2018-2019 Influenza Update

Karen Martin, MPH – Influenza Surveillance
Mary Ellen Bennett, MPH, RN, CIC – Infection Control
Jennifer Heath, DNP, MPH, RN – Vaccination
Michelle Dittrich, MPH- FluSafe
• Activity Update
• Infection Control Measures
• Influenza Vaccination
• FluSafe
• Antiviral Medications
Influenza Activity Update

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Minnesota Influenza Geographic Spread

During the week ending January 19, 2019 (Week 3), surveillance indicators showed widespread geographic spread of influenza (based on CDC’s Activity Estimates Definitions).

Since the start of the influenza season, no pediatric influenza-related deaths have been reported.

Minnesota Influenza Surveillance (http://www.health.state.mn.us/divs/idepc/diseases/flu/stats/)
World Health Organization (WHO) Surveillance (http://www.who.int/influenza/surveillance_monitoring/updates/en/)

Neighboring states’ influenza information:
Iowa: Iowa Flu Reports (http://idph.idph.iowa.gov/influenza/reports)
Wisconsin: Influenza (Flu) (http://www.dhs.wisconsin.gov/communicable/influenza/)
North Dakota: Reported Seasonal Influenza Activity in North Dakota (http://www.ndflu.com/default.aspx)
South Dakota: South Dakota Influenza Information (http://doh.sd.gov/diseases/infectious/flu/)
Hospitalized Influenza Surveillance

Hospitalized influenza cases are based on disease reports of laboratory-positive influenza (via DFA, IFA, viral culture, EIA, rapid test, paired serological tests or RT-PCR) and specimens from hospitalized patients with acute respiratory illness submitted to MDH-PHL by hospitals and laboratories. Due to the need to confirm reports and reporting delays, consider current week data preliminary.

### Hospitalized Influenza Cases by Type

#### Minnesota (FluSurv-NET*)

- B (no genotype)
- B (Yamagata)
- B (Victoria)
- A (not subtyped)
- A H3
- A H1 (unspecified)
- A (H1N1)pdm09
- A (H1N2v)
- A (H3N2v)
- A&B
- Unknown

#### Hospitalized Influenza Cases by Season, Minnesota (FluSurv-NET*)

<table>
<thead>
<tr>
<th>Season</th>
<th>Total hospitalizations (historic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2014</td>
<td>1,578</td>
</tr>
<tr>
<td>2014-2015</td>
<td>4,081</td>
</tr>
<tr>
<td>2015-2016</td>
<td>1,538</td>
</tr>
<tr>
<td>2016-2017</td>
<td>3,695</td>
</tr>
<tr>
<td>2017-2018</td>
<td>6,446</td>
</tr>
<tr>
<td>2018-2019</td>
<td>271 (to date)</td>
</tr>
</tbody>
</table>

*Influenza Surveillance Network*
Number of Influenza Hospitalizations and Incidence by Region, Minnesota September 30, 2018 – January 19, 2019

<table>
<thead>
<tr>
<th>Region</th>
<th>Hospitalizations this week</th>
<th>Total (to date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>3 (10%)</td>
<td>28 (10%)</td>
</tr>
<tr>
<td>Metro</td>
<td>13 (42%)</td>
<td>164 (61%)</td>
</tr>
<tr>
<td>Northeast</td>
<td>0 (0%)</td>
<td>12 (4%)</td>
</tr>
<tr>
<td>Northwest</td>
<td>1 (3%)</td>
<td>6 (2%)</td>
</tr>
<tr>
<td>South Central</td>
<td>5 (16%)</td>
<td>14 (5%)</td>
</tr>
<tr>
<td>Southeast</td>
<td>4 (13%)</td>
<td>30 (12%)</td>
</tr>
<tr>
<td>Southwest</td>
<td>3 (10%)</td>
<td>8 (3%)</td>
</tr>
<tr>
<td>West Central</td>
<td>2 (6%)</td>
<td>9 (3%)</td>
</tr>
</tbody>
</table>

