CHICAGO

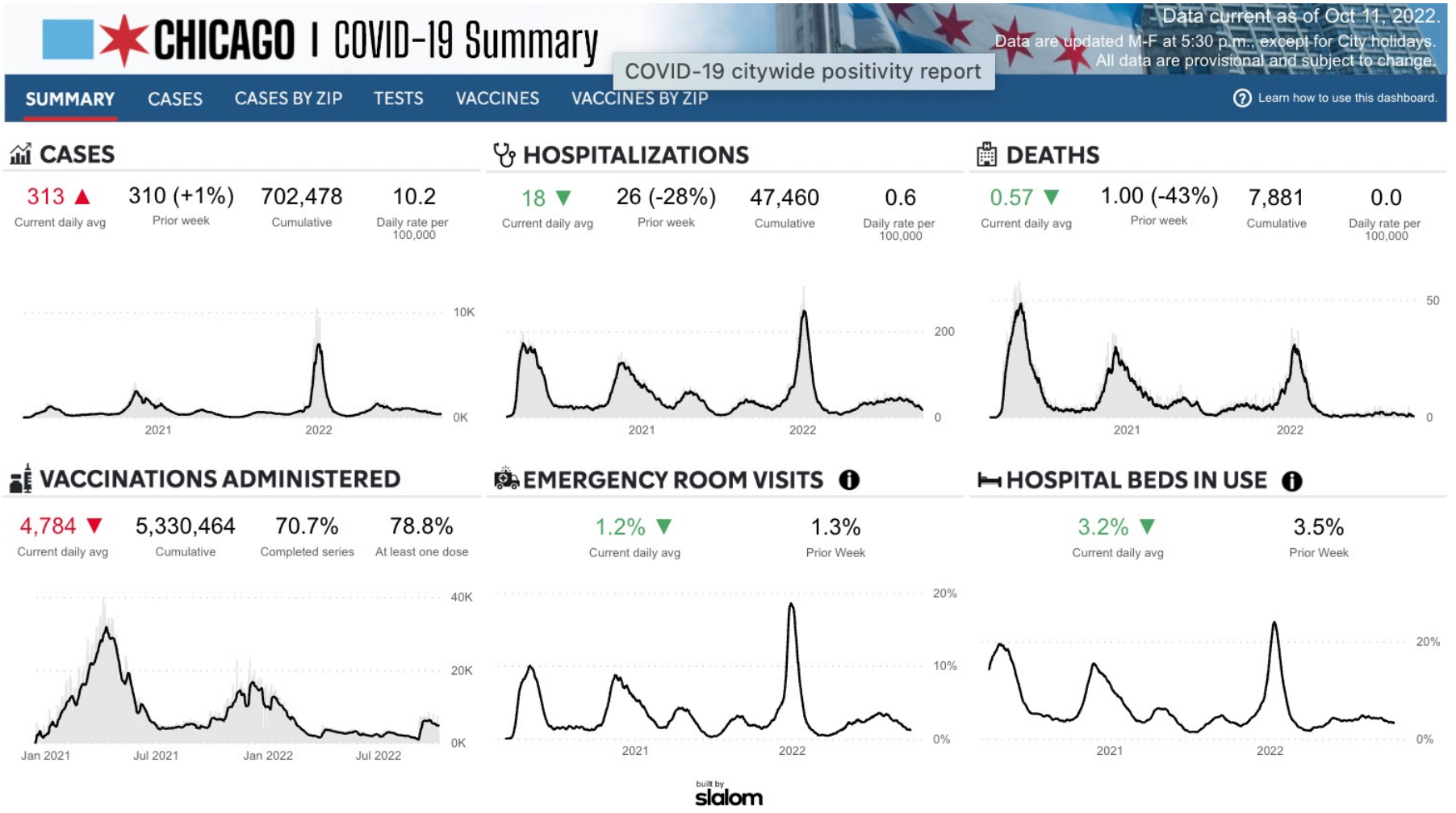
COVID-19
Chicago Long Term Care Roundtable

10-13-22

Agenda

- COVID-19 Epidemiology
- COVID Reminders, Updates, and FAQs
- Updated Influenza Guidance
- Questions & Answers

