SEASONAL INFLUENZA GUIDANCE

Federal Bureau of Prisons

Clinical Guidance

DECEMBER 2018

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WHAT'S NEW IN THIS GUIDANCE?

- **NEW CHECKLIST:** A one-page *Influenza Outbreak Response Checklist* has been added as *Appendix 1*.

- **HAND HYGIENE:** During influenza seasons, it is recommended that institutions develop a plan to emphasize hand hygiene for both staff and inmates. In particular, hand hygiene should be emphasized in substance abuse treatment programs in which hand shaking is an integral part of the program (e.g., RDAP, CHALLENGE, and BRAVE).

  ➔ *During outbreaks, temporarily discontinuing handshaking in these programs should be considered, but permission must be obtained from the Central Office Psychology Treatment Programs.*

- **ANTIVIRAL PROPHYLAXIS:** Antiviral prophylaxis is rarely indicated except during influenza outbreaks in inpatient long-term care settings. CDC guidance on *antiviral prophylaxis* is covered in Section 5.c.

- **HEALTH ALERT SIGNAGE:** Bilingual signs regarding **COUGH ETIQUETTE** and **DROPLET PRECAUTIONS**, which can be copied and posted, are available in *Appendix 2*.

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1. OVERVIEW

The following guidance is provided for management of seasonal influenza. An optional checklist for influenza outbreak response is provided in *Appendix 1*.

2. DEFINITION OF INFLUENZA-LIKE ILLNESS (ILI)

The Centers for Disease Control and Prevention (CDC) defines **ILI** as:

Fever (temperature greater than or equal to 100.0 degrees F [37.8 degrees C]) PLUS cough and/or sore throat—in the absence of a known cause other than influenza.

3. PREVENTION

a. VACCINATION: Influenza vaccination is the most critical measure for preventing seasonal influenza. The CDC recommends that all persons over 6 months of age receive influenza vaccination.

It is recommended that all staff and inmates in the facility be offered vaccination:

- Vaccination should be strongly promoted for all staff.
- Inmates who are either at high risk for influenza (see *Table 1*) or who work in health services are the highest priority among inmates to receive vaccination.

b. GOOD HEALTH HABITS: Educate staff and inmates that the following measures help protect against the spread of influenza.

- **Regular hand washing**—especially after sneezing, coughing, or touching the face.
- **Respiratory etiquette**—sneeze/cough into sleeve or tissue; avoid touching eyes, nose, or mouth.
- **Signage**—post signs, posters, and other visuals about good health habits in strategic places.
- **During influenza season, institutions are encouraged to develop a plan to emphasize hand hygiene for both staff and inmates.** In particular, it is recommended that hand hygiene be emphasized in institution substance abuse treatment programs in which hand shaking is an integral part of the program (e.g., RDAP, CHALLENGE, and BRAVE).

c. DISINFECTION OF HIGH-TOUCH SURFACES: During influenza season, institutions should emphasize cleaning of high-touch surfaces (i.e., door knobs, hand rails, telephones, keys, computer keyboards, etc.).

d. EDUCATE INMATES AND STAFF TO AVOID CLOSE CONTACT WITH PERSONS WITH INFLUENZA SYMPTOMS (fever with cough and/or sore throat).

f. EDUCATIONAL MATERIALS ON FLU PREVENTION can be obtained from the CDC's Seasonal Influenza Resource Center: *http://www.cdc.gov/flu/freeresources/index.htm*

4. CONTROL MEASURES

a. SCREENING: Based on the occurrence of influenza, the Clinical Director may recommend routine screening of new arrivals for ILI.

- *Elderly patients may have atypical complaints such as anorexia, mental status changes, or unexplained fever as the only presenting symptoms.*

b. ISOLATION/COHORTING: If feasible, inmates with evidence of ILI should be isolated or cohorted together, separated from non-symptomatic inmates. This is an important, effective measure to limit the spread of influenza and, if initiated promptly when a case is identified, can prevent an influenza outbreak in a facility.

