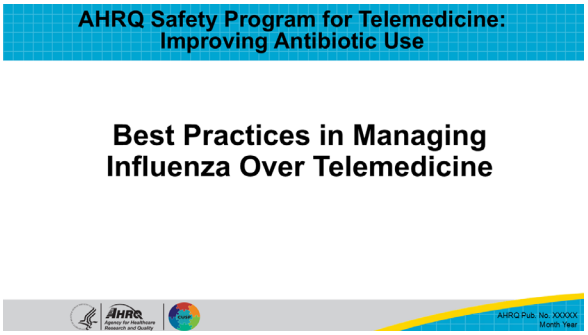
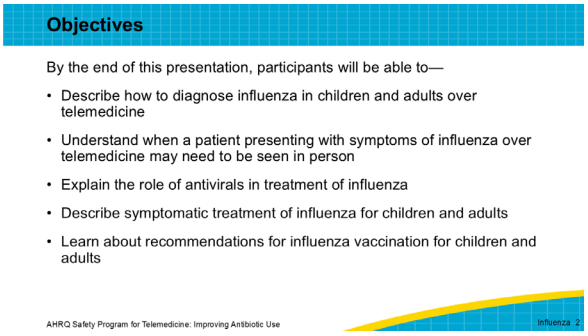
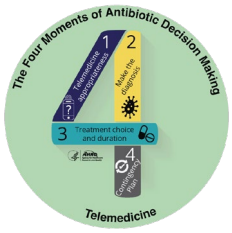
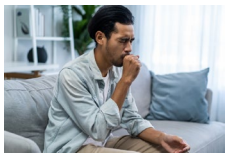
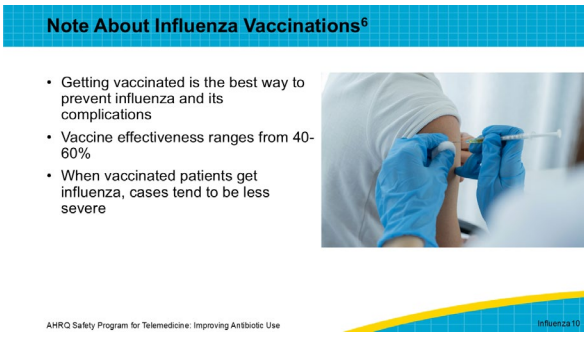
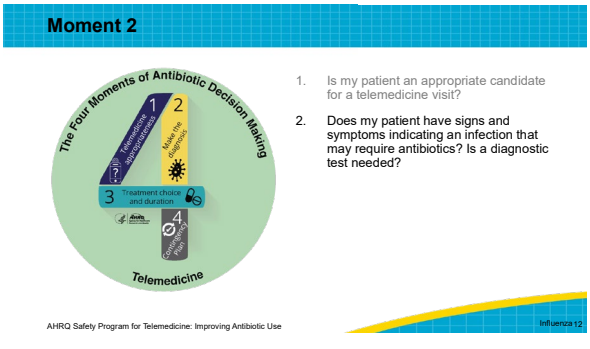
Best Practices in Managing Influenza Over Telemedicine

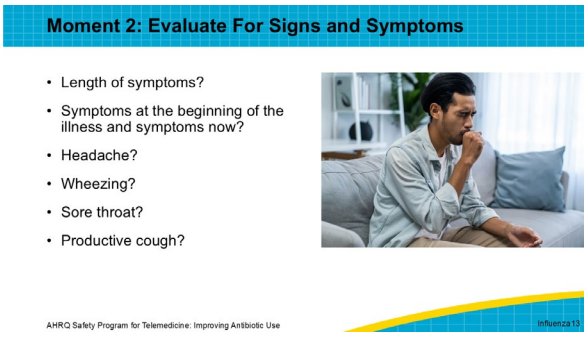
Slide Title and Commentary	Slide Number and Slide
Best Practices in Managing Influenza Over Telemedicine SAY: Welcome to the presentation titled, “Best Practices in Managing Influenza Over Telemedicine.”	**Slide 1** 
Objectives SAY: A clinical case–based format will be used to discuss the approach to managing influenza. By the end of this presentation, participants will be able to— • Describe how to diagnose influenza in children and adults over telemedicine • Understand when a patient presenting with symptoms of influenza over telemedicine may need to be seen in person • Explain the role of antivirals in treatment of influenza • Describe symptomatic treatment of influenza for children and adults • Learn about recommendations for influenza vaccination for children and adults	**Slide 2** 

