INFLUENZA-LIKE ILLNESS (ILI)

POLICY: Vaccination, treatment, chemoprophylaxis, and control measures will be standardized for seasonal influenza-like illness (ILI).

DEFINITION: Influenza–like illness is defined as fever of > 100 F (37.8ºC) oral or equivalent, with a cough and /or sore throat without a known cause other than influenza. *It’s important to note that not everyone with flu will have a fever.

PROCEDURES:

I. INFECTION CONTROL
   A. During the flu season, all units should:
      1. Encourage handwashing with soap (Attachment A)
      2. Encourage cough etiquette (cover mouth or wear mask if coughing, Attachment B)
      3. Ensure that ill staff are not allowed to come to or remain at work
      4. Disinfect common areas with a bleach solution
      5. Inform healthcare providers who provide direct patient care that they should be vaccinated because unvaccinated employees can transmit influenza to patients. Unvaccinated employees may be re-assigned to duties without direct patient involvement or asked to wear a mask during the flu season.
   B. Inmates complaining of symptoms consistent with ILI should be
      1. Triaged as soon as possible
   C. Inmates determined by medical to have ILI should
      1. Be single-celled (isolated) or cohorted (ie, co-housed) with other inmates with ILI if they cannot be single celled
      2. Remain in isolation until they have been off antipyretics and afebrile for 24 hours or until 7 days has passed (whichever is longer)
      3. Not be transported on a chain bus or MPV except for medical emergencies
   D. Units with inmates with ILI should
      1. Institute Standard and Droplet Precautions for inmates with ILI
      2. Ensure that sick inmates do not expose other inmates without ILI while in waiting rooms (consider setting up a separate waiting area for inmates with ILI). At a minimum, ensure that inmates with ILI wear surgical masks or sit at least 6 feet from other inmates while waiting to be seen by medical
      3. Have staff wear surgical masks if their responsibilities require them to remain less than 6 feet from a symptomatic individual. Mask, gloves, and gowns should be worn when examining or providing direct care to inmates with ILI
4. 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

II. VACCINATION

A. Although flu vaccine should be provided to any inmates wishing to decrease his or her risk of getting the flu, some groups of inmates are at high risk for influenza-related complications. Vaccinations should be given or a signed Refusal of Treatment of Services Form (HSM-82) should be obtained from inmates who

1. Have chronic pulmonary (including moderate to severe asthma), cardiovascular (excluding hyperlipidemia, hypertension), renal, hepatic, neurologic, hematologic (absence of spleen or non-functional spleen) or metabolic disorders (including diabetes mellitus)
2. Are immunosuppressed (including immunosuppression caused by medications or by human immunodeficiency virus)
3. Are or will be pregnant during the influenza season
4. Are <18 years of age and on chronic aspirin therapy
5. Are morbidly obese (body-mass index is 40 or greater)
6. Are ≥ 50 years of age

B. Vaccinations should be offered to inmates who are cell-mates of inmates at risk of complications because they fall into one of the above high-risk groups.

III. INFLUENZA TESTING

A. At the apparent beginning and end of the flu season on a unit, submit 3 – 5 diagnostic specimens for “influenza/RSV PCR.” If your unit is in the UTMB sector, these specimens should go to the UTMB laboratory; if your unit is in the Texas Tech sector, submit the diagnostic to the appropriate contracting laboratory. Prior to instituting any antiviral therapy, collect a posterior nasopharyngeal swab in the following manner:

1. Insert a fine-tipped Dacron, polyester, or rayon swab (such as that used to sample the male urethra for STDs) several inches into the nose, past the nasal turbinate.
2. Turn the swab several times and remove.
3. Put the swab into a tube of universal medium or viral transport medium (VTM).
4. Store tightly capped upright specimen at refrigerated temperature prior to courier pickup.
5. Do not
- collect a throat swab
- use a calcium alginate swab, a cotton swab, or a swab with a wooden shaft
- use supplies used for GenProbe testing
- re-use a swab that has already been used for a rapid test
- use expired medium

B. In unusual situations, special surveillance specimens may occasionally be requested by Office of Public Health (OPH) staff.
   1. In contrast to the diagnostic specimens which are sent either to the UTMB, or other contracted laboratories, these specimens are to be sent either to the central or regional network of DSHS Laboratories. OPH staff will discuss ordering and shipping instructions with you if you are asked to collect surveillance specimens.
   2. Collect and store a posterior nasopharyngeal swab in the manner described above.
   3. Ensure that the patient name and date of collection are written on each specimen tube that is submitted. Submit the specimen with a G2A (Attachment C) that has your unit’s submitter number. Also submit the Submitter Identification (ID) Number Request Form (Attachment D).