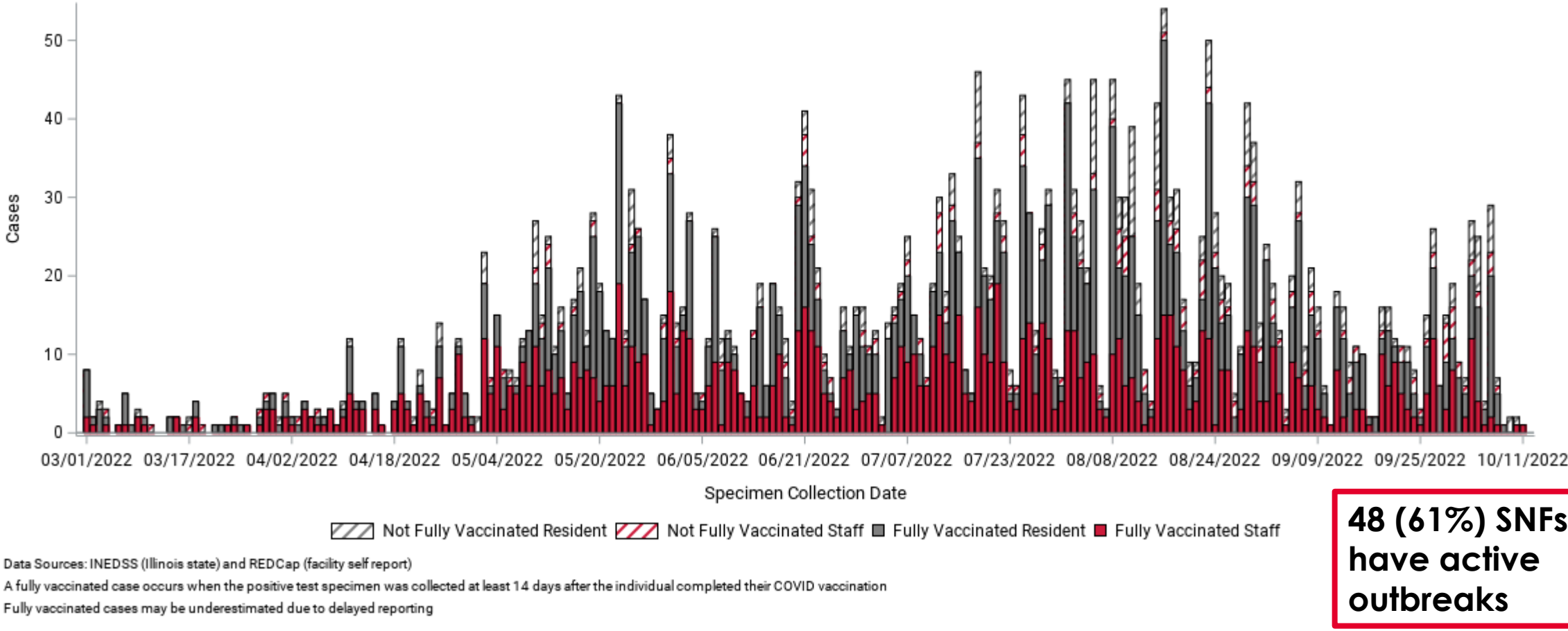
Chicago Dashboard



Source: https://www.chicago.gov/city/en/sites/covid-19/home/covid-dashboard.html

Skilled Nursing Home COVID-19 Cases

(Mar. 1, 2022 – Oct. 11, 2022)



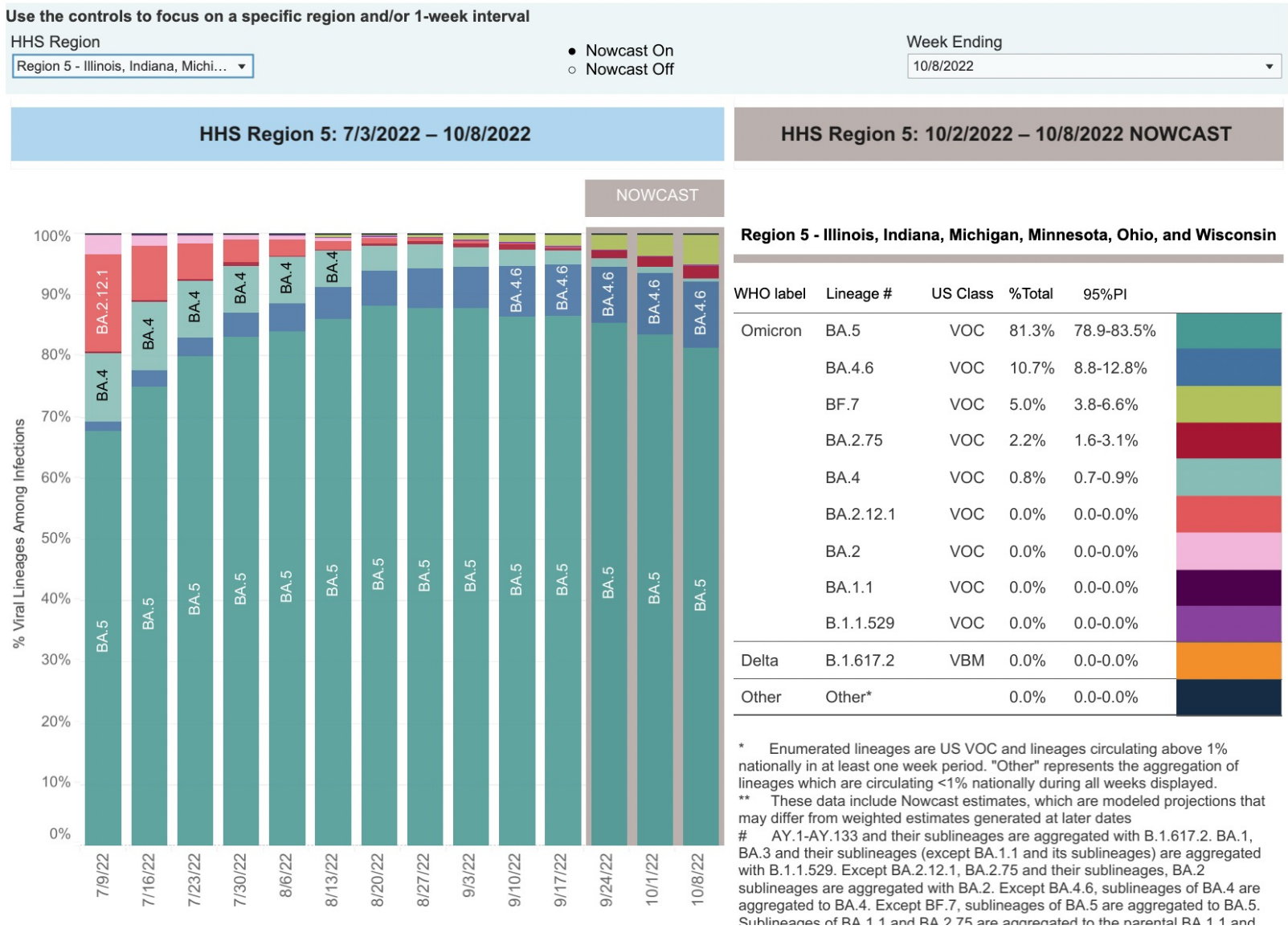
Data Sources: INEDSS (Illinois state) and REDCap (facility self report)

A fully vaccinated case occurs when the positive test specimen was collected at least 14 days after the individual completed their COVID vaccination