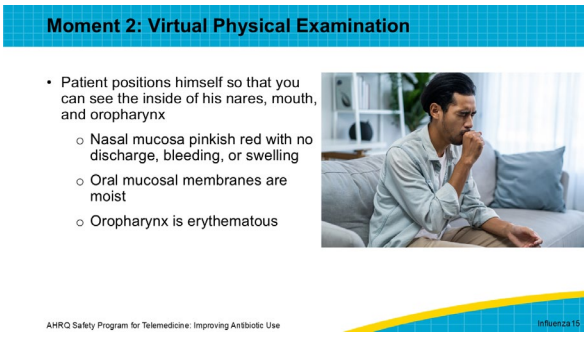
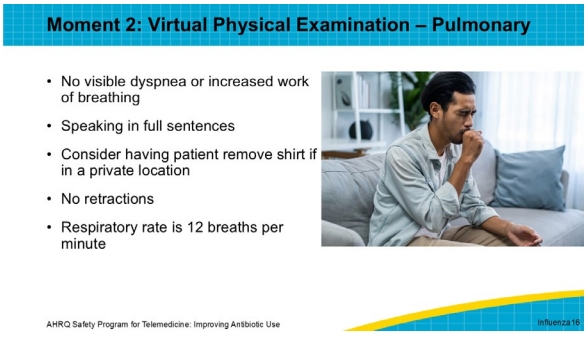
Slide Title and Commentary	Slide Number and Slide
The Four Moments of Antibiotic Decision Making SAY: This presentation will review a clinical case using the Four Moments of Antibiotic Decision Making framework. Briefly, this framework consists of the following moments: Moment 1: Is my patient an appropriate candidate for a telemedicine visit? Moment 2: Does my patient have signs and symptoms indicating an infection that may require antibiotics? Is a diagnostic test needed? Moment 3: If antibiotics are indicated, what is the narrowest, safest, and shortest regimen I can prescribe? Moment 4: What symptomatic relief should I offer or prescribe to my patient? What should I tell my patient about the expected course and the followup plan? This presentation will limit discussion to adults and children 3 years of age and older.	**Slide 3** **The Four Moments of Antibiotic Decision Making**  1. Is my patient an appropriate candidate for a telemedicine visit? 2. Does my patient have signs and symptoms indicating an infection that may require antibiotics? Is a diagnostic test needed? 3. If antibiotics are indicated, what is the narrowest, safest, and shortest regimen I can prescribe? 4. What symptomatic relief should I offer or prescribe to my patient? What should I tell my patient about the expected course and the followup plan? AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 3
Case Presentation SAY: Let's discuss a clinical case. You log into your telemedicine portal to see a 35-year-old man with no past medical history who reports 2 days of myalgias, subjective fevers, and cough. It is February, and he did not get his influenza vaccination this year.	**Slide 4** **Case Presentation** • A 35-year-old male with no past medical history presents via telemedicine with 2 days of myalgias, subjective fevers, and cough • Patient did not get vaccinated for influenza this year • It is currently February  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 4

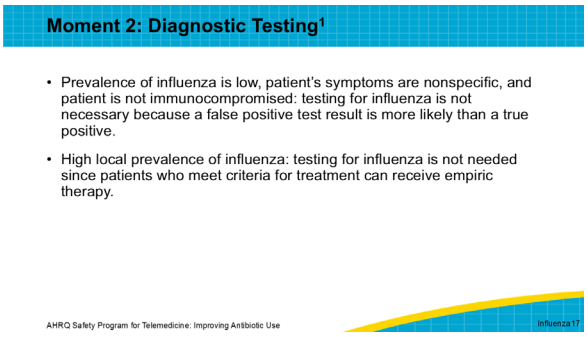
Slide Title and Commentary	Slide Number and Slide
Moment 1: Telemedicine Appropriateness SAY: Let's start with Moment 1 which again is: "Is my patient an appropriate candidate for a telemedicine visit?" This moment identifies patients who likely should be referred for an in-person evaluation based on the clinical presentation. When evaluating a patient for influenza, the time of the year and the amount of circulating influenza are important to keep in mind. If it is a time of high prevalence of influenza according to the Centers for Disease Control and Prevention (CDC) or your local health department, such as winter, your patient has already obtained a negative at-home COVID test, and the patient has common signs and symptoms of influenza such as a fever with a nonproductive cough or other respiratory symptoms, myalgia, headache, and often fevers, it is likely that the patient has influenza.	**Slide 5** **Moment 1: Telemedicine Appropriateness** • When evaluating a patient for influenza, keep in mind the following: ○ Time of the year ○ Amount of circulating influenza[1,2] • Current influenza information can be found at https://www.cdc.gov/fluview/overview/fluview-interactive.html   AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 5
Influenza Statistics SAY: Between 3 percent and 11 percent of all people in the United States develop symptomatic influenza in a typical season. Most have a mild illness that seems like a cold. However, a subset of people develops severe influenza. Compared with adults 65 and older, children younger than 18 are more than twice as likely to develop a symptomatic influenza virus infection. Influenza is responsible for up to 710,000 hospitalizations and up to 51,000 deaths in the United States annually.	**Slide 6** **Influenza Statistics** • Between 3 and 11 percent of the United States population develop symptomatic influenza in a typical season[3] ○ Most develop a mild illness while a subset of people develop severe influenza • 100,000–710,000 hospitalizations in the United States annually • 4,900–51,000 deaths annually in the United States annually[4] AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 6
Influenza Diagnosis SAY: The most common symptoms of influenza are fever, headache, sore throat, myalgias, cough, and rhinorrhea. An acute onset of a cough and fever, in the setting of a negative COVID test, has a positive predictive value of at least 70 percent in adult outpatients when influenza is known to be circulating. This means that if influenza is in the community, 70 percent of adult patients coming in with acute-onset cough and fever have influenza.	**Slide 7** **Influenza Diagnosis** • Most common influenza symptoms: ○ Fever ○ Headache ○ Sore throat ○ Myalgias ○ Cough ○ Rhinorrhea • An acute onset of a cough and fever has a positive predictive value of at least 70 percent if influenza is circulating[5]  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 7