- *In the case of widespread influenza and in certain institutional settings, isolation or cohorting of inmates with ILI may not be feasible. In these situations, one option is to require inmates who are symptomatic to wear surgical/procedure masks with concurrence of institution executive staff.*

The following DROPLET PRECAUTIONS guidelines should be followed while inmates are isolated or cohorted:

- Post a "**DROPLET PRECAUTIONS**" sign on the door of the room (see second sign in *Appendix 2*).
- Staff entering rooms with inmates with ILI, or coming into close contact (within three feet) with them, should wear a surgical or procedure mask (not a respirator).
- Staff should wear gloves for all interactions that may involve direct contact with inmates with ILI or with potentially contaminated areas in the immediate environment.
- Hand hygiene should be performed before donning AND after removing gloves.
- When leaving the room, face masks should be removed and disposed of (in regular trash); hands should be washed or disinfected.
- Food should be delivered to isolated/cohorted inmates. (Disposable dishes are not required.)
- Inmates with ILI should wear a surgical or procedure mask when coming out of an isolation/cohort room.
- Inmates with ILI should be instructed regarding cough etiquette, hand washing, wearing a mask outside the room, and proper disposal of masks (in regular trash).
- Isolation/cohorting of an individual should continue until 24 hours after the resolution of fever.
- Inmates with ILI should NOT be transferred out of the facility until 24 hours after resolution of fever.

5. CLINICAL MANAGEMENT

a. INFLUENZA TESTING: In general, in the context of a community outbreak of influenza, testing for influenza is NOT indicated. If testing is done, it is recommended that PCR (reverse transcriptase polymerase chain reaction) tests be performed from throat swabs, nasopharyngeal swabs, or sputum.

- *The use of rapid tests is not generally recommended because of their low (50–70%) sensitivity. A negative rapid influenza test result does NOT rule out influenza.*

b. ANTIVIRAL TREATMENT: Antiviral treatment with oseltamivir (Tamiflu®) or zanamivir (Relenza®) is indicated as early as possible for any inmate with confirmed or suspected influenza AND who has at least one of the following conditions:

- Is hospitalized.
- Has severe, complicated, or progressive illness.
- Is at higher risk for influenza complications, as listed in *Table 1* below.

TABLE 1. CONDITIONS THAT PUT PERSONS AT HIGH RISK FOR INFLUENZA COMPLICATIONS

- Age ≥ 65 years
- Chronic pulmonary (including asthma)
- Cardiovascular (except hypertension alone)
- Renal, hepatic, hematological (including sickle cell disease), metabolic disorders (including diabetes mellitus)
- Neurologic and neurodevelopment conditions (including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy [seizure disorders], stroke, intellectual disability [mental retardation], moderate to severe developmental delay, muscular dystrophy, or spinal cord injury)
- Immunosuppression, including that caused by medications or by HIV infection
- Women who are pregnant or postpartum (within 2 weeks after delivery)
- Age < 19 years and receiving long-term aspirin therapy
- American Indian/Alaska Native
- Morbidly obese (i.e., body-mass index ≥40)
- In long-term inpatient care settings

IMPORTANT NOTES ABOUT THE USE OF ANTIVIRAL TREATMENT:

- *Antiviral treatment requires non-formulary approval.*
- *Stockpiles of antiviral medication for pandemic influenza are NOT to be used for seasonal influenza.*
- *Treatment of patients at high risk for influenza complications should NOT wait for laboratory confirmation of influenza.*
- *Antiviral treatment works best when started within the first 2 days of symptoms. However, these medications can still help when given after 48 hours to those that are very sick, such as those who are hospitalized or those who have progressive illness.*
- *Dosages are adjusted with renal impairment (see manufacturer's prescribing information).*

c. ANTIVIRAL PROPHYLAXIS: Antiviral prophylaxis is rarely indicated EXCEPT in inpatient long-term care settings. The CDC's *Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities* (available at https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm) recommends that if at least two patients become ill within 72 hours, and at least one resident has laboratory-confirmed influenza, that antiviral prophylaxis be administered to all non-ill residents.

