



2018-19 INFLUENZA SEASON

County of Santa Cruz ~ Public Health Division

www.santacruzhealth.org/flu

September, 2018



Public Health
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Santa Cruz County

NEW FOR 2018-19! CHANGES IN REQUIRED INFLUENZA REPORTING

The requirements for influenza reporting have changed significantly this year. CDPH is **no longer asking for reports of ICU hospitalizations** of persons with influenza, or for reports of influenza **deaths among adults** age 18-64. CDPH has found alternative systems that they think will provide more comprehensive data while imposing less burden on providers.

The following events **must still be reported** to the Santa Cruz County Communicable Disease Unit. Please report using a Confidential Morbidity Report (CMR), available at SantaCruzHealth.org/CDUnit.

- Pediatric Deaths from influenza among children age 0-17
- Deaths from respiratory syncytial virus among children age 0-5
- Any suspected case of novel influenza
- Outbreaks of influenza or acute respiratory illness occurring in institutions or congregate settings

HEALTH CARE WORKER VACCINATION ORDER

On September 5, 2018, Santa Cruz County Health Officer Dr. Arnold Leff ordered all licensed health care facilities and Emergency Medical Services providers to implement a mandatory influenza vaccination program. It states that facilities must ensure that all health care workers either receive an annual flu vaccine or, if they decline, wear a mask while working in patient care areas. The order is effective from October 31 to March 31 and may be extended as needed. A link to the order is posted on the Health Services Agency's website here: <http://www.santacruzhealth.org/HSAHome/HealthAlerts.aspx>

Since infected health care workers (HCWs) can transmit the virus to their vulnerable patients, vaccinating HCWs is expected to protect medically fragile patients, as well as reduce employee absenteeism during influenza season. Mandatory vaccination policies with a masking option has been shown to increase HCW vaccination rates to above 90%.

VACCINATION

Annual influenza vaccination is recommended for **everyone age 6 months and older**, regardless of risk group. As long as flu viruses are circulating in the community, it's not too late to vaccinate your patients. For a complete list of recommendations and vaccine products for 2018-19, see <https://www.cdc.gov/mmwr/volumes/67/rr/pdfs/rr6703a1-H.pdf>.

There are three types of influenza vaccine: inactivated influenza vaccine (IIV), live attenuated influenza vaccine (LAIV nasal spray), and recombinant influenza vaccine (RIV). Depending on the type of vaccine, it may be available in a trivalent formulation with 3 strains, and/or a quadrivalent formulation with 4 strains. There is no preferential recommendation for trivalent versus quadrivalent vaccine; either is acceptable.

Unlike the past two seasons, the Advisory Committee on Immunization Practices (ACIP) now recommends that **live attenuated influenza vaccine -- "Flu Mist" -- should be used freely again**. In recent seasons LAIV had not been very effective, but this season, because of changes in the circulating strains, LAIV is expected to be effective.

Per CDC's 2018-2019 ACIP recommendations, **egg allergy is no longer a contraindication for influenza vaccination**.

INFLUENZA ANTIVIRAL MEDICATION

The CDC recommends using neuraminidase inhibitors such as oseltamivir (Tamiflu), although there are significant questions about their effectiveness. Oseltamivir might slightly reduce illness severity, shorten duration of illness or hospitalization, or reduce risk of complications or mortality from influenza. Oseltamivir has little or no effect unless given within 48 hours of symptom onset. CDC recommends that hospitalized patients, and outpatients at high risk for serious complications, be given antivirals as soon as possible, regardless of lab results.



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Those at high risk for influenza-related complications include:

- Children under 2 years, and adults 65 and older
- Persons with chronic pulmonary, cardiovascular, renal, hepatic, hematological, neurologic, or metabolic disorders
- Persons with immunosuppression, including from medications or by HIV infection
- Women who are pregnant or postpartum (within 2 weeks after delivery)
- Persons younger than 19 who are receiving long-term aspirin therapy
- American Indians / Alaska Natives
- Persons who are morbidly obese (BMI > 40)
- Residents of nursing homes and other chronic care facilities

Although annual influenza vaccination is the best way to prevent influenza, prophylactic antiviral medications may be helpful in preventing influenza. However, CDC does not recommend widespread or routine use of antiviral medications for prophylaxis, so as to limit the possibility that antiviral-resistant viruses could emerge. Antivirals may also cause significant side effects. The following are examples of situations where chemoprophylaxis is recommended if it can be initiated within 48 hours after exposure to influenza:

- Persons with severe immune deficiencies who might not respond to influenza vaccination
- Persons at high risk of influenza complications who have a contraindication to influenza vaccination
- Residents of institutions, such as nursing homes (even if they have already received influenza vaccine), once influenza cases have been identified at the facility (i.e., outbreaks); chemoprophylaxis should also be considered for unvaccinated staff

CDC's antiviral recommendations (<https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm>) are based largely on ACIP's 2011 *Antiviral Agents for the Treatment and Chemoprophylaxis of Influenza*.

SPECIMEN COLLECTION & TESTING

Influenza testing is indicated when it will help guide clinical decision-making. Testing may be most useful in hospitalized and/or critically ill patients. Rapid influenza diagnostic tests (RIDTs) may be used to help with diagnosis; however, negative results of RIDTs do not exclude influenza virus infection in patients with signs and symptoms suggestive of influenza. For more information on signs, symptoms, and diagnostic testing, visit <https://www.cdc.gov/flu/professionals/diagnosis/labrolesprocedures.htm>.

Specimens on cases that meet the criteria for influenza reporting (page 1) should be sent to the Santa Cruz County Public Health Lab, to characterize circulating strains causing severe illness or outbreaks. For questions about submitting specimens, contact the Public Health Lab at (831) 454-5445.

Specimen Collection Instructions for RT-PCR to send to the Public Health Lab:

- Specimens should be collected within 24–72 hours of symptom onset and no later than 5 days after symptom onset. The specimens should be kept refrigerated at 4°C and sent on cold packs if they can be received by the laboratory within 3 days of the date collected. If samples cannot be received by the laboratory within 3 days, they should be frozen at -70°C or below and shipped on dry ice.
- Upper respiratory samples suitable for RT-PCR include nasopharyngeal (NP) swabs, nasal swabs, throat swabs, nasal aspirate, nasal washes, NP wash, and NP aspirate. For patients hospitalized with pneumonia, specimens from the lower respiratory tract may also be obtained; lower respiratory tract specimens can yield the diagnosis when influenza virus is no longer detectable in the upper respiratory tract. Lower respiratory tract samples suitable for RT-PCR include bronchoalveolar lavage, bronchial wash, tracheal aspirate, and lung tissue.
- Swab specimens should be collected using swabs with a synthetic tip (e.g., polyester or Dacron®) and an aluminum or plastic shaft. Swabs with cotton tips and wooden shafts are NOT recommended. Specimens collected with swabs made of calcium alginate are NOT acceptable. Place appropriate swab specimen in a standard container with 2-3 ml of viral transport media (VTM).

COMMUNICABLE DISEASE UNIT: (831) 454-4114 (phone), (831) 454-5049 (fax)