Slide Title and Commentary	Slide Number and Slide
Influenza Diagnosis Continued SAY: You should suspect influenza in patients with typical symptoms if influenza is prevalent in the community. Although the influenza season is typically considered to start in October and end in May, moderate or high influenza activity generally begins in December and lasts through March. There is variation by state and by year, so it is useful to seek information about influenza prevalence for the area where the patient lives. This can be found on the Centers for Disease Control and Prevention's influenza website. You should also check state and local health department websites for local data applicable to where the patient lives.	**Slide 8** **Influenza Diagnosis Continued** • Suspect influenza in patients with typical symptoms when influenza is prevalent in the community, usually October–May • Look up prevalence of influenza circulating in the community[2]  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 8
Moment 1: When To Come in for an In-Person Visit SAY: Many patients with influenza can be evaluated over telemedicine. However, there are some patient groups that may require more workup and therefore may require an in-person visit. For example, some patients may be at high risk of worsening chronic medical conditions, which includes but is not limited to worsening of congestive heart failure, asthma exacerbation, and exacerbation of chronic obstructive pulmonary disease (COPD). Other patients, such as those with immunocompromise or immunosuppression, those who are pregnant, those with morbid obesity, those living in chronic care facilities, and those with heart disease, asthma, renal disease, metabolic disease, hematologic disease, and neurologic disease are at higher risk of increased complications from influenza. Certain populations such as indigenous Americans also may be at higher risk of increased complications from influenza. Children under the age of 2 or those at least 65 years of age are also at higher risk of complications, and in general, infants and young children under the age of 3 may be better evaluated in person. Some of these patients may be better evaluated in person to ensure they do not have any signs or symptoms of complications. Patients with severe symptoms also should be evaluated in person. You confirm with the patient that he has no past medical history or belong to any groups that would put him at high risk of an exacerbation of a chronic medical condition or at risk of complications.	**Slide 9** **Moment 1: When To Come in for an In-Person Visit** • Some patient groups require more workup and need to be evaluated in-person[1] ○ Patients at high risk of worsening chronic medical conditions ○ Patients at higher risk of increased complications ○ Infants and young children under the age of 3 ○ Severe symptoms  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 9

Slide Title and Commentary	Slide Number and Slide
Note About Influenza Vaccinations SAY: Note that while the influenza vaccine is the most important way of preventing influenza and its complications, patients can have received the vaccine and still contract influenza. Depending on the patient, the vaccine, and its match with the circulating strains, the effectiveness of the vaccine can range from approximately 40 percent to 60 percent. Even if the vaccine does not prevent someone from developing the flu, it can lessen the severity, which is very important to stress to patients.	**Slide 10** 
Moment 1: Possible Complications SAY: Ask the patient focused questions to determine if he has had altered mental status or shortness of breath, which would require emergency attention, and to see if he has a high fever of over 102 degrees Fahrenheit, which would require an in-person visit. You quickly assess the patient and determine that he has had no symptoms of altered mental status or shortness of breath and his temperature was 101 degrees Fahrenheit. Your patient has no past medical history that would indicate that he may need an in-person evaluation, or signs or symptoms that would warrant an in-person evaluation or emergency department referral. Even if you are using a triage protocol to determine whether patients with symptoms of influenza might be appropriate for telemedicine, the clinician may want to reconfirm these responses.	**Slide 11** 
Moment 2 SAY: Moment 2 asks: “Does my patient have signs and symptoms indicating an infection that may require antibiotics? Is a diagnostic test needed?”	**Slide 12** 

Slide Title and Commentary	Slide Number and Slide
Moment 2: Evaluate for Signs and Symptoms SAY: Let's gather some additional history and perform a virtual physical examination. You ask him questions. How long has he had these symptoms? What were his symptoms at the beginning of the illness, and what are his symptoms now? Does he have a headache, and if so, what does it feel like? Has he noticed any wheezing? Does he have a sore throat? Is his cough productive? You have already asked about his temperature.	**Slide 13** 
Moment 2: Additional Signs and Symptoms Answers SAY: You ask these questions and the patient states that the symptoms started 2 days ago. There hasn't been much of a change in symptoms over that period of time: he still has myalgias and feels like he has a fever. He also has a mild frontal headache that got better with acetaminophen. He hasn't noticed any shortness of breath or wheezing. He does have a mild sore throat but is able to drink and eat normally. His cough is dry. He performed a COVID test at home and it was negative.	**Slide 14** 

Slide Title and Commentary	Slide Number and Slide
Moment 2: Virtual Physical Examination SAY: When you are evaluating a patient via telemedicine, you can perform components of a virtual physical exam with help from the patient. It may be helpful to have the patient or caregiver obtain a spoon and a light source, and go to a private room before their appointment starts. Give the patient or caregiver clear instructions about what to do and where to move the camera and the light source (such as on a smart phone), and you can complete many components of a physical exam. Ask your patient to position himself and his camera, as well as any light sources he has available, so that you can see first the inside of his nares, then the inside of his mouth, and finally, perhaps with help from a spoon or other object, the oropharynx. You may need to ask the patient to reposition himself or the camera at different points so that you can have as clear a view as possible. You note that his nasal mucosa are pinkish red with no discharge, bleeding, or swelling. His oral mucosal membranes are moist. His oropharynx is erythematous.	**Slide 15** 
Moment 2: Virtual Physical Examination – Pulmonary SAY: You can also perform a pulmonary exam. When you are speaking with the person, check for visible dyspnea, increased work of breathing, and whether he is speaking in full sentences. You can also have him remove his shirt if he is in a private location so that you can assess for retractions when breathing. You can measure his respiratory rate by having him place his hands on his shoulders. You can then more easily observe when he takes breaths and count the rate at which you can see his shoulders raise and lower. You observe that there is no visible dyspnea or increased work of breathing. He is speaking in full sentences. When you look at his chest you note no retractions. His respiratory rate is 12 breaths per minute.	**Slide 16** 