Median age (years) at time of admission

60.0
Influenza-Associated Death Surveillance

Influenza deaths are collected via reports from Minnesota’s death certificate database, hospitals, and long-term care facilities. Decedents with influenza listed as a cause of or contributor to death, have recent laboratory confirmation of influenza, or are part of an ongoing influenza outbreak at a long-term care facility are reported to influenza surveillance. **Due to the need to confirm reports and reporting delays, consider current week data preliminary.**

Deaths Associated with Influenza by Season, Minnesota

<table>
<thead>
<tr>
<th>Season</th>
<th>Total deaths (historic)</th>
<th>Total pediatric (&lt;18 years) deaths (historic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2014</td>
<td>83</td>
<td>2</td>
</tr>
<tr>
<td>2014-2015</td>
<td>368</td>
<td>10</td>
</tr>
<tr>
<td>2015-2016</td>
<td>76</td>
<td>3</td>
</tr>
<tr>
<td>2016-2017</td>
<td>273</td>
<td>2</td>
</tr>
<tr>
<td>2017-2018</td>
<td>435</td>
<td>5</td>
</tr>
<tr>
<td>2018-2019</td>
<td>10 (to date)</td>
<td>0 (to date)</td>
</tr>
</tbody>
</table>

*Influenza Surveillance Network*
Long-Term Care (LTC) Outbreaks

LTC facilities report to MDH when they suspect an outbreak of influenza in their facility. Laboratory-confirmed outbreaks are reported here.

<table>
<thead>
<tr>
<th>Weekly Outbreaks</th>
<th>New LTC outbreaks this week</th>
<th>New LTC outbreaks last week</th>
<th>Total this season (to date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>24</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>2014-15</td>
<td>35</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>2015-16</td>
<td>26</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>2016-17</td>
<td>32</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>2017-18</td>
<td>30</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Confirmed Influenza Outbreaks in LTC by Season

Current week
Laboratory Surveillance

The MN Lab System (MLS) Laboratory Influenza Surveillance Program is made up of more than 310 clinic- and hospital-based laboratories, voluntarily submitting testing data weekly. These laboratories perform rapid testing for influenza and Respiratory Syncytial Virus (RSV). Significantly fewer labs perform PCR testing for influenza and three also perform PCR testing for other respiratory viruses. MDH-PHL provides further characterization of submitted influenza isolates to determine the hemagglutinin serotype to indicate vaccine coverage. Tracking the laboratory results assists healthcare providers with patient diagnosis of influenza-like illness and provides an indicator of the progression of the influenza season as well as prevalence of disease in the community.

Specimens Positive for Influenza by Molecular Testing*, by Week

<table>
<thead>
<tr>
<th>MMWR Week</th>
<th>% molecular tests positive this week</th>
<th>% molecular tests positive last week</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>11.3%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

* Beginning in 2016-17, laboratories report results for rapid molecular influenza tests in addition to RT-PCR results.
Specimens Positive by Influenza Rapid Antigen Test, by Week

Region | % rapid antigen influenza tests + (current week)
--- | ---
Northeast | 19%
South Central | 9%
Southwest | 33%
Southeast | 20%
Metro | 9%
Central | 18%
West Central | 10%
Northwest | 27%
State (overall) | 17%

Specimens Positive by RSV Rapid Antigen Test, by Week

Region | % rapid antigen RSV tests + (current week)
--- | ---
Northeast | 30%
South Central | 43%
Southwest | 41%
Southeast | 33%
Metro | 35%
Central | 20%
West Central | 25%
Northwest | 17%
State (overall) | 32%
Surveillance for respiratory syncytial virus (RSV) began in September 2016. Hospitalized inpatients of all ages who reside in the 7-county Twin Cities metropolitan area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington) with laboratory-confirmed RSV are reportable. Due to the need to confirm reports and reporting delays, consider current week data preliminary.

