

Partnerships & Communication

It is important that states establish and maintain partnerships and networks among PHLs, clinicians, state epidemiologist/influenza surveillance coordinator, clinical laboratories, RIDT sites, CDC and manufacturers. Many states already have existing partnership and communication networks for both influenza surveillance and other activities such as [Laboratory Response Network \(LRN\)](#) and [APHL's Lab System Improvement Program \(L-SIP\)](#).^{14,17} Professional organizations such as APHL and CSTE provide programmatic and technical support to member states and facilitate communications among CDC, PHLs, and epidemiologists. Improvements to influenza surveillance can be made by leveraging existing partnerships and communication networks for influenza surveillance, LRN and other laboratory-based surveillance activities. For example, contact databases that already exist for LRN can be enhanced to include laboratories that perform influenza testing without creating an entire new system. Many states have established courier services to transport specimens for LRN, newborn screening and other programs. These may be leveraged to improve access to specimens for influenza surveillance. Additional examples related to key partnerships, provided through stakeholder input and pilot site activities, are described below.

Collaboration between Epidemiologists and Laboratorians at the Washington State Department of Health

Every August, epidemiologists and laboratorians at the Washington State Department of Health (DOH) meet in person to discuss virologic surveillance plans for the upcoming influenza season. They discuss criteria for influenza testing at the PHLs, plans for engaging sentinel providers and laboratories and changes to specimen submission instructions. Written instructions for submitting specimens to PHL for influenza testing are revised collaboratively.

Healthcare providers and local health jurisdiction staff who want to submit non-routine specimens for influenza testing, including specimens from patients with suspected novel influenza and those in outbreaks, are asked to contact a DOH influenza epidemiologist prior to submission. The epidemiologist reviews the request and informs the laboratory staff about the estimated arrival time and priority status of the specimens. If critical specimens do not arrive at the PHL by the expected time a laboratorian will contact the submitter to determine the whereabouts of the specimens. This system ensures that epi and lab partners have access to timely information regarding status of high priority specimens.

The most important partnership for effective virologic surveillance is the relationship between the **PHL and epidemiology/influenza coordinators**. Examples of ways to optimize epidemiology-laboratory (epi-lab) partnerships:

- Conduct regular in-person epi-lab meetings to establish seasonal virologic surveillance strategies, determine appropriate sample sizes, allocate funds and regularly assess the effectiveness of the surveillance system.

- Collaborate in grant writing, monitor grant activities, identify and address problems and gaps and coordinate outbreak response.
- Establish consensus protocols for sharing influenza testing data. Examples include releasing laboratory data to a secure portal that epidemiologists can access or providing epidemiologists access to selected views in the laboratory databases.

PHL-Epidemiology-Clinician-Academic Partnerships

- Provide strategic communication from state epidemiologists and PHLs to clinicians and clinical laboratories as needed to increase awareness when targeted surveillance is needed to identify emerging viruses or characterize outbreaks.
- Provide education programs to clinicians, especially on the utility of rapid point of care tests, and provide training on specimen collection, handling and transport to ILINet and other surveillance specimen submitters. Training may be achieved through on-site presentations, teleconferences, mailings, and on-line training courses.
 - The Joint Commission [Strategies for Improving Rapid Influenza Testing in Ambulatory Settings \(SIRAS\)](#) offers two free on-line courses one for health care providers in ambulatory settings and one for specimen collectors.
- Collaborate with clinicians and academic researchers on studies to increase understanding of influenza infection and epidemiology.

Value of Epidemiology, PHL and Clinician Partnerships

Successful influenza virologic surveillance programs are not built overnight and cannot be sustained without proper care. Strong relationships between state epidemiology, PHL, and clinical partners are crucial to ensuring quality and consistent data and specimens for influenza virologic surveillance. Clinicians with a keen interest in public health who can help grow and foster surveillance efforts in the community and among their colleagues can be an enormous asset. Establishment of a strong network of providers who will submit timely and quality specimens requires dedicated resources to provide encouragement, feedback and guidance. When dedicated staff routinely work with submitters on appropriate reporting, specimen collection and submission, specimens are more likely to be of higher quality and improve the virus detection abilities at PHLs. Virologic surveillance efforts cannot be a one way street. Giving back to providers who participate serves as a reminder of the importance of their contributions. Providing incentives can be as simple as ensuring timely feedback of results and findings or as advanced as offering additional testing of negative samples for other respiratory pathogens.

Source: Unpublished communications with Influenza Incidence Surveillance Project (IISP) participants

PHL-Clinical Laboratory/Testing Site –Influenza Surveillance Coordinator Partnerships

Strong partnerships and communications with clinical laboratories and influenza testing sites are important to obtaining quality and consistent data and specimens. Listed below are some examples for enhancing the effectiveness of these relationships.