Slide Title and Commentary	Slide Number and Slide
Moment 2: Diagnostic Testing SAY: In a patient with influenza symptoms, the decision to test for influenza depends on the prevalence of influenza and on your patient's risk for complications or hospitalization. If the prevalence of influenza is low and the patient's symptoms are nonspecific, testing for influenza is not necessary because influenza is less likely, and a false positive test result is more likely than a true positive. If there is a high local prevalence of influenza, influenza testing is also not needed since patients who meet criteria for treatment can receive empiric therapy over telemedicine.	**Slide 17** 

Slide Title and Commentary	Slide Number and Slide
Moment 2: Diagnostic Testing, Continued	**Slide 18**

SAY:

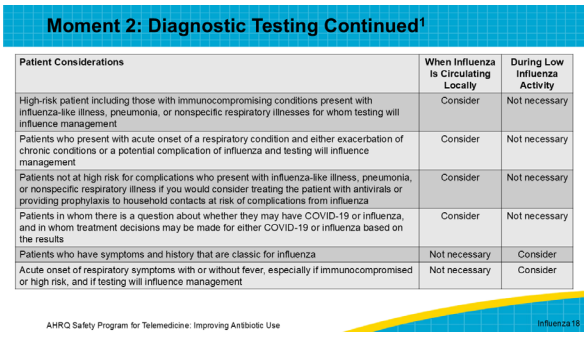
Influenza testing should be considered in circumstances where influenza is not highly prevalent but if the influenza test were positive, you would treat the patient. Examples of these include when a high-risk patient including those with immunocompromising conditions presents with an influenzalike illness, pneumonia, or nonspecific respiratory illnesses when influenza is circulating locally.

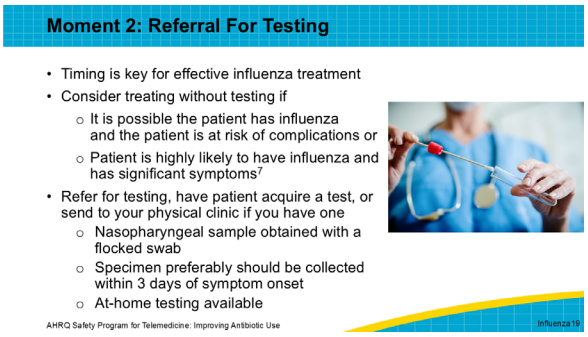
Another example includes patients who present with the acute onset of a respiratory condition and either exacerbation of chronic conditions or a potential complication of influenza, where influenza is circulating locally, and testing will influence management.

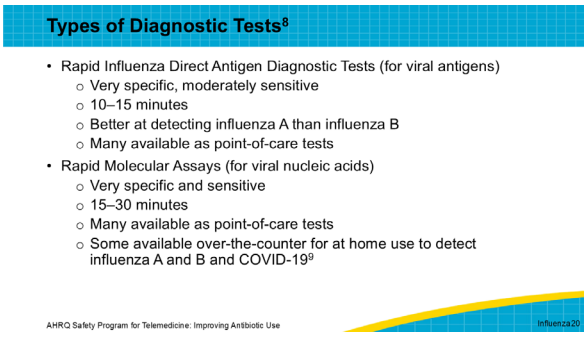
You can also consider testing patients not at high risk for complications who present with influenzalike illness, pneumonia, or nonspecific respiratory illness when influenza is circulating if you would consider treating the patient with antivirals or providing prophylaxis to household contacts at risk of complications from influenza. You can consider testing patients for whom there is a question about whether they may have COVID-19 or influenza, and for whom treatment decisions may be made for either COVID-19 or influenza based on the results.

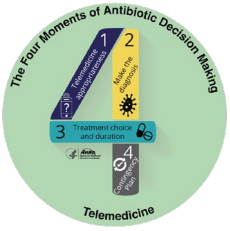
You can consider testing patients who have symptoms and history that are classic for influenza and the local prevalence is low or unknown.

Finally, you can consider testing if there was an acute onset of respiratory symptoms with or without fever, especially if the patient is immunocompromised or at high risk of complications, and influenza is not circulating at a high prevalence.