### Hospitalized RSV Cases by Subtype, Minnesota

<table>
<thead>
<tr>
<th>MMWR Week</th>
<th>Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NA</td>
</tr>
</tbody>
</table>

### Number of RSV Hospitalizations and Incidence by Age, Minnesota

<table>
<thead>
<tr>
<th>Age Group (years)</th>
<th>Number of Hospitalizations</th>
<th>Incidence (cases) per 100,000 Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;2</td>
<td>254.3</td>
<td></td>
</tr>
<tr>
<td>2-4</td>
<td>25.0</td>
<td></td>
</tr>
<tr>
<td>5-17</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>18-49</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>50-64</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>65+</td>
<td>5.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Median age at time of admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 months</td>
</tr>
</tbody>
</table>
Identifying and Reporting Influenza Outbreaks

• **Identifying an Outbreak**

  Outbreak definition: at least two residents with onset of influenza-like illnesses within 72 hours of each other AND at least one resident has laboratory-confirmed influenza.

• **Reporting an Outbreak to MDH**

  Submit a Long-Term Care Facility Influenza and RSV Report Form, 2018-19 ([www.health.state.mn.us/divs/idepc/diseases/flu/ltc/ltrechtreport.pdf](http://www.health.state.mn.us/divs/idepc/diseases/flu/ltc/ltrechtreport.pdf)) to MDH by email or fax when an influenza outbreak is identified in your LTC facility. Please call 651-201-5924 if you have questions regarding reporting or influenza outbreak control measures.
Sign Up for Weekly Influenza Updates

Influenza Infection Prevention – ICAR Program

Mary Ellen Bennett

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Infection Prevention

• Influenza characteristics
• Surveillance
• Isolation
• Prevention
• Tools for management
• References
Influenza Characteristics
Influenza in Elderly Persons

Disease Presentation

• Influenza-like illness (ILI) in elderly persons may be atypical
• New onset of cough, sore throat, nasal congestion or rhinorrhea, or a temperature 100° F or greater; however, fever may be absent
• Atypical complaints: anorexia, mental status changes, and unexplained fever may be the presenting symptoms

Disease Presentation in General Population

• Fever or feeling feverish/chills, cough, sore throat, runny or stuffy nose, muscle or body aches, headaches, fatigue (tiredness)
Influenza in Elderly Persons

Complications:

• Worsening respiratory status: (residents with COPD or CHF)
• Primary viral pneumonia and bacterial suprainfection (leading to tracheobronchitis or pneumonia)

Transmission

• Large respiratory droplets (particles >5 µ in diameter) expelled from resp. tract
• Close contact (< 3 feet) usually is required for transmission
• Direct contact with respiratory droplets or secretions
• Touching the nose or mouth
Influenza in Elderly Persons

Incubation

• 1 to 4 days, usually 2 days

Contagiousness (or Infectious Period)

• 24 hours prior to onset of illness to at least 5 days after onset of symptoms
• Immunocompromised shed virus for 7 days or more after onset of symptoms

Duration

• 1-2 weeks with severe symptoms in the first few days
Surveillance
Surveillance for Influenza & ILI in LTC Facilities

• Residents are monitored for illness on a routine basis
• Clusters of illness or infection can be detected by this type of monitoring
• A log of illnesses and infection is kept by nursing staff
• Influenza and influenza like illness can be kept on the routine tracking forms or the facility can use a special influenza tracking form from MDH
### Infection and Antibiotic Use Tracking Tool (Appendix L)

**Tracking Tool**

http://www.health.state.mn.us/divs/idepc/dtopics/antibioticresistance/hcp/asp/ltc/index.html
Influenza-like Illness (ILI) Line List:

For Long-Term Care Facilities

Use this 2-page form to collect data. Complete both pages for each resident with ILI.

<table>
<thead>
<tr>
<th>Name</th>
<th>Room No.</th>
<th>Age</th>
<th>Sex (M/F)</th>
<th>Influenza</th>
<th>Pneumococcal</th>
<th>Onset Date of ILI Symptoms</th>
<th>Duration (days)</th>
<th>Highest Temp</th>
<th>Symptoms (Y/N/U)</th>
<th>Lab Results</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>myalgia</td>
<td>headache</td>
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<td>1.</td>
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<td>9.</td>
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<td>10.</td>
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</tbody>
</table>
Isolation for Influenza and Influenza Like Illness (ILI)
The diagnosis of many infections is based on clinical signs and symptoms, but often requires laboratory confirmation. However, since laboratory tests (especially those that depend on culture techniques) may require two or more days to complete, transmission-based precautions may need to be implemented.