➔ *Seek approval of the Regional Medical Director prior to administering antiviral prophylaxis.*

Key points from the CDC guidance regarding antiviral prophylaxis include:

- Antiviral prophylaxis is NOT a substitute for vaccination. It is used as an adjunct in preventing and controlling influenza.
- It is administered to all non-ill residents, *regardless of influenza vaccination status*. Priority is given to residents living in the same unit or floor as an ill resident.
- It is continued for a minimum of 2 weeks and continued for at least 7 days after the last known case is identified.
- Dosages are adjusted with renal impairment (see manufacturer's prescribing information).

d. CLINICAL MONITORING: Inmates with ILI should be monitored for level of mental awareness (presence of lethargy, confusion, disorientation) and hydration status. Vital signs should be taken, as indicated.

e. PATIENT EDUCATION: Key patient education messages are outlined in *Table 2* below.

TABLE 2. PATIENT EDUCATION MESSAGES ABOUT INFLUENZA

- The incubation period (time period from exposure to development of symptoms) is typically 1–4 days.
- Infected adults are presumed to be contagious from one day before symptoms until 24 hours after temperature is normal (without fever-reducing medications). HOWEVER, patients should be very careful to continue to cover their cough and wash hands frequently for a few days after that.
- Fever usually declines after 2–3 days and normally disappears by the sixth day of illness.
- Cough, weakness, and fatigue can persist for 1–2 weeks and up to 6 weeks.
- Antibiotics do not benefit most people with influenza, but are sometimes needed to treat secondary infections.
- Generally recommended symptomatic treatment for influenza includes:
  - Treat fever, myalgias, and headache with acetaminophen or ibuprofen.
  - Rest.
  - Drink plenty of fluids.
  - Inmates should promptly report occurrence of shortness of breath or worsening of symptoms after initial improvement.

6. SURVEILLANCE AND REPORTING

a. INMATES WITH ILI (see *CDC definition*) should be coded with a BEMR Code of 488.1A. Inmates with laboratory-confirmed influenza should be coded as J111.

b. THE OCCURRENCE OF FIVE OR MORE CASES OF ILI WITHIN A ONE-WEEK PERIOD should be reported to the Region utilizing the BP-A664 Infectious Disease/Outbreak Report. See *Appendix 1*, *Influenza Outbreak Response Checklist*.

c. CONDUCT SURVEILLANCE of influenza vaccination rates and the occurrence of ILI.

APPENDIX 1. INFLUENZA OUTBREAK RESPONSE CHECKLIST

1. RECOGNITION, REPORTING, AND DATA COLLECTION	
	a. If greater than 5 cases of suspected of *ILI* in a 7-day period, report to the Regional Medical Director/Regional QI/IPC Coordinator, using BP-A664 Form (Infectious Disease/Outbreak Report).
	b. Code inmates with *ILI* with BEMR Code 488.1 A (J111 for lab-confirmed influenza) for tracking purposes.
	c. Start a line list (spreadsheet) of all staff and inmate cases.
2. INFECTION PREVENTION AND CONTROL MEASURES	
	a. Isolate/cohort inmates with ILI, if feasible. Staff use Droplet Precautions (see *Control Measures* in Section 4.b.). If isolation/cohorting is not feasible, consider requiring ill inmates to wear surgical/procedure masks with concurrence of institution executive staff.
	b. Educate staff & inmates about outbreak. Encourage staff and inmates to report cases of ILI. Promote hand hygiene (especially in substance abuse treatment programs); respiratory etiquette; and avoiding touching eye, nose, or mouth. Post signage about the outbreak and proper hand hygiene. Use staff recalls, email, inmate town halls, TRULINCS.
	c. Increase availability of hand hygiene supplies on housing units.
	d. In HSU, separate inmates with ILI from other inmates and/or have inmates with respiratory symptoms wear surgical/procedure masks while in HSU.
	e. Educate staff and inmate orderlies to increase cleaning schedule for high-traffic areas and high-touch surfaces (faucets, door handles, keys, telephones, keyboards, etc.). Assure adequate cleaning supplies.
	f. Re-offer influenza vaccine to unvaccinated staff and inmates (especially immunocompromised inmates).
3. CARING FOR THE SICK	
	a. Implement plan for assessing ill inmates. Promote hydration, ibuprofen or acetaminophen for fever, rest.
	b. Prescribe antiviral if risk factors for influenza complications, within 48 hours of symptom onset (*Table 1*).
4. POSSIBLE ADMINISTRATIVE CONTROLS DURING OUTBREAKS	
	a. Institute ILI screening on new inmate intakes.
	b. Waive co-pays for inmates in Health Services to promote reporting of illness.
	c. Minimize inmate movement between affected and unaffected units.
	d. Screen for ILI in inmate workers in Food Service and Health Services; exclude from work if symptomatic.
	e. Minimize self-serve foods in Food Service (e.g., eliminate salad bars).
	f. Do controlled movement by unit to dining hall (cleaning between units), or feed on the units.
	g. Temporarily discontinue group activities, e.g., recreation, chapel, activity therapy groups, education.
	h. Temporarily suspend handshakes in substance abuse treatment programs (e.g., RDAP, BRAVE, CHALLENGE). ***Note*:** Authorization required from Central Office Psychology Treatment Programs.
	i. Do controlled movement by unit to pill line, or administer medication on the units.
	j. Assign particular inmates to open doors with frequently touched door handles.
	k. Post visitor notifications regarding flu outbreak. (If large outbreak, consider suspending visits).
	l. During large outbreaks, consider halting inmate movement in and out (in consultation with Region/Central Office). Consider suspending court (detention centers).
5. RESPONSE IN LONG-TERM CARE UNITS	
	If 2 or more cases, provide *antiviral prophylaxis* to all residents (prioritize the unit where cases occurred).
6. OUTBREAK RESPONSE	
	a. Consider instituting the Incident Command System (ICS) for large outbreaks. Define roles and responsibilities. Schedule daily or twice-daily meetings to coordinate response. Engage all departments in the outbreak response. Regularly communicate with staff (staff recalls, emails) and inmates (town halls).
	b. Consider a final communication to staff and inmates when outbreak has resolved.

APPENDIX 2. HEALTH ALERT SIGNAGE

The following signs, in both English and Spanish, are located on the following two pages. They can be copied in color, or black and white, for use in the facility. Lamination is recommended, if feasible.

1. **"COUGHING SPREADS GERMS" –** For posting in the HSU.

2. **"DROPLET PRECAUTIONS"** – For posting on the doors of rooms where inmates with ILI are isolated or cohorted.

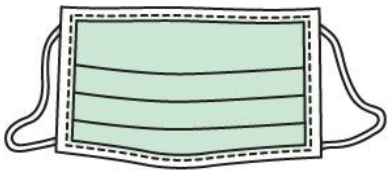
Health Alert!

¡Alerta de salud!

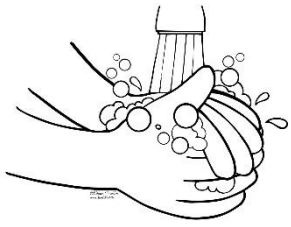
Coughing spreads germs.
Protect yourself and others.

Al toser se transmiten microbios.
Protéjase Ud. y a los demás.

Cover your cough.
Tápese la boca al toser.



If you are coughing, ask about a face mask to wear in Health Services.
Si usted esta tosiendo, pida al personal de Servicios Médicos una máscara para cubrirse.



Clean hands often.
Lávese las manos con frecuencia.

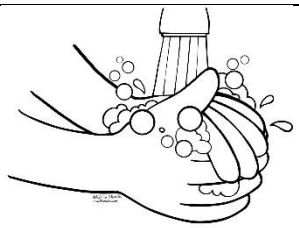
Droplet PRECAUTIONS

PRECAUCIONES contra particulas o gotitas

TO PREVENT THE SPREAD OF INFECTION,

ANYONE ENTERING THIS ROOM SHOULD USE:

Para prevenir el esparcimiento do infecciones,
todas las peronas que entren e esta habitacion tienen que:

	**HAND HYGIENE** ***Hygiene De Las Manos***
	**SURGICAL MASK** ***Mascara Quirurgica***
	**GLOVES** ***Guantes***
	**GOWN** ***Bata***