

Ministry of Health and Long-Term Care

Quick Reference: May 19th Updates to H1N1 Flu Virus Guidance Documents

The purpose of this document is to highlight the major changes or updates to advice provided in the MOHLTC guidance documents for the H1N1 influenza virus dated May 19, 2009. Guidance documents will continue to be updated as new information becomes available. Please note that the majority of changes here are common to all settings, but you should consult the guidance specific to your own setting for full recommendations.

Evidence to date indicates that in many ways the novel H1N1 influenza virus has characteristics similar to a seasonal influenza. However, as it is still a novel strain with pandemic potential, current clinical recommendations are not identical to recommendations for seasonal flu, and may change as the situation evolves.

1) Clinical Case Description

The requirement for a travel history has been removed from the case description, and therefore also from the screening tools. Additional information has also been provided on the symptoms of ILI.

Symptoms of ILI are currently defined as acute onset of respiratory illness with fever and cough **and** with one or more of a range of additional symptoms such as myalgia, sore throat, arthralgia, prostration and, in children, gastrointestinal symptoms.

Why was this change made?

We are now seeing the novel H1N1 influenza virus being transmitted from person to person in the community. It is the predominant strain of Influenza A circulating at this time. Travel history can no longer accurately predict who is infected with the novel H1N1 strain. Changes to the description of symptoms are in alignment with guidance from the national level and reflect evolving epidemiology.

2) Screening

Screening processes for ambulatory settings have been clarified.

The recommended measures have been divided into categories of passive and active screening. Passive screening usually involves signage at a facility. Active screening involves someone asking the patient about symptoms.

Why was this change made?

Questions were raised based on previous guideline documents regarding passive vs. active screening in these settings. As outlined in previous guidelines, in addition to the signage promoting self-screening, **active** screening measures should include triaging people by phone when they book an appointment or asking screening questions when patients present at reception. It should be noted that there is no indication for dedicated personnel to conduct screening at the point of entry into a facility.

3) Lab Testing

Changes have been made to recommendations for laboratory testing for the H1N1 influenza virus.

- Specimens from asymptomatic patients will not be tested
- In **Ambulatory Settings**, testing patients who have mild illness is not recommended. If a clinician feels that the severity of the clinical presentation or other unique circumstances that may impact patient management requires a test, a nasopharyngeal (NP) swab should be done.
- In **Emergency Department Settings**, testing is recommended on patients with influenza-like illness (ILI) if the patient presents with moderate to severe disease, or if in the clinical judgement of the clinician a test is required (i.e. for patients

at high risk for complications of ILI due to co-morbid conditions). Identification of moderate to severe disease is based on the clinician's judgement, and may include features such as abnormalities in a vital sign other than temperature.

- **In Emergency Department Settings**, the following specimens for patients are no longer required:
 - a. Bronchoalveolar lavage specimen
 - b. stool if symptoms include diarrhea
- **In Long-Term Care Settings**, residents who present with ILI symptoms should have a NP swab performed

Why was this change made?

Testing for influenza in patients with ILI may be carried out for either clinical management or surveillance purposes. Regarding clinical management, it is important to note that laboratory confirmation does not change the strategy for managing most patients with ILI whether it is seasonal influenza or H1N1 influenza.

With the novel H1N1 strain becoming one of the predominant circulating strains, the value of the surveillance information provided by laboratory testing is diminished. Sentinel physicians will continue to obtain NP swabs on patients who meet the definition of ILI for surveillance purposes.

4) Personal Protective Equipment

Additional detail has been provided regarding the use of personal protective equipment (PPE), including specific recommendations for reception staff in ambulatory settings.

Since travel history can no longer accurately predict who is infected with the novel H1N1 influenza virus, the following should be used by healthcare workers when within 2 metres of caring for **all** patients with ILI:

- Routine Practices including gown and gloves if widespread contamination with respiratory secretions and hand hygiene, and
- A fit tested N95 respirator and eye protection.

This includes reception staff in ambulatory settings if no physical barrier or 2 metre distance from patients is possible. If N95 respirators supplies have been depleted, healthcare workers should don a surgical mask, and wherever possible, the patient

should remain masked (with a surgical mask) as well. N95 respirator and PPE use by healthcare workers should be prioritized as recommended in chapter 7 of the Ontario Health Plan for an Influenza Pandemic. In patients who do not present with fever and cough, Routine Practices should be followed.

Why was this change made?

In making recommendations regarding PPE, Ontario is currently following the Precautionary Principle, which states that if the scientific evidence about the level of protection needed is unclear, then the higher level of protection should be recommended. While this strain is behaving much like a seasonal flu, it has only been circulating a short time, and may still have pandemic potential. Due to this, and to scientific debate about potential airborne transmission of influenza, we are recommending a higher level of precaution than for seasonal influenza. Specific guidance regarding reception staff has been provided in response to frequently asked questions through the healthcare providers hotline.

5) Reporting Requirements

Reporting requirements for ambulatory and emergency department settings have been changed.

There is now no requirement for reporting cases of ILI to your local health unit beyond that which is usually required for seasonal influenza.

Why was this change made?

The original goal of the enhanced reporting was to:

- 1) Detect the presence of H1N1 in the community
- 2) Monitor for community spread and ascertain the severity with which the virus was presenting.

Now that community circulation has been confirmed, the regular reporting measures used in seasonal flu are deemed to be sufficient.

6) Self-Isolation and Treatment

Guidance around length of time to self-isolate has been updated.

Recommended period of time to self-isolate is now dependent on the work setting. In general:

- Patients working in a non-healthcare setting should remain off work until they no longer have a fever and are feeling better.

- Patients who work in a healthcare setting should remain off work until 7 days after the onset of their symptoms and they no longer have a fever and are feeling better.

Why was this change made?

Previous guidelines advised self-isolating for 7 days or 24 hours until after all symptoms had resolved. However, it is not unusual for individuals to experience a cough or other minor symptoms for days to weeks after a viral infection, so the symptom criteria have been modified. Health care providers are still advised to wait a specific period of time as a precaution, because they may be working with patients who are at higher risk of complications, and their work usually requires close contact.

Guidelines around treatment have been streamlined in light of the removal of travel history.

Travel history or contact with a confirmed case is no longer required for the priority groups for treatment. Priority groups for treatment with antivirals include those with ILI and at risk for complicated disease. Those assessed as at risk of complicated disease are listed below. Clinical judgment is needed to guide treatment decisions.

- Adults (including pregnant women) and children with the following conditions:
 - Chronic pulmonary (including asthma)
 - Chronic cardiac disorders
 - Diabetes mellitus or other metabolic diseases
 - Renal disease
 - Hematological conditions
 - Immunosuppression (due to underlying disease and/or therapy)
 - Children and adolescents with conditions treated for long periods with acetylsalicylic acid
- Residents of nursing homes and other chronic care facilities
- People ≥65 years of age
- Healthy pregnant women (risk of influenza-related complications increases with increasing length of gestation)
- For guidance re children, see source below

Why was this change made?

Travel history can no longer accurately predict who is infected with the novel H1N1 strain as there is documented community spread in individuals who have not traveled outside Canada.

Additional treatment information has been provided on children and pregnant women.

This includes:

- Recommendations from the Canadian Paediatric Society regarding the use of antivirals in children
- In **Ambulatory and Emergency Department Settings**, additional information on the safety of antivirals for pregnant women
- In **Ambulatory and Emergency Department Settings**, a link to the May 12 recommendations from the CDC on the treatment of pregnant women

Why was this change made?

Additional guidance has become available as the situation evolves and expert discussions continue.