........ a resident with influenza and signs of infection should wear a facemask (e.g., surgical or procedure facemask) when leaving his/her room for medically-necessary care (i.e., droplet precautions for the duration of the illness).
Standard and Droplet Precautions

• Standard precautions: use for all patients
• Droplet precautions: use with standard precautions for residents with known or suspected influenza or influenza-like illness
• Precautions should be in place for the duration of the symptoms of illness
  o Best to have a private room if available – can cohort ill persons
  o Signage
  o Procedure mask: correct don/doff procedure
  o Care of patient care equipment – clean all equipment going in and out with a EPA registered disinfectant
  o Hand hygiene

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
• Clearly identify the type of precautions and the appropriate PPE to be used;
• Place signage in a conspicuous place outside the resident’s room such as the door or on the wall next to the doorway identifying the CDC category of transmission-based precautions (e.g. contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. Ensure that signage also complies with residents’ rights to confidentiality and privacy;
• Make PPE readily available near the entrance to the resident’s room;
• Don appropriate PPE upon entry into the environment (e.g., room or cubicle) of resident on transmission-based precautions;

State Operations Manual, Appendix PP – Guidance to Surveyors 11-22-2017 see pages 673-714 for Infection Control
Enforce Correct Mask Use

- Hand hygiene before and after touching (masks are contaminated)
- Follow instructions for donning and removal by type of mask (i.e., ear loops, ties)
- Do not wear around the neck, on an ear, on top of the head, or re-use between residents
- Provide easy access to masks, alcohol hand sanitizer, and waste receptacles

How to put on a face mask

1. **Clean your hands** with soap and water or hand sanitizer before touching the mask.
2. Remove a mask from the box and make sure there are no obvious tears or holes in either side of the mask.
3. Determine which side of the mask is the top. The side of the mask that has a stiff bendable edge is the top and is meant to mold to the shape of your nose.
4. Determine which side of the mask is the front. The colored side of the mask is usually the front and should face away from you, while the white side touches your face.
5. Follow the instructions below for the type of mask you are using.

*Face Mask with Ear loops:* Hold the mask by the ear loops. Place a loop around each ear.

*Face Mask with Ties:* Bring the mask to your nose level and place the ties over the crown of your head and secure with a bow.

*Face Mask with Bands:* Hold the mask in your hand with the nosepiece or top of the mask at fingertips, allowing the headbands to hang freely below hands. Bring the mask to your nose level and pull the top strap over your head so that it rests over the crown of your head. Pull the bottom strap over your head so that it rests at the nape of your neck.

6. Mold or pinch the stiff edge to the shape of your nose.
7. If using a face mask with ties: Then take the bottom ties, one in each hand, and secure with a bow at the nape of your neck.
8. Pull the bottom of the mask over your mouth and chin.
Prevention
Employee Illness

- Offer vaccination to all employees throughout the season
- Vaccinate new employees who start during the season
- Staff should know the symptoms of influenza so they can recognize it in themselves and the residents
- Enforce staff not working when they are sick
- Staff should know that they can be infectious 1 day before they exhibit classic symptoms of influenza
- Encourage staff to notify managers if they do develop an influenza like illness
Visitors Entering the Facility

- Post signs at entry to restrict ill visitors
- Publish visitor restriction notices to the local community
- Limit visitor movement in facility
- Alcohol hand rubs at entry with signage
- Cover your cough signs
- Encourage visitors to get a flu shot
Visiting the Ill Resident

- Limit visiting to persons necessary for the resident’s well-being and care
- Hand hygiene before entering, after leaving the resident’s room
- Instruct visitors how to wear and dispose of PPE as per facility policy
- Instruct visitors to not visit other residents before removing PPE (if worn) and perform hand hygiene
Visiting Restrictions

- Stronger measures can be implemented at the digression of the facility during an influenza outbreak

- For instance
  - Alerting visitors about the outbreak
  - Restricting visiting for children
  - Screening all visitors for illness before visiting
Tools
Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities

- Before an Outbreak Occurs
- Identifying an Outbreak
- Reporting an Outbreak to MDH
- Testing
- Monitor
- Control
- Additional Control Measures to Consider
- Treatment
- Chemoprophylaxis