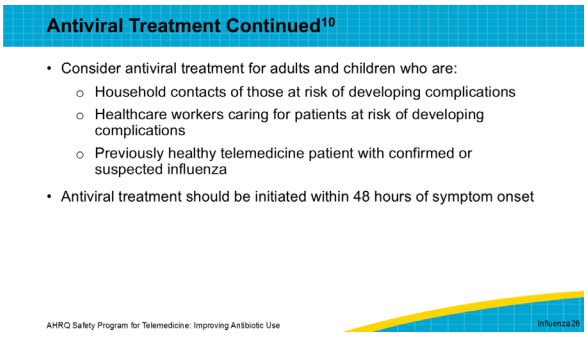


Slide Title and Commentary	Slide Number and Slide
Moment 2: Referral for Testing SAY: In treating influenza, timing is important. If the patient is highly likely to have influenza and has significant symptoms that may not warrant an in-person visit, consider treating even without testing. If you are unsure, and the patient is at risk of complications, you may also want to consider treating even if you can't get a test. However, there may be ways to get tests quickly. Accurate influenza testing requires attention to both specimen collection and test selection. If you have the ability to refer locally for testing, or if you have a physical clinic, this may be an option. The optimal specimen is a nasopharyngeal sample obtained with a flocked swab. Collection requires inserting the swab into the nasal cavity. The specimen should be collected as soon as possible after the onset of illness, preferably within 3 days of the start of symptoms.	**Slide 19**  Moment 2: Referral For Testing • Timing is key for effective influenza treatment • Consider treating without testing if ○ It is possible the patient has influenza and the patient is at risk of complications or ○ Patient is highly likely to have influenza and has significant symptoms[7] • Refer for testing, have patient acquire a test, or send to your physical clinic if you have one ○ Nasopharyngeal sample obtained with a flocked swab ○ Specimen preferably should be collected within 3 days of symptom onset ○ At-home testing available AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 19

Slide Title and Commentary	Slide Number and Slide
Types of Diagnostic Tests SAY: Consider where you might send patients who require testing for influenza. Practices use two types of tests to obtain rapid results: rapid antigen testing and rapid molecular assays. Rapid influenza direct antigen diagnostic tests look for viral antigens. These tests take only 10 to 15 minutes to run, and many are available as point-of-care tests. Most of these tests are specific—around 90 percent—so if the test is positive, you generally can trust the results. However, the tests are only 50 to 70 percent sensitive, so they frequently miss cases of influenza. Furthermore, these tests are generally better at detecting influenza A than influenza B. Because rapid influenza antigen tests are not very sensitive, rapid molecular assays, which detect the presence of viral nucleic acids in upper respiratory tract samples, are preferred. These rapid molecular assays are both highly sensitive and highly specific. Some of these rapid molecular assays take as little as 15 to 30 minutes for results to be available and many are cleared to be used as point-of-care tests in clinics. Note that some but not all rapid antigen and molecular tests also detect the presence of respiratory syncytial virus (RSV) or SARS-CoV-2. There are some over-the-counter rapid molecular influenza tests available that patients can purchase and use in the home. Some of these over-the-counter tests test for influenza A and B as well as other respiratory viruses such as COVID-19. These take approximately 30 minutes to run. If these are available to your patient, performing this test in the home just prior to or at the time of your telemedicine appointment, or having the patient obtain one of these tests shortly after your appointment and provide you with the results over a patient portal, may be helpful.	**Slide 20** 

Slide Title and Commentary	Slide Number and Slide
Types of Diagnostic Tests, Continued SAY: Besides the rapid tests discussed, other molecular tests may require sending out to a commercial or hospital lab. Some allow for detection of other respiratory viral pathogens such as SARS-CoV-2, RSV, adenovirus, rhinovirus, and parainfluenza. However, these tests are not rapid, taking 45 minutes to several hours, and usually have to be conducted in a lab. If there is not access to point-of-care testing and it is important to make the diagnosis of influenza or another respiratory virus such as in an immunocompromised patient with fever, sending out these tests can be considered. You should determine what influenza test, if any, is available to you in your setting or to your patient in the home so that you know how accurate the test is, as well as how long it takes to get a result, and what sample to collect. Finally, note that viral cultures and influenza serologies do not have a role in the evaluation of patients with influenzalike illnesses and should not be sent for the purposes of routine clinical care.	**Slide 21** **Types of Diagnostic Tests Continued[8]** • Laboratory-based molecular tests ○ Also check other respiratory viral pathogens ○ 45 minutes–hours ○ Conducted in a lab ○ If point-of-care testing is unavailable and making diagnosis is important • Viral cultures and influenza serologies not helpful  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 21
Moment 2: Our Patient SAY: Getting back to our patient, his symptoms are highly consistent with influenza during a time when influenza is circulating and he had a negative at-home COVID test. You can ask him whom he lives with and what he does for a living. Based on his answers about his family, none of his household contacts are high risk. He does not work in healthcare. You elect to not have him undergo testing.	**Slide 22** **Moment 2: Our Patient** • 35-year-old previously healthy male • Symptoms are highly consistent with influenza during time of high prevalence • Household contacts are not high risk • Does not work in healthcare • Diagnostic testing is not necessary  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 22
Moment 3 SAY: Let's discuss Moment 3: "If antibiotics are indicated, what is the narrowest, safest, and shortest regimen I can prescribe?"	**Slide 23** **Moment 3**  1. Is my patient an appropriate candidate for a telemedicine visit? 2. Does my patient have signs and symptoms indicating an infection that may require antibiotics? Is a diagnostic test needed? 3. If antibiotics are indicated, what is the narrowest, safest, and shortest regimen I can prescribe? AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 23

