
- Perform hand hygiene before and after touching the resident, after touching the resident's environment, or after touching the resident's respiratory secretions, whether or not gloves are worn.
- When hands are visibly soiled or contaminated with respiratory secretions, wash hands with soap (either plain or antimicrobial) and water.
- 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. For more information visit <http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>

c. Droplet Precautions

In addition to Standard Precautions, health-care personnel should adhere to Droplet Precautions during the care of a resident with suspected or confirmed influenza for at least 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer:

- Place ill resident in a private room. If a private room is not available, place (cohort) residents suspected of having influenza with one another; cohort residents with confirmed influenza with other residents confirmed to have influenza.
- Wear a facemask (e.g., a surgical or procedure mask) upon entering the resident's room or when working within 6 feet of the resident. Remove the facemask when leaving the resident's room, dispose of the mask in a waste container, and perform hand hygiene.
- If resident movement or transport is necessary, have the resident wear a facemask, if possible.
- Communicate information about residents with suspected or confirmed influenza to appropriate personnel before transferring them to other departments or healthcare facilities.

For more information visit

<http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>

d. Other Considerations

In addition to Standard and Droplet Precautions, the following procedures also may be considered for LTCFs:

- To maintain residents' ability to socialize and have access to rehabilitation opportunities during periods when influenza infections are unlikely and no influenza outbreaks are suspected or confirmed, a resident with symptoms of respiratory infection can be permitted to participate in group meals and activities if the resident can be placed 6 feet from other residents and can adhere to respiratory hygiene/cough etiquette.

- If influenza is suspected in any resident, influenza testing should be done promptly. Confine symptomatic residents with suspected or confirmed influenza and their exposed roommates to their rooms or group them together in rooms or on one unit (i.e., cohorted) for 7 days following the onset of symptoms. Personnel should work on only one unit, if possible.
- Droplet Precautions should be used for residents receiving antiviral treatment for influenza because they may continue to shed influenza viruses while on antiviral treatment. Using Droplet Precautions will also reduce transmission of viruses that may have become resistant to antiviral drugs during therapy.

e. Restrictions for Ill Visitors and Health-care Personnel

1. Health-care personnel with influenza-like illness should be excluded from work for at least 24 hours after they no longer have fever (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 a facemask during patient care activities. Adherence to respiratory hygiene/cough etiquette and the importance of performing frequent hand hygiene (especially before and after each resident contact) should be reinforced.
2. *If no or only sporadic influenza activity is in the surrounding community:*
 - Discourage persons with symptoms of a respiratory infection from visiting residents. Implement this measure through educational activities.
 - Monitor health-care personnel for symptoms of influenza-like illness and exclude ill persons as recommended above.
 - Monitor residents for symptoms of respiratory illness.
3. *If widespread influenza activity is occurring in the surrounding community:*
 - Notify visitors (e.g., via posted notices) that adults with respiratory symptoms should not visit the facility for 7 days and children with symptoms for 10 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 and perform rapid influenza tests to confirm the causative agent is influenza and exclude ill persons as recommended above.
 - Monitor residents for symptoms of respiratory illness to determine need for Droplet Precautions.

f. Using Antiviral Medications to Control Influenza Outbreaks

The use of antiviral medications for treatment and chemoprophylaxis of influenza is a key component of influenza outbreak control in LTCFs that house residents at higher risk for influenza complications. 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 influenza A in the United States.

Both oseltamivir and zanamivir are approved for treatment and chemoprophylaxis of influenza A and B. Oseltamivir may be used for treatment in those ≥ 2 weeks and for chemoprophylaxis in those ≥ 1 year of age. Zanamivir may be used for treatment in those ≥ 7 years of age and for chemoprophylaxis in those ≥ 5 years of age. Dosage recommendations vary by age group and medical condition. For more

information about the use of antiviral medication to control influenza, visit <http://www.cdc.gov/flu/antivirals/index.htm>

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. **Antiviral medications have been shown to be effective if administered within 48 hours after symptom onset.**