Example of a transmission based precaution isolation sign

Do not put resident’s name on the sign

Note: *MDH does not endorse any particular sign*
References

• MDH
  www.mdhflu.com

• CDC
  www.cdc.gov/flu/

• Minnesota Immunization Information Connection (MIIC)
  http://www.health.state.mn.us/miic
Influenza Vaccine

Jennifer Heath

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651-201-5591
Storage and Handling of Flu Vaccine

- Maintenance of temperature is critical to the vaccine’s viability and effectiveness
  - Loss of inventory, thousands of dollars even with a modest amount of vaccine

- Colder is not better
  - Especially vulnerable to freezing temperatures
  - CDC’s guidance recently changed, ideal temperature is 40F or 4.4C

- Temperature monitoring
  - Several options for monitoring
  - Temps recorded by a human twice per day

- Utilize MDH’s resources linked in the Fall Flu Guide.
Vaccine Storage Guide

**Proper REFRIGERATOR Temperatures**

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, Diphtheria, Pertussis, Polio</td>
<td>2-8°C</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>2-8°C</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>2-8°C</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>2-8°C</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella, Varicella (Combined vaccine)</td>
<td>2-8°C</td>
</tr>
</tbody>
</table>

**Proper FREEZER Temperatures**

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles, Mumps, Rubella, Varicella (Combined vaccine)</td>
<td>-20°C</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella, Varicella (Combined vaccine)</td>
<td>-20°C</td>
</tr>
</tbody>
</table>

**Proper Set-Up**

- **Refrigerator-only unit**
  - Store vaccines in the upper doors of the refrigerator.
  - Keep vaccines in the lower doors of the refrigerator.
- **Freezer-only unit**
  - Store vaccines in the upper shelves of the freezer.
  - Keep vaccines in the lower shelves of the freezer.
- **Combination refrigerator/freezer unit**
  - Store vaccines in the upper shelves of the refrigerator.
  - Keep vaccines in the lower shelves of the refrigerator.

**Inventory management**

- Ensure each vaccine is properly stored and monitored.
- Use a vaccine management system.

**Store vaccine correctly**

- Store vaccines in their original packaging.
- Keep vaccines in a cool, dry place.

**Monitor temperatures**

- Use a temperature monitoring device to monitor vaccine temperatures.
- Record temperature readings at least once a day.

**Take action on out-of-range temperatures**

- If the temperature exceeds the recommended range, immediately report and take necessary action.
- Contact the vaccine manufacturer for guidance.
- Discontinue use of the vaccine.

**For additional resources, contact:**

- Vaccine Information Program
- Local public health department
- State health department
Vaccination of Residents

• Continue to vaccinate
  • Vaccine protects against 3 or 4 strains
  • Second doses not recommended
  • Standard, high-dose, or adjuvanted—no preference

• Be mindful of proper administration techniques
  • Frail patients may require “bunching” or a shorter needle length for IM administration
  • Obese patients may require a longer needle length

• Use the Minnesota Immunization Information Connection (MIIC)
  • http://www.health.state.mn.us/miic
Vaccination of HCP

• Continue to vaccinate
  • New employees, former decliners
  • If you cannot provide vaccine refer employees to other sources: pharmacy, clinic, community vaccinator
  • Un and underinsured adult vaccine program: http://www.health.state.mn.us/divs/idepc/immunize/adultvax/clinicsearch.html

• Consider your educational resources
  • Tailor to a lay audience
  • Seek out translations (or interpreters)– even if proficient in English

• Use the Minnesota Immunization Information Connection (MIIC)
  • http://www.health.state.mn.us/miic
• Establish a culture of prevention in your organization

• Encourage employees via e-mail, posters, an employee newsletter and other communication tools to get the vaccine by reminding them their decision sets an example and protects them, their loved ones, and their patients:
  • Communicating the Benefits of Seasonal Influenza Vaccine
  • CDC's Flu Prevention Promotional Materials

• Track and report vaccination rates to staff and supervisors

• Remind unvaccinated employees with e-mail, letters, encouragement from supervisors, and telephone calls—really bug them!

