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To: Local Health Departments; Infection Control Professionals; Division of Quality Assurance; Wisconsin LTC D.O.N. Association; Wisconsin LTC Medical Directors Association; Wisconsin Healthcare Association; Wisconsin Association of Homes and Services for the Aging

From: Thomas Haupt M.S.
Wisconsin Division of Public Health

RE: Reporting Requirements, Prevention and Control of Influenza and other Respiratory Diseases in Assisted Living Facilities and Long-Term Care Facilities (including Novel Influenza H1N1) for the 2009-2010 influenza season

Assisted Living Facilities and other long-term care (LTC) facilities are required by law to report single cases of notifiable conditions such as (but not limited to) legionellosis, pertussis, and laboratory-confirmed invasive bacterial disease to their local health department. A complete list of notifiable conditions can be found at

http://dhs.wisconsin.gov/communicable/diseasereporting/index.htm

Outbreaks of communicable diseases must also be reported. The purpose of this letter is to clarify when, how and to whom to report respiratory disease outbreaks in a LTC facility.

Who should be notified when a respiratory disease outbreak is suspected or confirmed?
It is strongly recommended that the local public health department receive the initial notification of the outbreak. As an alternative, the Division of Public Health (DPH) can be notified.

What is *not* reportable to local health departments?
Individual cases of pneumonia and influenza-like illness (ILI) are not reportable, but should prompt a response by long term care staff to identify, treat and control the infection to prevent additional cases. A single laboratory-confirmed case of influenza is also not reportable unless associated with a pediatric death or death due to a novel strain of influenza A.

What *is* reportable to local health departments?
Disease outbreaks are reportable. A respiratory disease outbreak is defined as three or more residents from the same unit whose onset of illness was within 72 hours of each other who have pneumonia, ILI or laboratory-confirmed viral or bacterial infection (including influenza); OR a sudden increase in ILI or pneumonia over the facility's normal background rate.

Deaths and single cases of Novel Influenza A/H1N1 are reportable to the local health department.

What is the responsibility of local health departments when notified of an outbreak of respiratory disease?
The local health department response may vary from documentation of the outbreak notification without further response, to consultation with facility staff or organizing a cooperative disease investigation with the DPH.

Are local health departments responsible for notifying state LTC regulators?
No. When unusual circumstances such as increased mortality or hospitalization occur, the DPH will notify the Division of Quality Assurance.

Definition of terms used:
ILI is defined as illness characterized by fever* and at least one of the following:

- Rhinorrhea (runny nose) or nasal congestion
- Sore throat
- Myalgia (muscle aches) that are greater than the patient's norm
- Cough (productive or non-productive)

Pneumonia is defined as radiographic evidence of new or increased pulmonary infiltrates usually accompanied by fever

* Fever may be difficult to determine in elderly residents. Therefore, the definition of fever used for ILI may be defined as temperature >100° F or 2° above the established baseline for that resident.

Vaccinations:
At this time it is projected that 146 million doses of influenza vaccine will be available in the United States during the 2009-2010 influenza season. No delays in delivery have been identified. CDC recommends that all residents and employees of long term care facilities receive annual influenza vaccine. It is also essential that long term care staff monitor new and current residents for recommended vaccinations (pneumococcal, tetanus) in addition to annual influenza vaccine.

Novel Influenza H1N1vaccine may become available during the 2009 – 2010 influenza season. Residential facilities will be notified when and if vaccine becomes available.

Adamantane Resistance:
Testing of random influenza type A isolates for resistance to adamantanes (amantadine and rimantadine) is currently done at the Centers for Disease Control and Prevention (CDC) and the Wisconsin State Laboratory of Hygiene (WSLH). During the 2008-09 influenza season approximately 99% of Novel Influenza H1N1 and seasonal H3N2 isolates tested were resistant to adamantanes. ***Therefore the use of adamantanes for prophylaxis or treatment of seasonal influenza type A infections is strongly discouraged (CDC and Division of Public Health recommendation).*** CDC and the WSLH continue to monitor A/H1 isolates for increased resistance to adamantanes.

Neuraminidase Inhibitor Resistance:
Testing of random influenza type A isolates for resistance to oseltamivir (Tamiflu®) is currently being done at the CDC and the WSLH. During the 2008-09 influenza season approximately 99% of seasonal influenza A/H1 isolates were resistant to oseltamivir. All influenza A/H3 and type B isolates remain sensitive to oseltamivir and zanamivir (Relenza®)

Testing, Treatment, Infection Control, and Laboratory Guidelines are all available at www.pandemic.wisconsin.gov. These are the most up to date guidelines available from the State of Wisconsin.
CDC Guidelines are available at www.cdc.gov/flu and www.cdc.gov/h1n1flu .