Fully vaccinated cases may be underestimated due to delayed reporting

48 (61%) SNFs have active outbreaks

COVID-19 Variant Proportions



Region 5 - Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

WHO label	Lineage #	US Class	%Total	95%PI
Omicron	BA.5	VOC	81.3%	78.9-83.5%
	BA.4.6	VOC	10.7%	8.8-12.8%
	BF.7	VOC	5.0%	3.8-6.6%
	BA.2.75	VOC	2.2%	1.6-3.1%
	BA.4	VOC	0.8%	0.7-0.9%
	BA.2.12.1	VOC	0.0%	0.0-0.0%
	BA.2	VOC	0.0%	0.0-0.0%
	BA.1.1	VOC	0.0%	0.0-0.0%
	B.1.1.529	VOC	0.0%	0.0-0.0%
Delta	B.1.617.2	VBM	0.0%	0.0-0.0%
Other	Other*		0.0%	0.0-0.0%

* Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all weeks displayed.
** These data include Nowcast estimates, which are modeled projections that may differ from weighted estimates generated at later dates
# AY.1-AY.133 and their sublineages are aggregated with B.1.617.2. BA.1, BA.3 and their sublineages (except BA.1.1 and its sublineages) are aggregated with B.1.1.529. Except BA.2.12.1, BA.2.75 and their sublineages, BA.2 sublineages are aggregated with BA.2. Except BA.4.6, sublineages of BA.4 are aggregated to BA.4. Except BF.7, sublineages of BA.5 are aggregated to BA.5. Sublineages of BA.1.1 and BA.2.75 are aggregated to the parental BA.1.1 and

Soucre: https://covid.cdc.gov/covid-data-tracker/#variant-proportions

Reminder: CDC COVID Data Tracker

Indicator - If the two indicators suggest different transmission levels, the higher level is selected	Low Transmission Blue	Moderate Transmission Yellow	Substantial Transmission Orange	High Transmission Red
Total new cases per 100,000 persons in the past 7 days	0-9.99	10-49.99	50-99.99	≥100
Percentage of NAATs[1] that are positive during the past 7 days	0-4.99%	5-7.99%	8-9.99%	≥10.0%

Note: Community level metrics are updated every Thursday and community transmission metrics (including the map) updated daily

CDC COVID Data Tracker: Cook County

COVID-19 Community Level

Low

Recommended actions based on current level

Stay up to date with COVID-19 vaccines. Get tested if you have symptoms. Wear a mask if you have symptoms, a positive test, or exposure to someone with COVID-19. Wear a mask on public transportation. You may choose to wear a mask at any time as an additional precaution to protect yourself and others.

Weekly Metrics Used to Determine the COVID-19 Community Level

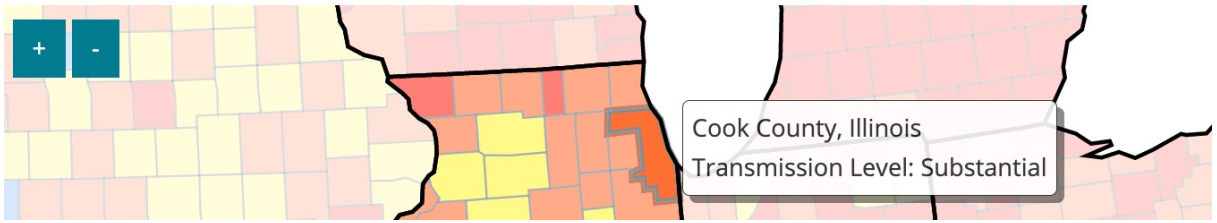
Case Rate per 100,000 population	90.75
New COVID-19 admissions per 100,000 population	7.9
% Staffed inpatient beds in use by patients with confirmed COVID-19	3.1%

How are COVID-19 Community Levels calculated?

Note: The COVID-19 Community Level and associated metrics presented above are updated weekly on Thursday and may differ from the values for the same metrics presented below, which are updated daily.

Data Type: Community Transmission

Map Metric: Community Transmission



Source: https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=Illinois&data-type=Risk&list_select_county=17031

Reminder: Minimum Routine Staff Testing Frequency

Vaccination Status	Community Transmission Level	Testing Frequency
Not up to date*	High	2x a week - **Future state TBD**
	Substantial	2x a week - **Future state TBD**
	Moderate	1x a week - **Future state TBD**
	Low	No required routine testing*
Up to date	All	No required routine testing*

Based on Illinois Executive Order and related Emergency Rules
* An individual has not received all COVID-19 vaccinations for which they are eligible
** Unless symptomatic, had a high-risk exposure, or your facility is in outbreak and performing unit/broad-based testing.

Sources: https://coronavirus.illinois.gov/resources/executive-orders/display.executive-order-number-16.2022.html; https://ilsos.gov/departments/index/register/volume46/register_volume46_issue_9.pdf