• Vaccinate the medical director and all managers in front of the staff
ALL HEALTHCARE WORKERS NEED FLU VACCINES

VACCINATING HEALTHCARE WORKERS

REDUCES
FLU AMONG WORKERS

REDUCES
WORK ABSENCES

PROTECTS
PATIENTS

3 OF 4 HEALTHCARE WORKERS GET FLU VACCINES

HIGHEST WHEN
EMPLOYER REQUIRED VACCINE OR GAVE ONSITE

LOWEST FOR
LONG-TERM CARE WORKERS

WORKPLACE STRATEGIES CAN HELP!

PROMOTE
ON-SITE VACCINATION

OFFER
LOW OR NO COST VACCINES

REMEMBER
NON-CLINICAL STAFF
I won’t spread flu to my patients or my family.

Even healthy people can get the flu, and it can be serious.
Everyone 6 months and older should get a flu vaccine. This means you.
This season, protect yourself—and those around you—by getting a flu vaccine.

For more information, visit [http://www.cdc.gov/flu](http://www.cdc.gov/flu).
HCP as the adult population

• Re-frame Efficacy
  • Preventing disability, severe illness and death

• Protect themselves
  • High risk conditions are common
  • Missing work is inconvenient

• Protect their families (and patients!)
  • Children and spouses
• Health literacy can negatively impact a person’s decision to get vaccine (especially for adults)
  • Don’t strive to make it simple, make it understood

• Distribute/utilize materials from the HHS National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

• Provide educational materials in multiple languages, including
  • CDC’s Vaccine Information Statements
  • MedlinePlus: Flu - Multiple Languages
Finding the Flu and Vaccine Materials

Influenza (Flu)

- **Vaccine Clinic Look-Up**
  Find a flu vaccine clinic near you.

- **Influenza Basics**
  General information about flu, including symptoms, complications, vaccines, and treatment.

- **Influenza Statistics**
  Weekly reports of disease statistics, including the type and severity of disease in Minnesota.

- **For Health Professionals**
  Information specific to health care providers regarding specimen collection, submission, and treatment for flu.

Related Topics
- Enterovirus
- Immunization
- Cover Your Cough
- Infectious Diseases A-Z
- Infectious Diseases by

**Flu.gov**
Flu.gov will be retired soon.

Translated Materials

Spotlight
Order Influenza Immunization Materials

FluSafe
Health care worker flu vaccination program.

Attention: Non-MDH link
If you have questions or comments about this page, use our IDEA Comment Form or call 651-201-5414 @ for the MDH Infectious Disease Epidemiology, Prevention and Control Division.
Influenza Vaccine Information For Health Professionals

Get an email alert when there are major additions or updates for Health Professionals on influenza.

2018-19 Minnesota Fall Flu Guide (PDF)
Summary of the 2018-19 influenza vaccination recommendations.
Updated 9/2018

- **MMWR: Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, 2018-19 Influenza Season**

- **Influenza Vaccine Administration**
  All about the influenza vaccines: VIIs, storage and handling, package inserts, dosing charts, protocols, and administration.

- **Storage and Handling**
  Guidelines to ensure that patients receive viable vaccine and that valuable doses of vaccine don’t go to waste because of improper storage and handling.

**Spotlight**

- Subscribe to Influenza Information for Health Professionals
  Get an email alert when there are major additions or updates of Influenza Information for health professionals.

**FluSafe**
Health care worker flu vaccination program.

**Weekly Influenza Activity**
The statistics page has information on occurrence of influenza in Minnesota.

**Seasonal Influenza Vaccination Resources for Health Professionals**
Attention: Non-MDH link

If you have questions or comments about this page, use our MDH Feedback Form or call 1-800-544-4444 for the MDH Infectious Disease Epidemiology, Prevention and Control Division.
FluSafe Update

Michelle Dittrich

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651-201-4567
Recognition Changes