If you have any questions, comments or concerns about this memo, please notify Thomas Haupt, Influenza Surveillance Coordinator at 608-266-5326 or by e-mail at thomas.haupt@wisconsin.gov

The Wisconsin Weekly Influenza Report can be viewed at www.pandemic.wisconsin.gov.

RECOMMENDATIONS FOR THE PREVENTION AND CONTROL OF INFLUENZA IN LONG TERM CARE FACILITIES IN 2009-2010

ILI is defined as fever ≥ 100° F and either a cough, rhinorrhea* or sore throat.

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Employees with influenza-like illness (ILI) must be removed from contact with residents or their environment for 7 days or 24 hours after illness has ceased (whichever is longer)

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Monitor all residents for symptoms consistent with ILI.

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Test residents or staff who present with ILI, submitting specimens to a laboratory equipped to test for novel influenza**

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Within 48 hours of the onset of illness, **treat** probable or confirmed and suspect cases with oseltamivir (Tamiflu®) or zanamivir (Relenza®) to reduce the severity and shorten the duration of the illness.***

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For single or multiple, confirmed or highly suspect, cases of influenza, notify the facility medical director and administration.

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Post signs on each entry advising against visitation unless necessary. If visitation is necessary request any visitor with ILI wear a surgical mask while in the facility.

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Restrict new admissions to the facility or to the area where the confirmed residents reside **until one week** after the illness onset of the last confirmed or suspected case of influenza.

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As much as possible, **restrict** the movement of residents and employees within the facility.

Enhance surveillance for influenza-like illness among residents and staff.

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Provide oseltamivir or zanamivir for chemoprophylaxis to:

- **ALL** employees
- **ALL** residents

Chemoprophylaxis should continue for a minimum of 10 days, or 1 week after the onset of symptoms in the last confirmed or suspected case.

If definition of an outbreak is met, NOTIFY public health officials!!

Treatment recommendations may change as the circulating virus changes. Check the WI Weekly Report to find out what is circulating in your area.

* Rhinorrhea was added to the standard case definition of ILI specifically for long term care residents
** WI State Laboratory of Hygiene, Milwaukee Public Health Lab, Marshfield Clinic Laboratory
*** At the discretion of the clinician, antiviral treatment can be initiated > 48 hours past illness onset

For additional information, contact the Bureau of Communicable Diseases and Emergency Response at 608-266-5326 and Hwww.pandemic.wisconsin.govH.

Laboratory Guidelines for Influenza Testing
in Long Term Care Facilities

Accurate diagnosis of influenza requires laboratory testing, especially early during the influenza season. There are a number of commercially available tests for influenza that can be used at the point of care, including the long term care facility (LTCF) setting. These tests provide the potential for immediate diagnosis of influenza illness to guide patient management and outbreak control.
These tests have limitations, including variable sensitivity and specificity, a lack of thorough evaluation in the elderly, and a potential high rate of false positives during periods of low influenza prevalence.

Following the guidelines below can improve the reliability of the test result, providing both useful and relevant information to the clinician.

- Any test result must be interpreted in the context of known influenza in the community or the LTCF and the clinical presentation of the patient.
- Attention to surveillance data can provide the user with an indication of increasing influenza prevalence and improved positive predictive value (lower rate of false positives).

Surveillance data are available as follows:
DPH http://dhs.wisconsin.gov/communicable/influenza/Tracking.htm
WSLH http://www.slh.wisc.edu/labupdates/flu.php
CDC http://www.cdc.gov/flu/weekly/

- During periods of low prevalence (early and late in the influenza season), positive results should be confirmed by culture or molecular methods. Negative results are more reliable at this time.
- During periods of increasing prevalence, the positive result becomes more reliable.
- At the peak of influenza activity (as indicated by surveillance data), the positive result is most reliable. At this time, negative results may need to be confirmed by culture or molecular methods.

The Wisconsin State Laboratory of Hygiene (WSLH) asks that sites using rapid influenza tests report the number of specimens tested and positive by weekly fax reports to the WSLH throughout the year. Viral culture for confirmation of rapid test results is available at any of the clinical virology laboratories in Wisconsin. The Wisconsin State Laboratory of Hygiene can provide limited fee-exempt transport and molecular testing for confirmations, if the cost of specimen transport or testing is a concern.

Although influenza is of foremost concern, respiratory syncytial virus (RSV), parainfluenza viruses, rhinoviruses and adenoviruses are also capable of causing outbreaks of severe respiratory illness in the LTC facility.

Please contact Carol Kirk (608-262-1021, email cjk@mail.slh.wisc.edu) or Mary Wedig (608-890-0353, email wedig@mail.slh.wisc.edu) if you would like forms and instructions for weekly reporting or for submitting specimens to the WSLH for confirmatory testing.