Reminder: Minimum Routine Resident Testing Frequency

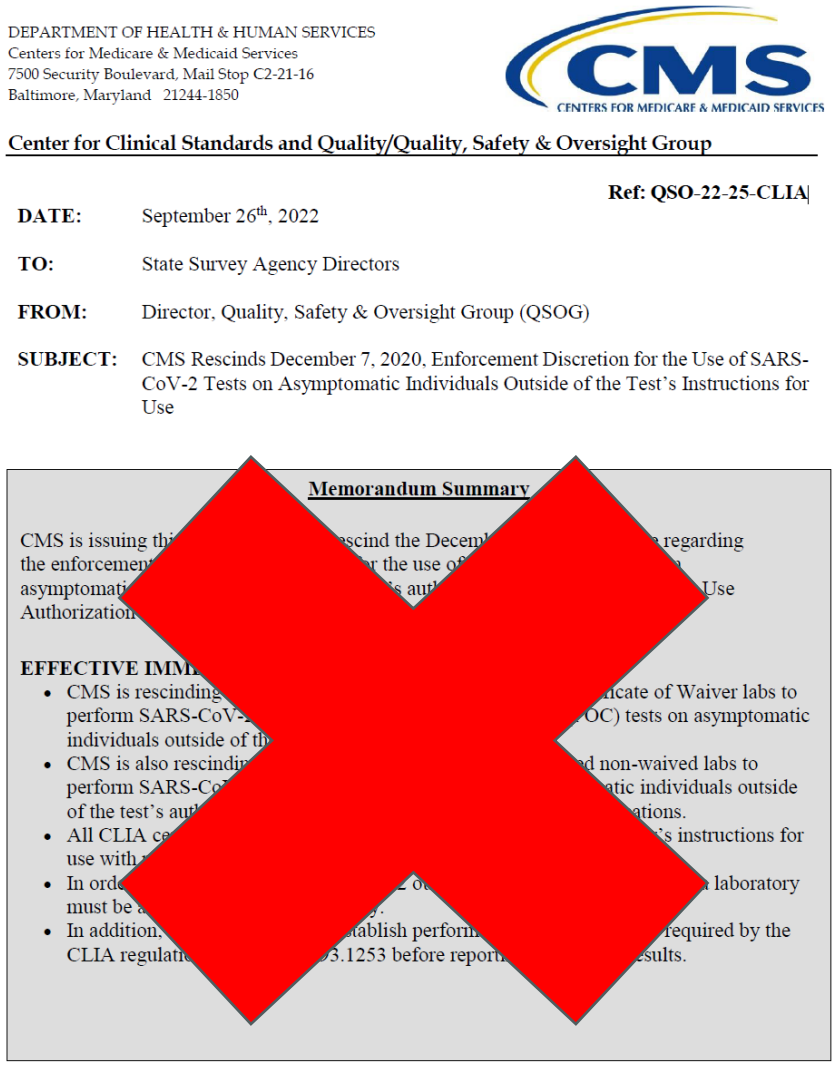
Vaccination Status	Community Transmission Level	Routine Testing Frequency
Unvaccinated*	All	No required routine testing**
Partially vaccinated*	All	No required routine testing**
Vaccinated but not up to date*	All	No required routine testing**
Up to date*	All	No required routine testing**
New and readmissions, regardless of vaccination status	Low & Moderate	No required routine testing**
New and readmissions, regardless of vaccination status***	Substantial & High	Currently upon admission and 5-7 days; **Future state TBD**

*Excluding new/readmissions when community transmission is substantial or high
**Unless symptomatic, had a high-risk exposure, or your facility is in outbreak and performing broad-based testing.
***Unless COVID+ within the prior 90 days (will likely be 30 days in the near future)

Rescinded QSO Memo

- **QSO-22-25-CLIA has been rescinded**

- Should ideally use tests that are indicated for asymptomatic individuals, but can still use tests that are only indicated for symptomatic individuals (e.g., can continue to use BinaxNOW antigen cards)



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-22-25-CLIA

DATE: September 26th, 2022

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: CMS Rescinds December 7, 2020, Enforcement Discretion for the Use of SARS-CoV-2 Tests on Asymptomatic Individuals Outside of the Test's Instructions for Use

Memorandum Summary

CMS is issuing thi… …scind the Decem… …regarding the enforcement… …r the use of… asymptomati… …is auth… …Use Authorization…

EFFECTIVE IMM…

- CMS is rescinding… …icate of Waiver labs to perform SARS-CoV-… …OC) tests on asymptomatic individuals outside of th…
- CMS is also rescindi… …d non-waived labs to perform SARS-Co… …atic individuals outside of the test's aut… …ations.
- All CLIA ce… …'s instructions for use with…
- In orde… …laboratory must be a… …y.
- In addition, … …tablish perform… …required by the CLIA regulati… …3.1253 before report… …esults.

Question 1: A CNA is working on the COVID unit. She takes care of a resident, exits the room, and removes her PPE. She then immediately dons new PPE and enters the next resident's room. Is this acceptable?

- Yes, this is acceptable
- No, she missed something
- Not sure

Answer

- No, she missed something
  - The CNA should have performed hand hygiene

Properly Donning PPE

Properly Doffing PPE

Source: https://jackson-medical.com/properly-donning-and-doffing-ppe-a-how-to-guide/

Question 2: Matilda, a resident at your facility, received her first COVID vaccine (Pfizer) three months ago but has not yet received the second vaccine. Can she get the bivalent booster at your next clinic?

- Yes
- No
- I don't know

Answer

- No
- Bivalent mRNA vaccines are not authorized/approved as primary series doses
- Matilda would need to complete her primary series and then wait two months until she is eligible to receive the bivalent booster

Source: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html

Question 3: A 3rd floor resident tested positive for COVID yesterday. Do all staff members need to wear N95s for 14 days?

- Yes
- No
- I don't know

Answer

- No
- The current IDPH guidance document, which was released in March 2022, does not require universal use of N95s following COVID+ case(s)
- N95s must be worn:
  - When caring for residents under transmission-based precautions for suspected or confirmed COVID
  - When performing aerosol-generating procedures
- Note that your facility may choose to have more stringent policies around N95 use
  - For example, could consider having universal N95 use on outbreak-impacted units

Question 4: A resident tested positive today. His roommate got the bivalent booster five days ago and is asymptomatic. Is it true that the roommate does not need to quarantine?

- Yes
- No
- I don't know

Answer

- Yes
- A person is considered up to date as soon as they have received the booster dose
- Residents who are up to date do not need to quarantine following an exposure to a positive case, but they must wear a mask for 10 days following the exposure and be tested immediately (but no sooner than 24 hours) and between 5-7 days post-exposure