- Access alternate data sources to supplement influenza surveillance, as described in the Data Management Implementation Guidance section. Commercial, web-based survey instruments are available at little to no cost (e.g., SurveyMonkey™, SurveyGizmo) to collect testing data from partners. Some of the tools can provide participants with an identifying login and be pre-filled with participant information to ease the burden and increase participation rates. The data collected can include information on a variety of agents and test methods. Data can be downloaded to a spreadsheet for analysis. These reports provide data from thousands of tests performed by clinical laboratories and test sites throughout the influenza season. In addition, a number of clinical laboratories perform their influenza testing as part of a respiratory virus molecular panel; access to this data allows for a more complete picture of circulating respiratory pathogens.
- Establish collaborative relationships with specimen providers to ensure and/or improve the quality and consistency of specimen submissions as outlined in the Sampling Requirements Intent and Implementation Guidance sections. For more information on implementation for establishing specimen provider networks, please reference the sampling implementation guidance.
 - In addition to the standard communication methods, some states distribute a “handbook” containing instructions, forms and summary data of laboratory surveillance needs in their jurisdiction. The [Wisconsin Laboratory-Based Surveillance Plan](#) is one such example.
- Promote the value of participating in the surveillance system, provide incentives when permissible. Incentives do not need to be monetary; they can be test kits, training, certificates of appreciation, attendance at state conferences and reference books, as well as the “added value” of improved surveillance data that can be used to improve clinical management recommendations.
- Provide specimen collection and shipping supplies and courier service to virologic surveillance participants. Most health care providers and clinical laboratories will not be able to absorb the cost of surveillance supplies or shipping.
- Provide timely updates to specimen providers via email, web or fax. Clinical laboratory partners and PHLs both benefit from exchanges of information related to current influenza activity, commercial test shortages, and emerging disease threats (e.g., 2013 novel coronavirus and H7N9).
- Provide workshops, teleconferences/webinars and educational materials related to influenza surveillance, proper specimen collection and use of RIDT.
- Provide proficiency assessment challenges or exercises related to influenza testing and specimen packaging if budget permits. These exercises may be coordinated with other state/ local preparedness activities.

PHL and CDC Partnerships

Collaboration between the PHLs and CDC's Influenza Division is imperative for effective virologic surveillance. The CDC Influenza Division, especially the Virus Surveillance and Diagnosis Branch, provides vital support to the PHLs and relies on data and specimens submitted by the PHLs. Coordination between the CDC and PHLs is often facilitated by APHL.

- CDC provides didactic and hands-on training to PHLs in test methods and national teleconferences to share surveillance guidance for laboratory testing and influenza coordinator activities.
- CDC provides technical support to PHLs including assistance with assay troubleshooting and interpreting unusual results.
- CDC provides testing reagents and materials through the IRR along with updates to the assay and implementation support when novel viruses emerge (e.g., H3N2v, H7N9).
- CDC partners with PHLs to complete the necessary validation studies for regulatory approval of new assays.
- CDC provides guidance to assist states develop emergency outbreak and pandemic response plans and provides essential support in actual response situations.

Considerations for Building Effective Partnerships and Communications

1. Has your influenza surveillance program and PHL identified the appropriate contacts among public health, clinician and laboratory partners within your jurisdiction?
2. If so, do you routinely and collaboratively review the list of contacts to ensure that all key partners are included (e.g., identify new partners, update for staffing changes, etc).
3. Does your laboratory maintain a database of current contact information and influenza testing capabilities for identified laboratories within your jurisdiction?
 - Some SPHLs maintain multiple separate databases – one for the LRN, one for a statewide laboratory network for surveillance, etc. while some SPHLs have added influenza testing sites and included influenza testing capability, surveillance participation, etc. to the existing LRN database.
4. Does your influenza surveillance program and PHL designate one or more staff members to coordinate outreach activities (e.g., network or surveillance coordinator/manager/advisor)?
5. Do you maintain a communication plan that identifies and links system partners?
6. Do you collaborate with other laboratories and rapid influenza testing sites to acquire virologic testing result data and specimens for further virologic testing?
7. Do you have a method to collect influenza testing data from clinical laboratories/testing sites (e.g., survey tool, fax or web portal)?

8. Does your laboratory and/or influenza surveillance program maintain the capability to exchange information and data via email, fax or other electronic tools with laboratories within your jurisdiction?
9. Do you provide reports on the current status of circulating influenza types and subtypes, and other respiratory viruses if available, via website, newsletter or other means?
10. Do you provide an end of year summary to all stakeholders about the influenza season? Do you provide individualized reports to participating laboratories and/or providers?
11. Do you relay the importance of receiving specimens for confirmatory testing, subtyping and identification of unsubtypable specimens to your clinical partners especially when the threat of a novel virus is high (e.g., H3N2v, H7N9)?
12. Does your influenza surveillance program and/or laboratory provide teleconferences, webinars or in-person training and outreach to clinician and laboratory surveillance partners and potential partners?
13. Is there a mechanism for feedback and corrective action to providers who incorrectly or inappropriately send specimens to the PHL (e.g., improperly shipped, incorrect form, incomplete information, sent dry swab not in media)?