1. Residents who have confirmed or suspected influenza should receive antiviral treatment immediately in accordance with current recommendations. Treatment should not wait for laboratory confirmation of influenza. Residents receiving antiviral treatment for influenza should be maintained in Droplet Precautions for at least 7 days after illness onset, or until 24 hours after the resolutions of fever and respiratory symptoms, whichever is longer.
2. Antiviral chemoprophylaxis should be given to residents and offered to health-care personnel in accordance with current CDC recommendations. 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.
 - In outbreak settings, antiviral chemoprophylaxis should typically be administered to at-risk residents, regardless of whether they received influenza vaccine. Depending upon the size and configuration of the facility, staffing arrangements, patient and visitor movements, etc, it is not always necessary to administer antiviral chemoprophylaxis to all residents in the facility.
 - In outbreak settings, chemoprophylaxis also can be offered to unvaccinated personnel who provide care to at-risk residents. 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.
 - Antiviral prophylaxis should be continued for at least 2 weeks, and as long as 1 week after the last resident case occurred.

V. Control of Influenza Outbreaks in Long-Term Care Facilities

A. Influenza Testing During Outbreaks

1. Facilities should be prepared to perform diagnostic testing if index of suspicion is high. Facilities should develop a plan for collecting respiratory specimens and performing influenza testing (e.g., Real time PCR, immune fluorescence, and rapid diagnostic test) for influenza when influenza-like illness (ILI) clusters occur or when influenza is suspected in a resident. LHDs have influenza testing kits and will facilitate submission to the IDPH state laboratory.
2. If your facility is experiencing outbreak, institute the facility's plan for collection and handling of specimens to identify influenza virus as the causative agent early in the outbreak (within 1-2 days of symptom onset) by performing rapid influenza virus testing of multiple residents (3-6 specimens) with recent onset of symptoms suggestive influenza. In addition, consult with your local health department regarding the shipment of specimens for RT-PCR testing at IDPH in order to determine the influenza virus type and influenza A subtype. If testing through a hospital or private laboratory, ensure that the laboratory performing the

tests notifies the facility of tests results promptly. Once an outbreak is confirmed, additional testing is not typically indicated.

B. Control Measures During Outbreaks

1. If your facility has an influenza outbreak, the following measures should be taken to limit transmission.
 - Inform local and state health department officials within 24 hours of outbreak recognition (see attached Influenza Report Form). Determine if the health department wants clinical specimens or viral cultures.
 - Implement daily active surveillance for respiratory illness among all residents and health-care personnel until at least 1 week after the last confirmed influenza case occurred. It is important to collect information that will assist in development and targeting of outbreak control strategy.
 - Implement Droplet Precautions for all residents with suspected or confirmed influenza.
 - Confine symptomatic residents to their rooms or group (cohort) them in the affected unit.
 - Confine the first symptomatic resident and exposed roommate to their room, restrict them from common activities and serve meals in their rooms.
 - If other residents become symptomatic, cancel common activities and serve all meals in resident rooms. If residents are ill on specific wards, do not move residents or personnel to other wards, or admit new residents to the wards with symptomatic residents.
 - Limit visitation, exclude ill visitors, and consider restricting visitation of children via posted notices.
 - Monitor health-care personnel absenteeism due to respiratory symptoms and exclude those with influenza-like symptoms from patient care for at least 24 hours after they no longer have fever (without use of fever-reducing medicines).
 - Restrict health-care personnel movement from areas of the facility having outbreaks to areas without residents with influenza.
 - Limit new admissions.
 - **Administer the current season's influenza vaccine to unvaccinated residents and health-care personnel.** Follow current vaccination recommendations for nasal and intramuscular influenza vaccines. Have a system in place to readily identify unvaccinated residents and staff.
 - Administer influenza antiviral chemoprophylaxis and treatment to residents and health-care personnel according to current recommendations.
 - Consider antiviral chemoprophylaxis for all health-care personnel, regardless of their vaccination status, if the health department has announced the outbreak is caused by a variant of influenza virus that is a sub-optimal match with the vaccine.
2. If a novel influenza strain emerges, resulting in an epidemic, the Illinois Department of Public Health (IDPH) may delegate orders for Isolation and Quarantine to the certified Local Health Department(s). Please take time to review IDPH's statutes for Isolation and Quarantine, which are hyperlinked below:
 - a. [Section 2 of the Public Health Act \[20 ILCS 2310/2310-15\]](#),
 - b. [Section 2310-15 of the Department of Public Health and Duties Law](#)
 - c. [Control of Communicable Diseases Code \[77 Ill Adm. Code 690 Subpart H\]](#)