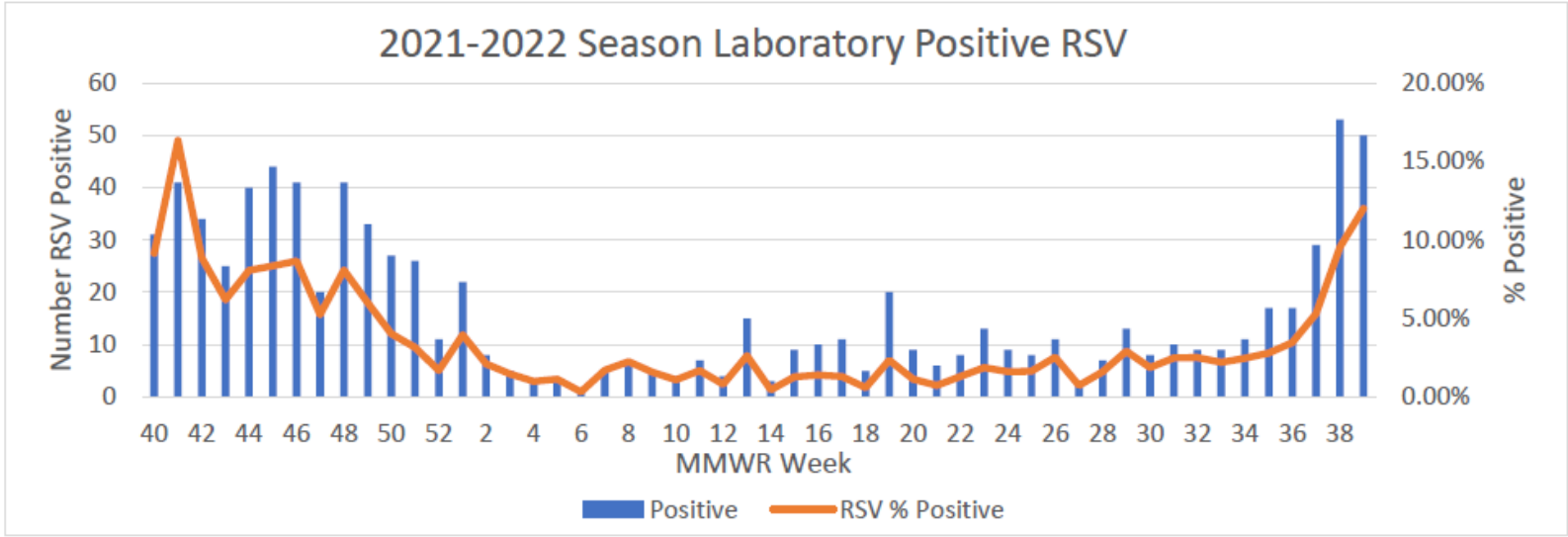
Update: Increased RSV Activity

- Adults at risk of severe disease:
  - Over the age of 65
  - Chronic heart or lung conditions
  - Weakened immune systems

- RSV can exacerbate conditions such as:
  - Asthma
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Congestive Heart Failure (CHF)

Situational Awareness

Although RSV typically circulates during the winter months, during the week ending October 1, 2022, RSV had a lab positivity rate of almost 12%, which is higher than normally expected at this point in the season. It is unknown how long this increased activity will continue.



***Laboratory data included in this graph are from surveillance data from ACL labs and NREVSS.

Source: IDPH, https://www.cdc.gov/rsv/clinical/index.html

Update: 2022-2023 Flu Shot Recommendations

- ACIP recommends that adults 65+ receive one of the following vaccines:
  - Quadrivalent high-dose inactivated influenza virus (HD-IIV4)
  - Quadrivalent recombinant influenza vaccine (RIV4)
  - Quadrivalent adjuvanted inactivated influenza vaccine (aIIV4)

Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season

Recommendations and Reports / August 26, 2022 / 71(1);1–28

Lisa A. Grohskopf, MD[1]; Lenee H. Blanton, MPH[1]; Jill M. Ferdinands, PhD[1]; Jessie R. Chung, MPH[1]; Karen R. Broder, MD[2]; H. Kelpp Talbot, MD[3]; Rebecca L. Morgan, PhD[4]; Alicia M. Fry, MD[1] (VIEW AUTHOR AFFILIATIONS)

View suggested citation

Summary

This report updates the 2021–22 recommendations of the Advisory Committee on Immunization Practices (ACIP) concerning the use of seasonal influenza vaccines in the United States (MMWR Recomm Rep 2021;70[No. RR-5]:1–24). *Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications. For each recipient, a licensed and age-appropriate vaccine should be used.With the exception of vaccination for adults aged ≥65 years, ACIP makes no preferential recommendation for a specific vaccine when more than one licensed, recommended, and age-appropriate vaccine is available. All seasonal influenza vaccines expected to be available in the United States for the 2022–23 season are quadrivalent, containing hemagglutinin (HA) derived from one influenza A(H1N1)pdm09 virus, one influenza A(H3N2) virus, one influenza B/Victoria lineage virus, and one influenza B/Yamagata lineage virus. Inactivated influenza vaccines (IIV4s), recombinant influenza vaccine (RIV4), and live attenuated influenza vaccine (LAIV4) are expected to be available. Trivalent influenza vaccines are no longer available, but data that involve these vaccines are included for reference.*

Influenza vaccines might be available as early as July or August, but for most persons who need only 1 dose of influenza vaccine for the season, vaccination should ideally be offered during September or October. However, vaccination should continue after October and throughout the season as long as influenza viruses are circulating and unexpired vaccine is available. For most adults (particularly adults aged ≥65 years) and for pregnant persons in the first or second trimester, vaccination during July and August should be avoided unless there is concern that vaccination later in the season might not be possible. Certain children aged 6 months through 8 years need 2 doses; these children should receive the first dose as soon as possible after vaccine is available, including during July and August. Vaccination during July and August can be considered for children of any age who need only 1 dose for the season and for pregnant persons who are in the third trimester if vaccine is available during those months.

