



Jim Doyle  
Governor

Karen E. Timberlake  
Secretary

**State of Wisconsin**  
Department of Health Services

1 WEST WILSON STREET  
P O BOX 2659  
MADISON WI 53701-2659

608-266-1251  
FAX: 608-267-2832  
TTY: 888-701-1253  
dhs.wisconsin.gov

December 2, 2008

**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:** Clarification of Reporting Requirements for Influenza and other Respiratory Disease Outbreaks in Long-Term Care Facilities

Nursing homes 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 who report respiratory disease outbreaks in a LTC facility should be reported.

**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 due to a novel strain of influenza A. Novel influenza A viruses will be reported by the laboratory where it has been identified.

**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.

**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 2008-09 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.

**Adamantane Resistance:**

Testing of random influenza type A isolates for resistance to adamantanes (amantadine and rimantadine) is currently being done at the Centers for Disease Control and Prevention (CDC) and the Wisconsin State Laboratory of Hygiene (WSLH). During the 2007-08 influenza season approximately 99% of influenza A/H3 isolates and 10% of A/H1 isolates tested were resistant to adamantanes.

***Therefore the use of adamantanes for prophylaxis or treatment of 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 2007-08 influenza season approximately 11% of influenza A/H1 isolates were resistant to oseltamivir. All influenza A/H3 and type B isolates remain sensitive to oseltamivir and zanamivir (Relenza®)

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](mailto:thomas.haupt@wisconsin.gov)

# RECOMMENDATIONS FOR THE PREVENTION AND CONTROL OF INFLUENZA IN LONG TERM CARE FACILITIES

Provide influenza vaccine to **ALL** residents and employees of long term care facilities.

Ensure that employees with influenza-like illness (ILI) are restricted from contact with residents or their environment until acute symptoms have resolved (usually 3-5 days). ILI is defined as fever  $\geq 100^{\circ}$  F and either a cough, muscle aches, rhinorrhea or sore throat.

Monitor all residents for symptoms consistent with ILI.

Test residents who present with ILI utilizing the guidelines provided by the Wisconsin State Laboratory of Hygiene.

Within 48 hours of the onset of illness, provide treatment for culture-confirmed and suspect cases of influenza type A or type B with oseltamivir (Tamiflu®) or zanamivir (Relenza®) to reduce the severity and shorten the duration of the illness.

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

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

For a **single** culture-confirmed or a highly suspected case of influenza

For **multiple** culture-confirmed or highly suspected cases of influenza

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

Consider the use of oseltamivir or zanamivir for chemoprophylaxis for:

- **All** unvaccinated employees
- Vaccinated employees if less than 2 weeks since their vaccination.
- **ALL** residents, regardless of their influenza vaccination status

The decision to use chemoprophylaxis should be made based on the likelihood of further spread of the illness within the facility. **If used, chemoprophylaxis should continue for a minimum of 10 days or 1 week after the onset of symptoms in the last confirmed or suspected case.**

**Provide oseltamivir or zanamivir for chemoprophylaxis to:**

- **All** unvaccinated employees
- Vaccinated employees if less than 2 weeks since their vaccination.
- **ALL** residents, regardless of their influenza vaccination status.

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

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

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

## **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 is 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](mailto:cjk@mail.slh.wisc.edu)) or Mary Wedig (608-890-0353, email [wedig@mail.slh.wisc.edu](mailto: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.