Unexplained Respiratory Clusters and Enterovirus D68 (EV-D68)

Recent cases of severe respiratory illness due to Enterovirus D68 have been reported in Illinois and in other states. Health care professionals should be aware that EV-D68 is one of many causes of viral respiratory illness and should report all **clusters** of severe unexplained respiratory illness to their local public health department. Available commercial PCR tests can detect enteroviruses. Results are commonly reported as “entero-rhinovirus” or “human rhinovirus/enterovirus”. If enterovirus is confirmed by PCR in an ICU-hospitalized individual with respiratory illness or if multiple cases (patients hospitalized with respiratory illness with PCR tests positive for enterovirus/rhinovirus) occur in a long-term care facilities, health care providers or facilities can contact their local health department to discuss typing of specimens at CDC. Additional information about EV-D68 is available on the IDPH website at http://www.idph.state.il.us/health/infect/enterovirus_D68.htm or the CDC website at <http://www.cdc.gov/non-polio-enterovirus/>

VI. References

1. “Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities” from CDC (CDC - last updated 12/19/11)
<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. Seasonal Influenza in Adults and Children—Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management: Clinical Practice Guidelines of the Infectious Diseases Society of America
http://www.idsociety.org/uploadedFiles/IDSA/Guidelines-Patient_Care/PDF_Library/Infuenza.pdf

**VII. IDPH INFLUENZA OUTBREAK REPORT FORM FOR CONGREGATE SETTINGS
(e.g. Long Term Care & Correctional Facilities)**

Fax to Local Health Department or IDPH after Completion along with the Outbreak Log

| | | |
|--|---------------|--|
| 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 number of staff: |
| Number of residents in the facility currently with influenza-like illness (ILI) [Fever >100° F [37.8° C] or higher orally AND new onset cough or sore throat]: | | |
| Number of staff in the facility currently with ILI: (for all) # Seen by Provider _____ # Hospitalized _____ # Fatalities _____ | | |
| Date of symptom/onset detection for the first case of ILI during the outbreak: | | |
| Dates of symptom/onset detection for additional cases of ILI during the outbreak: | | |
| Type of setting: <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Long-Term Care Facility <input type="checkbox"/> Group Home <input type="checkbox"/> Other _____ | | |
| If long-term care facility, please specify (check only one): <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Assisted Living <input type="checkbox"/> Combined Care <input type="checkbox"/> Other _____ | | |
| Have specimens been sent to a laboratory for confirmation of influenza: <input type="checkbox"/> Yes <input type="checkbox"/> 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 or Planned: |

Updated June 2014

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

VIII.

Influenza Surveillance for Congregate Setting Outbreak Log

An influenza outbreak or cluster should be suspected whenever 10 percent of the resident population becomes ill with a febrile, respiratory disease consistent with influenza, when two cases of influenza-like illness occur on the same unit within 72 hours, or if at least one resident tests positive for influenza by any testing method. Health care facilities are required by law to report outbreaks and suspected outbreaks of disease to the Illinois Department of Public Health

Facility Name: _____

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

| Name | Age | 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), chills (CH), sore throat (ST), pneumonia (P), myalgias (M)

IX.

Employee Influenza Vaccination Tracking Form

This form can be used to track employee influenza vaccination status

| Date | Last Name | First Name | Unit/Floor/Dept | Date Vaccine Received | Declined Vaccine (Y or N) | Educational Information Received (Y or N) | Date Educational Information Received |
|-------------|------------------|-------------------|------------------------|------------------------------|----------------------------------|--|--|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |