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, IDPH Long Term Care Regional Contacts

FROM: Talmage M. Holmes, Chief, Division of Infectious Diseases &
Debra D. Bryars, Deputy Director, Office of Health Care Regulation

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

DATE: October 3, 2016

The purpose of this memorandum is to provide long term care facilities[1] 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.

Influenza is a highly contagious respiratory illness that can cause substantial sickness and death among long-term care facility (LTCF) residents and personnel. Influenza from the community usually enters LTCFs via newly admitted residents, health care workers, and/or visitors. Vaccination is the primary way to prevent influenza, limit transmission, and prevent complications from influenza in LTCFs. It is recommended that influenza testing occur year-round (and not just during flu season) whenever a resident has an influenza-like illness, regardless of whether the affected resident has been vaccinated.

Local health departments (LHDs) and LTCFs should print the attached document for use during the upcoming influenza season. The guidance is 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 the jurisdiction where the LTCF is located. If there is no LHD for a jurisdiction, IDPH will assume the LHD role in the influenza outbreak investigation. In addition to this guidance, the Centers for Disease Control and Prevention (CDC) has an online Toolkit for Long-Term Care Employers that may also assist your facility with the influenza season.

[1]LTCF includes Assisted Living Facilities and Shared Housing Establishments (77 Illinois Administrative Code Part 295), Community Living Facilities (77 Illinois Administrative Code 370), Illinois Veterans Homes (77 Illinois Administrative Code Part 340), Intermediate Care Facilities for the Developmentally Disabled (77 Illinois Administrative Code Part 350), Skilled Nursing and Intermediate Care Nursing Facilities (77 Illinois Administrative Code Part 300), Long Term Care for Under Age 22 Facilities (77 Illinois Administrative Code Part 390), Shared Housing Establishments (i.e., 77 Illinois Administrative Code 295), Shelter Care Facilities (77 Illinois Administrative Code Part 330), Skilled Nursing Facilities, Supportive Residences (i.e., 77 Illinois Administrative Code 385), and Supportive Residences (77 Illinois Administrative Code Part 385).

Influenza
Disease and Outbreak Management for Long-term Care Facilities

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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 higher 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 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.)

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 one - four days, with an average 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 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^{o} F [37.8^{o} 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).

After seven days have passed without a new case of ILI in the facility, the outbreak can be considered resolved and can be finalized or closed.

Note: When influenza is circulating in the surrounding community, a high index of suspicion should be maintained. Some ill residents may not have fevers 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 **LHD AND** to your respective IDPH Long-term Care Regional Office or applicable State agency within 24 hours (i.e., within 8 regularly scheduled business hours) by telephone or fax. Please refer to list of regional contacts at the bottom of this document. 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 outbreak of influenza or ILI should be reported by the LTCF to the LHD. Any 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 included with this memorandum to assist them in collecting and disseminating the information to the LHD.

IV. Prevention and Control of Influenza Outbreaks in LTCF

Strategies for the prevention and control of 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

1. Health care personnel and persons at high risk for complications from influenza (including all residents of LTCFs), are recommended to receive the 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). **Of note, the ACIP recommends that live, attenuated influenza vaccine (LAIV) (FluMist®) NOT be used during the 2016-2017 season for any population.**

2. **Vaccination of 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, 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.

c. 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.
   - Persons with a history of severe allergic reaction to eggs should be vaccinated in an inpatient or outpatient medical setting (i.e. hospital, clinics, health departments, physician offices, or other supervised medical facility) under the supervision of a health care provider who is able to recognize and manage severe allergic reactions.
   - Flublok® is a trivalent influenza vaccine that has been FDA approved for use in adults ages 18 years of age and older with severe egg allergies because it does not use the influenza virus or chicken eggs in its manufacturing process.

d. Pneumococcal vaccine should be given to long term care residents. For detailed and specific recommendations, visit the CDC website where this topic is discussed in detail.

e. For information on Medicare reimbursement for the cost of influenza and pneumococcal vaccines and for administration of vaccines go to: https://www.cms.gov/Medicare/Prevention/Immunizations/index.html?redirect=/AdultImmunizations/ or call (312) 886-6432.

f. 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 Inactivated Influenza Vaccine (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%). For additional information about Fluzone visit CDC's website.

3. **Vaccination of Health-Care Personnel**

Pursuant to the Illinois Administrative Code, Part 956 (Health Care Employee Vaccination Code), Section 956.30, (Influenza Vaccination), "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) unless the vaccine is unavailable."

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.)

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. For the 'health care setting' definition see:
http://www.ilga.gov/commission/jcar/admincode/077/077009560000100R.html

For more information regarding influenza vaccination for healthcare employees, see:
http://www.ilga.gov/commission/jcar/admincode/077/077009560000300R.html

a. 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).
b. ACIP recommends that live, attenuated influenza vaccine (LAIV) (FluMist®) NOT be used during the 2016-2017 season for any population.

4. **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. 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.

LTCFs should work with their laboratory providers to identify a laboratory that can perform the influenza testing. If possible, samples from any influenza outbreak should be sent to the IDPH laboratory. For collection, shipping and submission details, please contact your LHD. For more information regarding influenza testing, please visit
http://www.cdc.gov/flu/professionals/diagnosis/index.htm

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, immunofluorescence, 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.
   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-two days of symptom onset) by performing rapid influenza virus testing of multiple residents (three-six specimens) with recent onset of symptoms suggestive of influenza. In addition, consult with your LHD regarding the shipment of

specimens for RT-PCR testing at IDPH in order to determine the influenza virus type and subtype. If testing through a hospital or private laboratory, ensure that the laboratory performing the tests notifies the facility of test results promptly. Once an outbreak is confirmed, additional testing is not typically indicated.