• 90% coverage and above

• Select and report on barrier to HCP vaccination

http://www.health.state.mn.us/divs/idepc/diseases/flu/vaccine/vaxhcw/index.html
<table>
<thead>
<tr>
<th>2018-19 FluSafe Activities</th>
<th>Due by Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities register and select barrier to address</td>
<td>November 30, 2018</td>
</tr>
<tr>
<td>Facilities work to address selected barrier and track vaccinations in MIIC</td>
<td>October 2018- March 2019</td>
</tr>
<tr>
<td>Facilities finish tracking vaccinations for FluSafe</td>
<td>March 31, 2019</td>
</tr>
<tr>
<td>Facilities upload final FluSafe spreadsheets into MIIC</td>
<td>April 12, 2019</td>
</tr>
<tr>
<td>MDH sends rate confirmation survey</td>
<td>May 10, 2019</td>
</tr>
<tr>
<td>Facilities confirm rates and report on selected barrier</td>
<td>May 30, 2019</td>
</tr>
<tr>
<td>MDH publically recognizes facilities with confirmed rates ≥ 90% and reported work to address selected barrier</td>
<td>Fall 2019</td>
</tr>
<tr>
<td>MDH sends FluSafe 2018-19 program evaluation</td>
<td>Fall 2019</td>
</tr>
</tbody>
</table>
2018-2019 Enrollment

149 facilities
- 77 hospital
- 72 nursing homes
Direct questions to FluSafe inbox:
health.flusafe@state.mn.us
Antiviral Medications for the 2018-2019 Season

• Antiviral medications reduce illness and severe outcomes of influenza based on evidence from randomized controlled trials, meta-analyses of randomized controlled trials, and observational studies.  
  https://www.cdc.gov/flu/professionals/antivirals/index.htm

• Four FDA-approved influenza antiviral drugs recommended by CDC this season to treat influenza:
  • oseltamivir (available as a generic version or under the trade name Tamiflu®),
  • zanamivir (trade name Relenza®), and
  • peramivir (trade name Rapivab®)
  • Baloxavir (trade name Xofluza®).

• Oseltamivir (Tamiflu®) is the most common antiviral used in LTC facilities.
  • Circulating strains are sensitive to oseltamivir at this time.
Antiviral Shortage?

• Manufacturers report being able to meet expected demand of season

• No supply shortage, but temporary spot shortages have been reported in parts of the country

• CDC recommends
  • Call pharmacy in advance
  • Call multiple pharmacies if needed
  • Remember to ask for generic and brand-name oseltamivir
CDC Antiviral Recommendations for LTC and Assisted Living

- Can be difficult logistically and financially
- Severe season underscores need for treatment/chemoprophylaxis
- Priority groups specified if not implementing chemoprophylaxis for entire facility
Treatment with Antiviral Medications

• Treat residents with confirmed or suspected influenza with antivirals immediately.
  • Treatment should not wait for laboratory confirmation of flu.

• Antiviral treatment works best when started within the first 2 days of symptoms, but can be beneficial after that period.

• Dosing: oseltamivir (Tamiflu®) antiviral treatment is typically 75 mg twice daily for 5 days.
  • Longer treatment courses for patients who remain severely ill after 5 days of treatment can be considered.
  • Always consult the resident’s physician for dosing guidance.
  • Patients with renal impairment may require lower doses.
Chemoprophylaxis with Antiviral Medications

• All eligible well residents in affected wards should promptly receive antiviral chemoprophylaxis as soon as an influenza outbreak is determined.
  • Priority should be given to residents living in the same ward/unit as ill resident(s).
  • Assess risk of transmission to other wards/units
  • At minimum, do active surveillance in all wards/units
  • Once transmission is detected outside of initial ward/unit, consider facility-wide chemoprophylaxis

• Dosing: In the LTC facility setting, oseltamivir (Tamiflu®) antiviral chemoprophylaxis is typically 75 mg once daily for a minimum of 14 days, continuing for 7 days after the last known case was identified.
  • Always consult the resident’s physician for dosing guidance.
  • Patients with renal impairment may require lower doses.

• Consider offering prophylaxis to staff in the facility. Alternatively, have staff contact their primary care provider to discuss prophylaxis.
Resources

CDC

https://www.cdc.gov/flu/professionals/antivirals/index.htm

IDSA


MDH

http://www.health.state.mn.us/divs/idepc/diseases/flu/lc/index.html
Questions?