IV. TREATMENT

Decisions to treat severely ill patients with antivirals must be based on clinical impression and knowledge of local circulation of virus. Institution of antiviral therapy should always precede receipt of laboratory results, as a delay may contribute to an adverse outcome. Providers also should recall that bacterial pneumonias can either complicate or follow influenza.

A. Treat patients within the first 48 hours of illness with 5 days of antivirals (oseltamivir/Tamiflu™) if the 2009 strain of H1N1 is confirmed or probable and they appear very ill.

B. Treat with oseltamivir even if not seen within 48 hours if:
   1. They are at high risk for complications
   2. They have warning symptoms (e.g., dyspnea) or signs (e.g., tachypnea, unexplained oxygen desaturation) of lower respiratory tract illness.
   3. Their illness appears to be worsening
   4. The treatment dose for individuals with normal renal function is 75 mg BID for 5 days

C. Oseltamivir/Tamiflu™ dosing must be adjusted for patients with renal insufficiency
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1 eg, outbreaks or from patients that are hospitalized or have fatal cases

1. Dialysis Patient
   a. Usual Dose Adjustment: 30 mg immediately, followed by a dose after every dialysis session. Treatment duration not to exceed 5 days.
   b. Usual Frequency: 30 mg immediately, then after every dialysis session for three doses (e.g., Mon-Wed-Fri dialysis patient receives first 30 mg dose on Monday, then 30 mg dose on Wednesday following dialysis and 30 mg dose on Friday following dialysis and would then be finished with treatment).

2. Renal Insufficiency, but Not Dialysis
   a. Usual Dose Adjustment for estimated creatinine clearance of greater than 30 mL/min up to 60 mL/min: 30 mg twice daily for 5 days.
   b. Usual Dose Adjustment for estimated creatinine clearance of greater than 10 mL/min up to 30 mL/min: 30 mg once daily for 5 days.

V. CHEMOPROPHYLAXIS

A. If the 2009 strain of H1N1 is confirmed or probable and the supply of antivirals is adequate, provide 10 days of antiviral (oseltamivir) chemoprophylaxis to inmates with underlying chronic diseases who are close contacts (less than 6 feet) to inmates with ILI. All cell-mates are close contacts. Close contact may also include sitting or riding next to someone in a dialysis unit or vehicle. Chemoprophylaxis does not need to be instituted if more than 5 days has passed since the exposure.

B. The chemoprophylaxis dose in those with normal renal function is 75 mg once daily for 10 days.

C. Oseltamivir/Tamiflu™ dosing must be adjusted for patients with renal insufficiency.

1. Dialysis Patient
   a. Usual Dose Adjustment: 30 mg immediately and then 30 mg after every other dialysis session. Usual duration of prophylaxis is at least 10 days.
   b. Usual Frequency: 30 mg immediately, then after every other dialysis session (e.g., Mon-Wed-Fri dialysis patient receives 30 mg dose on Monday, no dose with next hemodialysis session, and then 30 mg dose given on Friday after hemodialysis session and then repeat following Monday and Friday to complete prophylaxis.)

2. Renal Insufficiency, but Not Dialysis
   a. Usual Dose Adjustment for estimated creatinine clearance of greater than 30 mL/min up to 60 mL/min: 30 mg once daily.
   b. Usual Dose Adjustment for estimated creatinine clearance of 10 mL/min up to 30 mL/min: 30 mg once every other day.

D. Antiviral chemoprophylaxis also may be considered when outbreaks occur on units with a large proportion of inmates at high risk of complications. In such situations, call OPH to discuss which inmates and staff should be treated and for how long.
VI. REPORTING

A. Once flu has been identified on a unit and until 2 weeks has lapsed since your last ILI
1. Submit a daily ILI log (Attachment E) by 9 AM.
   a. The list is only for the 24-hour period ending at 6 AM that morning.
   b. Although you may submit logs over the weekend if you wish, you may also simply submit 3 logs on Monday morning.
2. In addition to identifying the submitting unit, the log should give totals for number of inmates with ILI, numbers of staff with ILI, and provide detailed information on inmates for whom you have submitted specimens.
3. The log may be either submitted as an email attachment or Faxed to 936.437.3572.
4. The subject line should include the your “[Unit] Name, ILI Log, and the Date Sent ( / / ).”

REFERENCES


2. Centers for Disease Control and Prevention. Interim Guidelines for Influenza Outbreak Management in Long-Term Care Facilities and Post Acute Care Facilities. Available at:https://www.cdc.gov>professionals>infectioncontrol>ltc-facility-guidance