



## 2020-21 INFLUENZA SEASON

County of Santa Cruz ~ Public Health Division

[www.santacruzhealth.org/flu](http://www.santacruzhealth.org/flu)

October 2020



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**Santa Cruz County**

### **COVID-19 DURING INFLUENZA SEASON 2020-2021**

Though [recent research](#) suggests mitigation strategies aimed to limit SARS-COV-2 transmission may potentially decrease influenza activity this season, both viruses will be circulating in our community in the coming months. Where clinically indicated, we recommend patients be tested for both COVID-19 and influenza. Some of the symptoms of flu and COVID-19 are [similar](#), making it hard to tell the difference between them based on symptoms alone. Diagnostic testing can help make this distinction and detect if a co-infection has occurred, though health experts are still studying how common this can be. For patients with respiratory illness, please consider influenza infection, SARS-COV-2 infection, or a co-infection. The CDC has [released a list](#) of multiplex assays authorized for simultaneous detection of influenza and COVID-19, though our County of Santa Cruz Health Services Agency (HSA) Lab has not received one of these tests at this time. Additional review of the Center of Disease Control and Prevention's (CDC) recent flu testing and treatment provider webinars for [adults](#) and [children](#) may also be helpful.

### **INFLUENZA AND OTHER RESPIRATORY VIRUS REPORTING FOR 2020-2021**

This guidance is specific for influenza reporting. For COVID-19 specific information see the [County of Santa Cruz Provider Homepage](#).

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

- Pediatric Deaths from influenza among children age 0-17. If co-infected with COVID-19, both conditions should be reported.
- Deaths from respiratory syncytial virus among children age 0-4. If co-infected with COVID-19, both conditions should be reported.
- Any suspected case of novel influenza
- Outbreaks of influenza or acute respiratory illness occurring in institutions or congregate settings. For COVID-19 outbreak information see [CDPH Guidance](#).
- Outbreaks assessed as having public health importance (e.g. case[s] that have recent exposure to swine, recent travel to an area where novel influenza is circulating or contact with a confirmed case of novel influenza). For COVID-19 outbreak information see [CDPH Guidance](#).

Similar to the 2019-2020 influenza season, the following situations are **not reportable: Intensive Care Unit (ICU) hospitalizations** of persons with influenza or influenza **deaths among adults** age 18 and up.

### **HEALTH CARE WORKER VACCINATION ORDER**

On September 14, County of Santa Cruz Health Officer Dr. Gail Newel 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](#).

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. According to the CDC, 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 who do not have contraindications**, regardless of risk group or vaccine type. During the COVID-19 pandemic, reducing the overall burden of respiratory illnesses is important to protect vulnerable populations at risk for severe illness and to protect the healthcare system from becoming overwhelmed. For guidance on safely administering vaccines during the pandemic, please visit the [CDC site](#). **For those who have acute illness with suspected or laboratory-confirmed COVID-19, clinicians can consider delaying influenza vaccination until the patients are no longer ill.** Additionally, a prior infection with suspected or confirmed COVID-19 or flu does not protect someone from future flu infections. The best way to prevent seasonal flu is to get vaccinated every year.



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As long as flu viruses are circulating in the community, it's not too late to vaccinate your patients. However, CDC and the Advisory Committee on Immunization Practices (ACIP) recommend adults and children (including those 6 months to 8 years of age who need two doses) receive their influenza vaccinations by the end of October. Where vaccine supply is limited, emphasis should be placed on vaccination of [high-risk groups and their contacts/caregivers](#). However, [CDC has announced](#) manufacturers project they will provide as many as 194-198 million doses of flu vaccine, which is more than the doses provided in the 2019-2020 flu season.

For a complete list of recommendations and vaccine products for 2020-21, refer to this [table](#). Please note that the U.S. Food and Drug Administration (FDA) approved a change in dose volume, age requirements, and availability for Fluzone Quadrivalent and Afluria Quadrivalent, which is noted in the footnotes of the table. For a summary of contraindications and precautions for the use of influenza vaccines, refer to this [table](#).

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 quadrivalent formulation with the exception of MF59-adjuvanted IIV, which will be available in both quadrivalent and trivalent formulations. There is no preferential recommendation for trivalent versus quadrivalent vaccine; either is acceptable. However, all regular-dose flu shots and recombinant vaccines will be quadrivalent this season.

There are two new vaccine licensures—Fluzone High-Dose Quadrivalent (HD-IIV4) and Flud Quadrivalent (allv4) expected to be available this season. Both are approved for use in persons aged > 65 years.

Per [CDC's 2020-21 ACIP recommendations](#), **individuals aged 6 months and up should receive any of the licensed, recommended influenza vaccine (IIV, LAIV nasal spray, or RIV) that is appropriate for their age and health status.** The selected vaccine should be administered in an inpatient or outpatient medical setting (i.e. clinics, physician offices). For those who have acute illness with suspected or laboratory-confirmed COVID-19, clinicians can consider delaying influenza vaccination until the patients are no longer acutely ill. If influenza vaccination is delayed, patients should be reminded to return for influenza vaccination once they have recovered from their acute illness.

For additional information on vaccination recommendations, commonly asked questions, and resources, please visit CDC's [website](#).

## **TREATMENT**

While COVID-19 and influenza are both circulating, empiric antiviral treatment of influenza is recommended as soon as possible for the following priority groups: hospitalized patients with respiratory illness, outpatients with severe progressive respiratory illness, and outpatients at [high risk](#) for [complications](#) who present with acute respiratory illness. Note that dexamethasone treatment for severe COVID-19 may prolong influenza viral replication.

Treatment with antivirals works best within 48 hours of illness onset and has been proven to prevent serious flu complications. For hospitalized patients with suspected or confirmed influenza, initiation of antiviral treatment with oral or enterically-administered oseltamivir is recommended as soon as possible.

While annual influenza vaccination is the best way to prevent influenza, antiviral medication can be considered for chemoprophylaxis to prevent influenza in certain situations. However, CDC does not recommend widespread or routine use of antiviral medications for prophylaxis, in order 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



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- 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

More information about treatment options can be found on [CDC's Antiviral Medication: Summary for Clinicians](#) or the [Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza Guidelines](#).

### **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, in patients linked to a congregate setting, in patients connected to an outbreak, or in ruling out a COVID-19 infection. Rapid influenza diagnostic tests (RIDTs) may be used to help with diagnosis in the outpatient setting; 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/index.htm>.

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

Specimen Collection Instructions for RT-PCR to send to the Health Services Agency 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 should also be obtained; 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)