Updates described in this report reflect discussions during public meetings of ACIP that were held on October 20, 2021; January 12, 2022; February 23, 2022; and June 22, 2022. Primary updates to this report include the following three topics: 1) the composition of 2022–23 U.S. seasonal influenza vaccines; 2) updates to the description of influenza vaccines expected to be available for the 2022–23 season, including one influenza vaccine labeling change that occurred after the publication of the 2021–22 ACIP influenza recommendations; and 3) updates to the recommendations concerning vaccination of adults aged ≥65 years. First, the composition of 2022–23 U.S. influenza vaccines includes updates to the influenza A(H3N2) and influenza B/Victoria lineage components. U.S.-licensed influenza vaccines will contain HA derived from an influenza A/Victoria/2570/2019 (H1N1)pdm09-like virus (for egg-based vaccines) or an influenza A/Wisconsin/588/2019 (H1N1)pdm09-like virus (for cell culture–based or recombinant vaccines); an influenza A/Darwin/9/2021 (H3N2)-like virus (for egg-based vaccines) or an influenza A/Darwin/6/2021 (H3N2)-like virus (for cell culture–based or recombinant vaccines); an influenza B/Austria/1359417/2021 (Victoria lineage)-like virus; and an influenza B/Phuket/3073/2013 (Yamagata lineage)-like virus. Second, the approved age indication for the cell culture–based inactivated influenza vaccine, Flucelvax Quadrivalent (ccIV4), was changed in October 2021 from ≥2 years to ≥6 months. Third, recommendations for vaccination of adults aged ≥65

Article Metrics

Altmetric:

759

News (94)
Blogs (1)
Policy documents (1)
Twitter (60)
Facebook (2)
Mendeley (3)

Citations: 0

Views: 9,906

Views equals page views plus PDF downloads

Metric Details

On This Page

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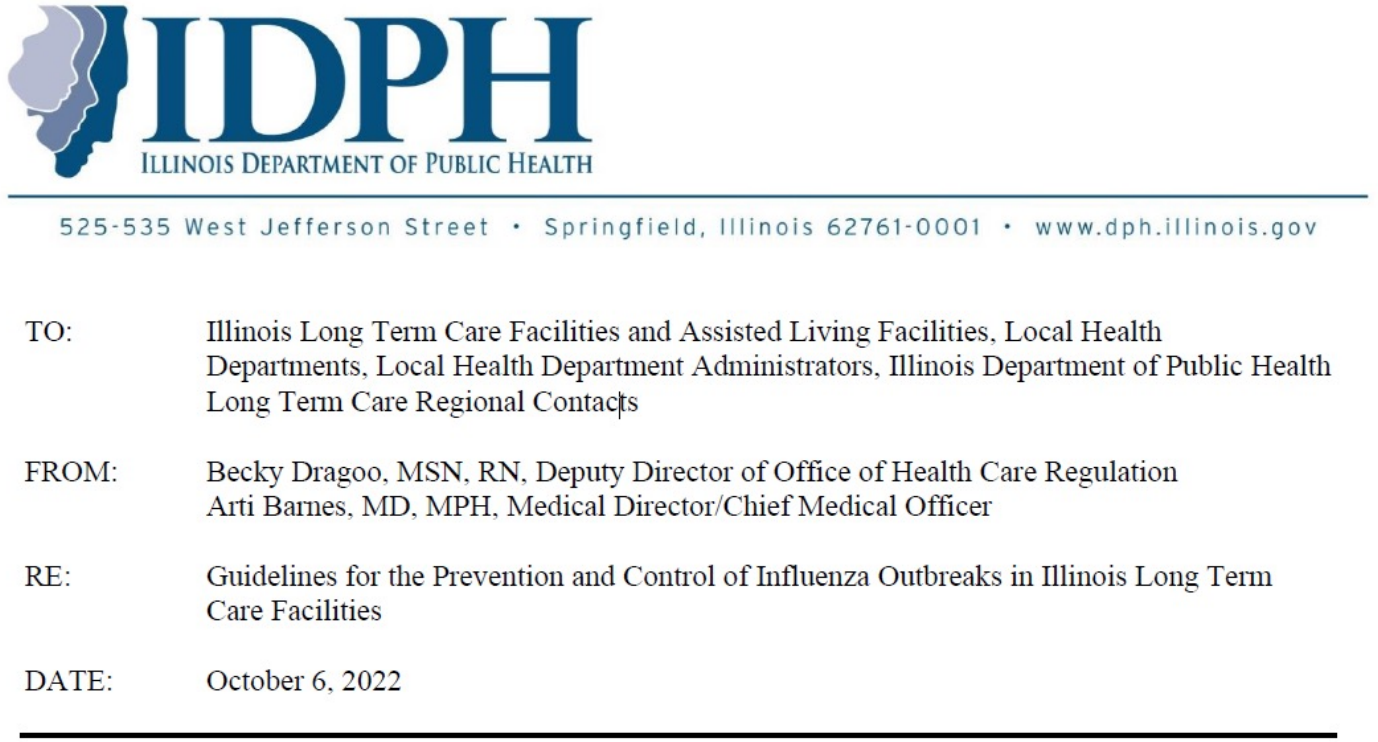
Recommendations for the Use of Influenza Vaccines, 2022–23
Influenza Vaccine Composition and Available Vaccines
Storage and Handling of Influenza Vaccines
Additional Sources of Information Regarding Influenza and Influenza Vaccines
Advisory Committee on

Source: Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season | MMWR (cdc.gov)

Update: Influenza Guidance for LTCFs

- IDPH has released updated guidelines for the prevention and control of influenza outbreaks in Illinois long-term care facilities



IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

TO: Illinois Long Term Care Facilities and Assisted Living Facilities, Local Health Departments, Local Health Department Administrators, Illinois Department of Public Health Long Term Care Regional Contacts

FROM: Becky Dragoo, MSN, RN, Deputy Director of Office of Health Care Regulation
Arti Barnes, MD, MPH, Medical Director/Chief Medical Officer

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

DATE: October 6, 2022

Source: IDPH

Important Definitions

- **Influenza-like Illness (ILI):**
  - Fever (a temperature of 100^0 F [37.8^0 C] or higher orally) **AND**
  - New onset of cough and/or sore throat

- **Confirmed influenza outbreak:**
  - 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 (positive PCR, culture, and/or rapid test)

Source: IDPH

Reporting

- All outbreaks of influenza must be reported within 24 hours to:
  - CDPH
    - E-mail Enrique Ramirez (Enrique.Ramirez@cityofchicago.org), who may reach out to you for more information
  - Your IDPH LTC Regional Office (Bellwood)

REGION 8/9 - BELLWOOD 4212 W. St. Charles Road Bellwood, IL 60104 708-544-5300 Ext 263 Janette Williams-Smith

- Please complete and submit the Influenza Outbreak Report Form and the Influenza Surveillance Outbreak Log