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**
   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 the CDC website.
   a. Ensure availability of supplies for 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 or visitors.

2. **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:
   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, 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.
   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. For more information visit http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html

3. **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:
   a. 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.
   b. Wear a facemask (e.g., a surgical or procedure mask) upon entering the resident's room or when working within six 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.

c. If resident movement or transport is necessary, have the resident wear a facemask, if possible.
d. 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

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 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.

You can monitor the Illinois Weekly Influenza Surveillance Report for information about influenza activity in Illinois during the season on the IDPH website's influenza page.

a. ***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.

b. ***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 seven 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 causal agent is influenza and exclude ill persons as recommended above.
- Monitor residents for symptoms of respiratory illness to determine need for Droplet Precautions.

5. **Surveillance**
Implement daily active surveillance for respiratory illness among all residents and health-care personnel until at least one week (seven days) after the last confirmed influenza case occurred. It is important to collect information that will assist in development and targeting of outbreak control strategy. 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. 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 (but are not limited to):
a. Monitor for symptoms of respiratory illness among residents, health care personnel, and visitors to the facility.
b. Maintain line listing of those ill, including both staff and residents.
c. Maintain log of staff call-ins and review daily for symptoms of respiratory illness; inquire if influenza testing was performed and request results if available.

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.

7. **Other Considerations**
   In addition to the above, the following procedures also may be considered for LTCFs:
   a. 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 six feet from other residents and can adhere to respiratory hygiene/cough etiquette.
   b. 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 seven days following the onset of symptoms. Personnel should work on only one unit, if possible.
   c. 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.
   d. 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-registered, hospital grade disinfectant labeled with an influenza or virucidal statement must be used in accordance with product instructions.
   e. If a novel influenza strain emerges, resulting in an epidemic, the 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:
      - Section 2 of the Public Health Act [20 ILCS 2310/2310-15],
      - Section 2310-15 of the Department of Public Health and Duties Law
      - Control of Communicable Diseases Code [77 Ill Adm. Code 690 Subpart H]

D. Antiviral Treatment

The use of antiviral medications for treatment of influenza is a key component of influenza outbreak control in LTCFs whose residents are 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.

1. Oral oseltamivir, inhaled zanamivir and intravenous peramivir are approved for treatment of influenza A and B.
2. Oseltamivir may be used for treatment in those $\geq$2 weeks of age.
3. Zanamivir may be used for treatment in those $\geq$ 7 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/professionals/antivirals/summary-clinicians.htm

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

E. Antiviral Chemoprophylaxis

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.

1. Oral oseltamivir, inhaled zanamivir and intravenous peramivir are approved for chemoprophylaxis of influenza A and B.
2. Oseltamivir may be used for chemoprophylaxis in those ≥1 year of age.
3. Zanamivir may be used 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/professionals/antivirals/summary-clinicians.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.

1. 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.
2. 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.
3. Antiviral prophylaxis should be continued for at least two weeks, and as long as one week after the last resident case occurred.

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 (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. Illinois Weekly Influenza Surveillance Reports and Updates
   http://www.dph.illinois.gov/topics-services/diseases-and-conditions/influenza/surveillance

7. Prevention and Control of Seasonal Influenza with Vaccines; Recommendations of the Advisory Committee on Immunization Practices – United States, 2016-2017
   http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6505.pdf

VI. Regional and other Long Term Care Contacts

REGION 1 – ROCKFORD 4302 North Main Street Rockford, IL 61103 815/987-7511 William Schubert, SPSA	**REGION 2 – PEORIA** 5415 N. University Street Peoria, IL 61614 309/693-5360 Kim Stoneking, SPSA
REGION 4 – EDWARDSVILLE 22 Kettle River Drive Glen Carbon, IL 62034 618/656-6680 Keo Sabengsy, SPSA	**REGION 5 – MARION** 2309 W. Main Street Marion, IL 62959 618/993-7010 Keo Sabengsy, SPSA
REGION 6 – CHAMPAIGN 2125 S. 1st Street Champaign, IL 61820 217/278-5900 Kim Stoneking, SPSA	**REGION 7 – WEST CHICAGO** 245 W. Roosevelt Road, Bldg. #5 West Chicago, IL 60185 630/293-6900 William Schubert, SPSA
REGION 8/9 - BELLWOOD 4212 W. St. Charles Road Bellwood, IL 60104 708/544-5300 Wanda Higginbotham, SPSA	**ICF/IID and Under 22 Facilities** 525 West Jefferson, 5th Floor Springfield, IL 62761-0001 217-785-5182 Daniel Levad, SPSA
Assisted Living Facilities 525 West Jefferson, 5th Floor Springfield, IL 62761-0001 217-785-9174 Lynda Kovarik, SPSA	**Supportive Living Facilities** 201 S. Grand Avenue, 3rd Floor Springfield, IL 62763 217/782-1868 Kara Helton

VII. Regional Counties

REGION 1 – ROCKFORD

Boone	DeKalb	Lake	McHenry	Stephenson	Winnebago
Carroll	Jo Davies	Lee Ogle	Ogle	Whiteside	

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
Grundy	Kankakee	Will

REGION 8/9 – BELLWOOD

Cook County – Outside of Chicago (Collar Counties)

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

Fax, along with the Outbreak Log, to your Local Public Health Department after completion

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: ☐ 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 09/2016

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

IX. 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), chills (CH), sore throat (ST), pneumonia (P), myalgias (M)

Reviewed 09/2016

X. 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

Reviewed 09/2016