Slide Title and Commentary	Slide Number and Slide
Moment 3: Antibiotics Indicated? SAY: Antibiotics are not indicated to treat uncomplicated influenza in the absence of pneumonia. A small subset of patients may develop a secondary bacterial pneumonia after presenting with influenza. These patients will usually report that they were getting better and then developed new fevers and often worsening dyspnea or cough. If a patient reports these symptoms, they should be evaluated in person. If they sound ill, refer them directly to the emergency room. The patient doesn't meet criteria for antibiotics. However, the patient might need antiviral treatment for his influenza.	**Slide 24** **Moment 3: Antibiotics Indicated?** • No antibiotics indicated for treatment of uncomplicated influenza • In rare cases, can develop secondary bacterial pneumonia • Our patient does not meet criteria for antibiotics  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 24
Antiviral Treatment SAY: Antiviral medications should be prescribed for adults and children with documented or suspected influenza who are at high risk of complications, regardless of influenza vaccination status. This includes those with severe or progressive illness, no matter how long they have been sick, including complications such as pneumonia or exacerbation of chronic conditions; those with chronic medical conditions or with immunocompromise; children under the age of 2 years; adults 65 years or older; and pregnant women and those within 2 weeks postpartum. While it is best to start the antiviral medications within 48 hours of the onset of symptoms, for patients who are at high risk for influenza complications, antiviral medications should be started as soon as possible, even as late as 5 days after symptom onset. If you can't get an influenza test easily in a patient with suspected influenza and who is at high risk of complications or may be experiencing complications, it is recommended to start treatment anyway.	**Slide 25** **Antiviral Treatment[10]** • Prescribe antiviral medications for patients at high risk of complications ○ Severe or progressive illness ○ Chronic medical conditions or immunocompromise ○ Children <2 years ○ Adults ≥65 years ○ Pregnant women and women within 2 weeks postpartum • Start antiviral treatment as early as possible, ideally within 48 hours and up to 5 days from symptom onset ○ Reduces risk of complications ○ Will reduce duration of symptoms by 1–2 days ○ In some cases, start treatment prior to testing AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 25

Slide Title and Commentary	Slide Number and Slide
Antiviral Treatment, Continued SAY: Consider antiviral treatment for adults and children who are household contacts of people at risk of developing complications from influenza, and healthcare workers who care for patients who are at risk of developing complications from influenza. Finally, you can consider treatment for any previously healthy telemedicine patient with confirmed or suspected influenza. Antivirals should be initiated within 48 hours of symptom onset to have a benefit, such as reduced duration of fever and symptoms, reduced likelihood of developing acute otitis media in children, and reduced lower respiratory tract complications or hospitalizations in adults. If initiated within 48 hours of symptom onset, antiviral therapy is expected to reduce the duration of symptoms by 1 to 2 days. For some patients, starting antiviral treatment within 48 hours of symptom onset may require starting treatment prior to or without testing.	**Slide 26** 

Antiviral Treatment Options

SAY:

There are a few options for antiviral medications. Oral oseltamivir for 5 days can reduce the risk of complications from influenza including hospital admission in high-risk patients. Oseltamivir can reduce the duration of symptoms by 1 to 2 days in lower risk patients who are initiated on therapy within 48 hours of symptom onset.

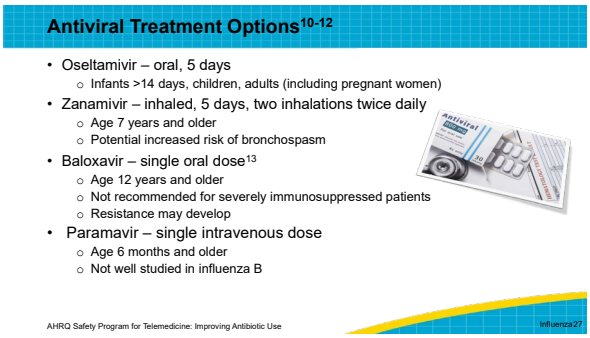
Although the U.S. Food and Drug Administration has not approved oseltamivir in children younger than 14 days old, both the Centers for Disease Control and Prevention and the American Academy of Pediatrics recommend use of oral oseltamivir for the treatment of infants under 14 days of age with the flu. Pregnant women are at high risk of serious complications from influenza including adverse outcomes to the fetus and maternal mortality. For this reason, while data are limited, oseltamivir is encouraged for the treatment of influenza in pregnancy.

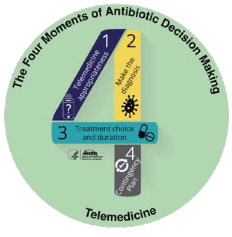
The 2018 Infectious Diseases Society of America influenza guidelines recommend inhaled zanamivir for outpatients, as an alternative to oseltamivir. The recommended dose is two inhalations twice daily for 5 days. Of note, zanamivir is approved in children ages 7 and older. There is a concern for a potential increased risk of bronchospasm with use of inhaled zanamivir, so for this reason, oseltamivir is preferred in patients with chronic lung disease such as chronic obstructive pulmonary disease, or COPD, and asthma. However, in a placebo-controlled trial of patients with influenza and mild to moderate asthma or COPD, inhaled zanamivir was well tolerated.

Baloxavir was approved in 2018 as a single oral dose for otherwise healthy patients 12 years of age and older who have been symptomatic with the flu for less than 2 days. It works differently than other influenza antiviral drugs, so can be particularly helpful if there is known resistance circulating to antiviral drugs like oseltamivir. It may be particularly effective in treatment of influenza B. However, there is a risk of emergence of resistance during treatment, so for this reason, baloxavir is not recommended for treatment in severely immunosuppressed people as they may experience prolonged viral replication and therefore resistance.