Source: IDPH

Influenza Outbreak Report

IDPH INFLUENZA OUTBREAK REPORT FORM FOR CONGREGATE SETTINGS
(e.g. Long Term Care & Correctional Facilities)
Fax or secure email, along with the Outbreak Log, to your Local Public Health Department to report an outbreak

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 exposed): _____	**Total number of staff: _____** **Number of staff currently with ILI: _____**	
Number of residents in the facility currently with influenza-like illness (ILI): _____	**% of residents vaccinated with seasonal flu vaccine: _____** **% of staff vaccinated with seasonal flu vaccine: _____** **% of outbreak cases vaccinated with flu vaccine: _____**	
(ILI) [Fever >100° F [37.8° C] or higher orally AND new onset cough or sore throat]		
(for those with ILI) **# Seen by Provider _____ # Hospitalized _____ # Fatalities _____**		
Date of symptom/onset detection for the first case of ILI during the outbreak:	**Dates of onset for most recent case 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:**	

Revised 08/2019

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.

Influenza Surveillance Outbreak Log

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)

Reviewed 08/2019

* Symptoms/Signs: e.g. cough(C), fever (F), sore throat (ST), or Other (O) {list: i.e., chills (CH), pneumonia (P), myalgias (M)}

Source: IDPH

Resident Immunizations

- Facility immunization policies must include annual influenza vaccine for all residents. Policies should also include pneumococcal vaccine for those who are eligible.
  - Should have a standing order in effect for all residents

- Flu clinics should ideally be held prior to the end of October. Continue to offer clinics throughout the flu season.
  - Recommend offering both COVID and flu vaccinations at your clinics. A person can get both shots at the same time.

Source: IDPH

Staff Education/Immunizations

- LTCFs are required to:
  - Ensure that all employees are provided education on influenza
  - Ensure that all employees are offered the opportunity to receive the influenza vaccination during the influenza season (September 1 – March 1)
  - Maintain a system for tracking and documenting influenza vaccine offered and administered to employees.
    - Documentation must be kept for three years

Employee Declinations

- Staff are only able to decline the influenza vaccine if it is medically contraindicated or against their religious beliefs.
  - Cannot decline for moral or philosophical reasons.

- Staff who decline must sign a statement declining vaccination and certifying that he or she received education about the benefits of influenza vaccine.
  - Retain declination forms for for three years

Employee/Resident Influenza Vaccination Tracking Form

Employee/Resident Influenza Vaccination Tracking Form

This form can be used to track employee and resident influenza vaccination status

Date	Last Name	First Name	Unit/Floor/Dept	Date Vaccine Received	Declined Vaccine (Y or N)	Declination Form Signed (Y or N)	Educational Information Received (Y or N)	Date Educational Information (VIS) Received

Reviewed 10/2022

Source: IDPH

Testing

- If a resident has ILI or COVID-like symptoms during flu season, test for influenza **AND** COVID

- Consider a respiratory viral panel (RVP), especially if there are concerns about co-infection and/or when multiple viruses are circulating in the community
  - RVPs test for a number of viruses including rhinovirus, RSV, influenza/parainfluenza, and metapneumovirus

Source: IDPH

Influenza Infection Prevention & Control Measures

- Respiratory Hygiene & Cough Etiquette
- Standard Precautions
- Droplet Precautions
- Restrictions for Ill Visitors and Staff
- Surveillance
- Education

Standard Precautions

- During the care of residents with symptoms of an unknown respiratory infection:
  - Wear gloves if hand contact with secretions or potentially contaminated surfaces is anticipated
  - Wear a gown if soiling of clothes with a resident's respiratory secretions is anticipated
  - Change gown/gloves after each resident encounter
  - Perform hand hygiene before/after touching the resident, after touching the resident's environment, and/or after touching the resident's respiratory secretions, regardless of whether gloves are worn
    - If hands are not visibly soiled, use alcohol-based hand rub
    - When hands are visibly soiled, wash hands with soap and water

Source: IDPH

Droplet Precautions

- Residents with suspected/confirmed influenza must also be placed under droplet precautions:
  - Place in a private room (cohorting is allowed in certain situations)
  - Wear a facemask and eye protection while in the resident's room and/or when caring for the resident.
    - If COVID is also suspected or confirmed, must wear a N95 respirator, eye protection, gown, and gloves
  - Discard PPE when leaving resident's room (e.g., do not employ extended facemask use) and perform hand hygiene
  - If resident movement or transport is necessary, resident must wear a facemask

Source: IDPH

Length of Droplet Precautions

- Residents with influenza must remain in droplet precautions for **whichever is longer**:
  - Seven days after illness onset **OR**
  - 24 hours after the resolution of fever and respiratory symptoms

- If residents also have COVID, they must remain in isolation for ten days after illness onset/specimen collection date for the positive COVID test
  - If they test positive for influenza >3 days *after* testing positive for COVID, their total isolation period must be extended accordingly

Source: IDPH

Staff Exclusion

- Staff members with ILI/influenza must be excluded from work until at least 24 hours after fever has subsided, without the use of fever-reducing medications
  - If coughing or sneezing are still present, they must wear a facemask during patient care activities
    - Note: At this time, universal masking is still in place for LTCFs
  - If the staff member also has COVID, follow the COVID-related exclusion guidance

Source: IDPH

Surveillance

- LTCFs should implement daily active surveillance for respiratory illness for residents and staff

- Examples of surveillance activities include:
  - Monitoring for symptoms of respiratory illness among residents, staff, and visitors
  - Maintaining a line list of ill residents and staff
  - Maintaining a log of staff call-ins and reviewing daily for symptoms of respiratory illness

Antiviral Chemoprophylaxis

- Antiviral chemoprophylaxis helps to prevent transmission to asymptomatic exposed residents
  - Neuraminidase inhibitor antiviral medications (e.g., Tamiflu) are ~70-90% effective in preventing influenza, assuming it is a susceptible strain

- During a confirmed influenza outbreak:
  - Use of antiviral chemoprophylaxis within 48 hours of exposure is recommended for all non-ill residents who reside on an outbreak affected unit, regardless of whether they got the influenza vaccination
  - Can also consider giving prophylaxis to staff in certain circumstances (see IDPH guidance document)

Source: IDPH, https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm

Duration of Chemoprophylaxis

- For outbreaks in LTCFs, CDC recommends antiviral chemoprophylaxis for a minimum of 2 weeks and continuing up to 1 week after the last known case was identified.

