

# Example Strategy for Improving Influenza Specimen Submissions and Data

## Lessons from Louisiana

Provided by Julie Hand

In late summer, early fall, I decided it might be best to plan a trip to different regions of the state to recruit virologic surveillance sites and ILINet providers. We always seem to get better results from in-person meetings, and I hoped that this would help with provider retention. Also, this was the first time we were recruiting hospitals for virologic surveillance. Successful implementation at a hospital involved meeting with multiple departments including: infection control, emergency department, and laboratory. Many larger states have regional staff that can certainly conduct these meetings but for a smaller state like Louisiana I felt it was important to make every effort to do recruitment myself.

Louisiana is divided into 9 public health regions so I asked each surveillance epidemiologist to send a recruitment email out to providers in their respective regions including the [Influenza Surveillance Handbook](#). This [handbook](#) is a general overview of all parts of influenza surveillance in Louisiana. Each epidemiologist used a standard recruitment email, and as responses came in expressing interest in participating in the program, we set up meetings all over the state. Once we had confirmation of interest and meetings scheduled, I provided sites with the more specific [Influenza Virologic Surveillance Handbook](#). I wanted sites to have a chance to review ahead of time if possible since the main focus was to recruit for increased sampling; if they also agreed to send ILINet data that was a bonus!

I made 4 trips to different areas of the state along with the surveillance epidemiologists if they were available. The meetings were not long but I went through each [handbook](#) briefly and laid out the perks of being a surveillance site:

- 1) All sites perform their own rapid testing. We did not want them to do anything different other than do two swabs rather than one. They reported the screening results on the virology test request form (which as a surveillance site was pre-filled for them except for patient information). I keep track of the data and at the end of the season the sites will receive a report back on how the rapid tests perform in the entire state, at their site, and for each manufacturer. For sites that serve populations that can't afford rapid testing, our PCR often provided the only results.
- 2) We did not require an NP swab, but for sites that were doing them we promised RVP results on all flu negative samples. This point did actually convince a couple of sites to change from nasal to NP.
- 3) If a novel event occurred, they would be asked to submit extra samples and those would be placed ahead of other surveillance samples. (This was important to sites, especially the hospitals we recruited, because the 2009 pandemic was still fresh on their minds). When oseltamivir resistance was detected in Louisiana, our sites were very eager to participate in enhanced surveillance. (We will be using the oseltamivir resistance in Louisiana as a point of how important sentinel sites are for the 2014-2015 season.)
- 4) A subset of surveillance samples would be sent to CDC for further testing (antiviral resistance, antigenic characterization). Each site will receive a report back at the end of season for any of their samples tested.

If you are unable to conduct in-person meetings due to budget, staffing, or travel restrictions I think a conference call would also work. I think it's very important to have a detailed handbook which providers can refer back to if they have any questions.