Peramivir is approved as a single intravenous dose for patients age 6 months and older who have been symptomatic with the flu for less than 2 days. This may be difficult to provide over telemedicine. In addition, most studies of its effectiveness have occurred when influenza A

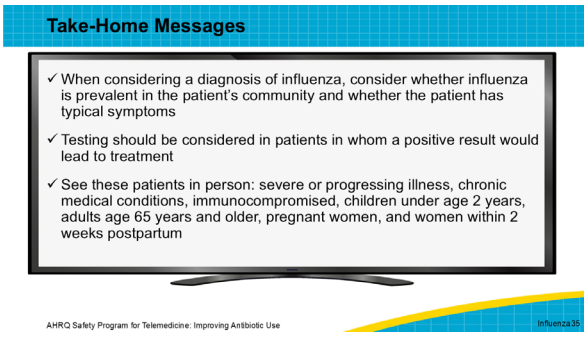
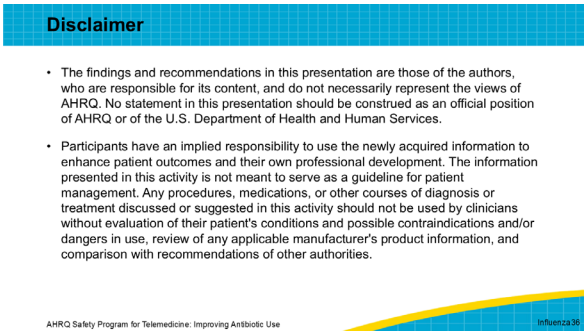
Slide 27

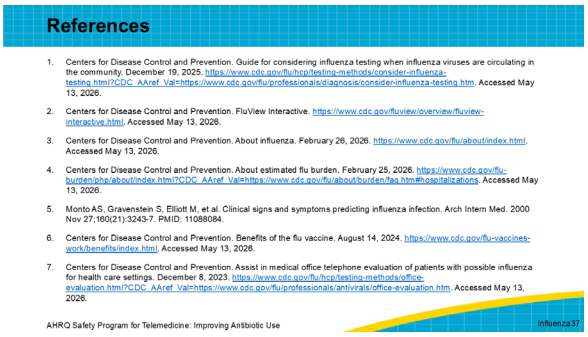
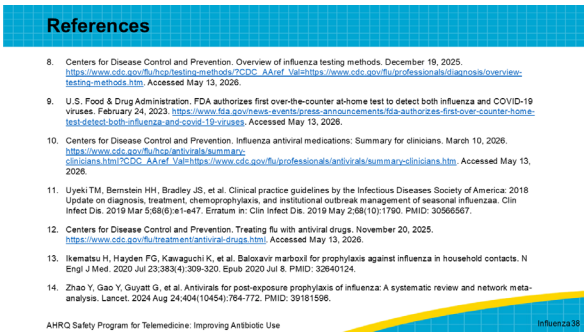
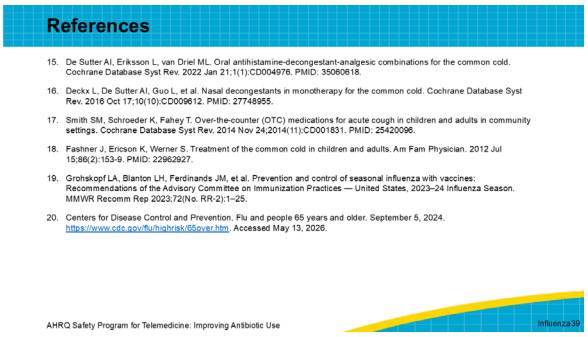


Slide Title and Commentary	Slide Number and Slide
was circulating, so its effectiveness on influenza B is less clear.	
Antiviral Prophylaxis SAY: What about people who are exposed to influenza? Should they be given antiviral medications? Patients with significant immunocompromise and other groups at high risk for complications who are household contacts to someone with influenza should be considered for prophylaxis, especially if they were unable to be vaccinated or it was thought that the vaccine would not be effective. If prophylaxis is administered to high-risk contacts of patients with influenza, it should begin within 48 hours of exposure to the infected individual. Prophylaxis should continue for 7 days after the most recent exposure, with either oseltamivir in those over 3 months of age or inhaled zanamivir for those at least 5 years of age. Baloxavir can also be used for prophylaxis within 48 hours of exposure as a single dose.	**Slide 28** **Antiviral Prophylaxis[14]** • Consider in patients with significant immunocompromise or those at high risk of complications who are household contacts of influenza patients • Administer prophylaxis within 48 hours of exposure to influenza patient  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 28
Moment 3: Our Patient SAY: Let's get back to our 35-year-old healthy male patient, with no concerning signs or symptoms indicating severe disease, who has no household contacts with individuals at high risk of influenza complications, and does not work in healthcare. He has had symptoms for 2 days, so is just at the 48-hour mark where he could potentially get a benefit from antiviral treatment. While guidelines do not recommend for or against treatment in healthy adults, you could consider discussing with him starting oral oseltamivir for 5 days, inhaled zanamivir for 5 days, or one dose of oral baloxavir, and make a decision about treating with antiviral medications together.	**Slide 29** **Moment 3: Our Patient** • You discuss starting antiviral therapy: oral oseltamivir for 5 days, inhaled zanamivir for 5 days, or one dose of oral baloxavir  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 29
Moment 4 SAY: Next is Moment 4, which is: "What symptomatic relief should I offer or prescribe to my patient? What should I tell my patient about the expected course and the followup plan?"	**Slide 30** **Moment 4**  1. Is my patient an appropriate candidate for a telemedicine visit? 2. Does my patient have signs and symptoms indicating an infection that may require antibiotics? Is a diagnostic test needed? 3. If antibiotics are indicated, what is the narrowest, safest, and shortest regimen I can prescribe? 4. What symptomatic relief should I offer or prescribe to my patient? What should I tell my patient about the expected course and the followup plan? AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 30