- Oseltamivir (Tamiflu) is the recommended antiviral drug for chemoprophylaxis
  - Baloxavir (Xofluza) is not recommended for chemoprophylaxis in LTCF residents

Antiviral Treatment

- Empiric use of antiviral treatment should be started as soon as possible for residents with suspected or confirmed influenza
  - Antivirals are most effective if started within 48 hours after symptom onset. However, antivirals can still help if given those with severe illness after 48 hours.

- Recommended duration for antiviral treatment is 5 days for oral oseltamivir or inhaled zanamivir.
  - Longer daily dosing can be considered for patients who remain severely ill after 5 days of treatment.

Source: IDPH, https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm

Antiviral Treatment & Chemoprophylaxis Options

- Note: Due to antiviral resistance, neither amantadine or rimantadine are recommended for influenza prophylaxis or treatment.

Antiviral Agent	Activity Against	Use	Recommended For	Not Recommended for Use in	Adverse Events
Oral Oseltamivir	Influenza A and B	Treatment	Any age[1]	N/A	**Adverse events:** nausea, vomiting, headache. Post marketing reports of serious skin reactions and sporadic, transient neuropsychiatric events[2]
		Chemo-prophylaxis	3 months and older[1]	N/A	
Inhaled Zanamivir	Influenza A and B	Treatment	7 yrs and older[3]	people with underlying respiratory disease (e.g., asthma, COPD)[3]	**Adverse events:** risk of bronchospasm, especially in the setting of underlying airways disease; sinusitis, and dizziness. Post marketing reports of serious skin reactions and sporadic, transient neuropsychiatric events[2]
		Chemo-prophylaxis	5 yrs and older[3]	people with underlying respiratory disease (e.g., asthma, COPD)[3]	
Intravenous Peramivir	Influenza A and B[4]	Treatment	6 months and older[4]	N/A	**Adverse events:** diarrhea. Post marketing reports of serious skin reactions and sporadic, transient neuropsychiatric events[2]
		Chemo-prophylaxis[5]	Not recommended	N/A	
Oral Baloxavir	Influenza A and B[6]	Treatment	5 yrs and older[6]	N/A	**Adverse events:** none more common than placebo in clinical trials
		Chemo-prophylaxis[6]	Approved for post-exposure prophylaxis in persons 5 yrs and older[6]		

Source: IDPH, https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm

Other Outbreak Management Considerations

- When your facility is experiencing a widespread outbreak, consider temporarily:
  - Limiting or suspending large group activities
  - Limiting or suspending communal dining

- Should also increase the frequency of environmental cleaning and disinfection
  - Make sure the disinfectant product is EPA registered and effective against influenza
  - Ensure that the product is used according to its instructions
  - Product(s) should ideally have a shorter contact time

Question 1: Can you cohort a resident who tested positive for Influenza A with a resident who tested positive for Influenza B?

- Yes
- No
- I don't know

Answer

- No, do not cohort a resident who has an Influenza A infection with a resident who has an Influenza B infection

- Should ideally place residents with influenza in a private room but, if necessary, can cohort like with like as follows:
  - Influenza A with Influenza A (do not put in the COVID unit)
  - Influenza B with Influenza B (do not put in the COVID unit)
  - Influenza A/COVID & Influenza A/COVID (put in the COVID unit)
  - Influenza B/COVID & Influenza B/COVID (put in the COVID unit)

Question 2 : A staff member says that they had a sore arm last time they got a flu shot and they consider that to be a medical contraindication. Based on that, can they decline the influenza vaccine?

- Yes
- No
- I don't know

Answer

- No, having a sore arm is not a contraindication to getting the influenza vaccination
- For staff requesting a medical exemption, ask for a doctor's note indicating that the influenza vaccination is contraindicated for the employee

People who SHOULD NOT get a flu shot include:

- Children younger than 6 months of age are too young to get a flu shot.
- People with severe, life-threatening allergies to any ingredient in a flu vaccine (other than egg proteins) should not get that vaccine. This might include gelatin, antibiotics, or other ingredients. See Special Considerations Regarding Egg Allergy for more information about egg allergies and flu vaccine.
- People who have had a severe allergic reaction to a dose of influenza vaccine should not get that flu vaccine again and might not be able to receive other influenza vaccines. If you have had a severe allergic reaction to an influenza vaccine in the past, it is important to talk with your health care provider to help determine whether vaccination is appropriate for you.

People who should talk to their health care provider before getting a flu shot:

If you have one of the following conditions, talk with your health care provider. He or she can help decide whether vaccination is right for you, and select the best vaccine for your situation:

- If you have an allergy to eggs or any of the ingredients in the vaccine. Talk to your doctor about your allergy. See Special Considerations Regarding Egg Allergy for more information about egg allergies and flu vaccine.
- If you ever had Guillain-Barré Syndrome (a severe paralyzing illness, also called GBS). Some people with a history of GBS should not get a flu vaccine. Talk to your doctor about your GBS history.
- If you had a severe allergic reaction to a previous dose of any other flu vaccine, talk to your health care provider.
- If you are not feeling well, talk to your doctor about your symptoms.

Source: https://www.cdc.gov/flu/prevent/whoshouldvax.htm

Question 3: A staff member says that they do not want to get the influenza vaccine because it is against their personal beliefs. Is that allowed?

- Yes
- No
- I don't know

Answer

- No
- Declinations due to moral or philosophical reasons are not allowed for the influenza vaccination.

Questions & Answers

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For additional resources and upcoming events, please visit the CDPH LTCF HAN page at:
https://www.chicagohan.org/covid-19/LTCF