Slide Title and Commentary	Slide Number and Slide
Moment 4: Influenza Symptomatic Treatment SAY: There is no good evidence for or against the effectiveness of over-the-counter medicines for symptom relief in patients with influenza. However, it is important for the patient to rest and stay hydrated while feeling ill. Some medications that may help your patients include: • Acetaminophen • Nonsteroidal anti-inflammatory medications (NSAIDS) • Nasal decongestants • Oral decongestants • Antihistamine-decongestants • Antihistamine-decongestant-analgesic combinations Of note, several systematic reviews have suggested that nasal or oral decongestants, antihistamine-decongestant combinations, and antihistamine-decongestant-analgesic combinations may only have some limited benefit. The risk of adverse events from the medications should be taken into consideration before recommending them to individual patients. Albuterol is suggested only for patients with known issues with airflow obstruction.	**Slide 31** **Moment 4: Influenza Symptomatic Treatment[15-18]** • Some medications may help: ○ Acetaminophen ○ Nonsteroidal anti-inflammatory medications (NSAIDS) ○ Nasal decongestants (less benefit) ○ Oral decongestants (less benefit) ○ Antihistamine-decongestants (less benefit) ○ Antihistamine-decongestant-analgesic combinations (less benefit) ○ Albuterol (only for patients with airflow obstruction) AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza31
Moment 4: Expectations and Followup Plan SAY: Patients should be aware that they will likely feel ill for a week or more. For the followup plan, give them specific reasons to return for an in-person appointment. For example, statements such as the following can be considered: “Come for an in-person visit if you develop a persistent high fever, severe headache, pain in your face or forehead, severe fatigue, or a rash. Go to the emergency room if you develop confusion or difficulty breathing or swallowing.” These symptoms may be signs of complications from influenza, such as a secondary bacterial pneumonia or encephalitis that should be evaluated and treated.	**Slide 32** **Moment 4: Expectations and Followup Plan** • May feel ill for a week or more • Return for in-person evaluation if: ○ Persistent high fever (above 102°F) ○ Severe headache ○ Pain in the face or forehead ○ Severe fatigue ○ Rash • Emergency department visit: ○ Confusion ○ Difficulty breathing or swallowing  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza32

Slide Title and Commentary	Slide Number and Slide
Case Presentation: Influenza Prevention SAY: Let's say that the following October the same patient presents for a routine telemedicine appointment. During the visit, he asks you if he should do anything to prevent influenza.	**Slide 33** **Case Presentation: Influenza Prevention** • Patient asks if he should do anything to prevent influenza  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 33
Case Presentation: Influenza Prevention Continued SAY: You use this as an opportunity to advocate for influenza vaccination. Although you can't provide the influenza vaccination over telemedicine, the patient could present for an in-office appointment or receive the vaccine at an alternative site. Routine annual influenza vaccination is recommended for everyone over the age of 6 months who do not have contraindications. While vaccination is most ideally performed in September or October, vaccination can continue throughout the influenza season. Children aged between 6 months and 8 years who have not had two doses of the influenza vaccine at least 4 weeks apart in the past in the same season, consecutive seasons, or nonconsecutive seasons should get two doses of the vaccine, but other children and everyone at least 9 years of age only require one dose. Older adults at least 65 years of age should receive a higher dose or an adjuvanted influenza vaccine. There is a live influenza vaccine—this should only be given to those between 2 and 49 years of age, and should not be used during pregnancy, in patients with immunocompromise, in patients with chronic medical conditions, and in caregivers and contacts including healthcare workers of patients with severe immunocompromise. Of note, egg allergy is no longer considered a contraindication to influenza vaccination.	**Slide 34** **Case Presentation: Influenza Prevention Continued[19]** • Routine annual influenza vaccination: ○ Recommended for everyone >6 months ○ Children 6 months–8 years should get two doses, unless they received two doses ≥4 weeks apart in the past season ○ Other children and everyone ≥9 should get one dose ○ Adults ≥65 years can receive higher dose or adjuvanted influenza vaccine[20] ○ Egg allergy is not a contraindication  AHRQ Safety Program for Telemedicine: Improving Antibiotic Use Influenza 34

Slide Title and Commentary	Slide Number and Slide
Take-Home Messages SAY: Let's summarize this presentation. The most important information to know when considering a diagnosis of influenza is whether influenza is prevalent in the patient's community, whether they have been tested for COVID, and whether the patient has typical symptoms. Testing should be considered in patients in whom a positive result would lead to treatment. Critical groups of patients who should be seen in person and treated include those with severe or progressing illness, those with chronic medical conditions, including the immunocompromised, children under age 2 years, adults aged 65 years and older, pregnant women, and women within 2 weeks postpartum. There are additional resources that you can review about how you and your practice will manage influenza such as the one-page summary on managing influenza in the telemedicine setting intended for clinicians and healthcare workers, the sample patient portal scripts for communicating with patients efficiently about influenza, and the patient and family education materials.	**Slide 35** 
Disclaimer SAY: Please review this disclaimer.	**Slide 36** 

Slide Title and Commentary	Slide Number and Slide
References 1 SAY: Here are the references.	**Slide 37** 
References 2 SAY: Here are the references.	**Slide 38** 
References 3 SAY: Here are the references.	**Slide 39** 

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