

Influenza and RSV Update for Long-term Care (LTC)

Transcript

JANURAY 11, 2023

All right, it's 3:32, so hopefully, uh, those folks who are coming in, had a chance to get settled and on to the webinar, although I'm sure we'll have more joining us in the next few minutes. Um, good afternoon and welcome to Minnesota Department of Health webinar on influenza and RSV in long term care facilities. Next slide. Please.

So, my name is Karen Martin, and I'm going to go through some quick housekeeping, uh, before we get started today. First of all, a big thank you for joining us. Um, we know you're all very busy. Um, as Tracy had also posted in the chat, this webinar is being recorded and will be posted as soon as we're able to for those who are either not able to make it today, or, um, who want to use it as a reference throughout the respiratory season. Next, I want to direct your attention to the question-and-answer function of the webinar for those of you, who've been on the monthly, COVID long-term care calls. You should be very familiar with this. If you go to the bottom, right hand corner of your screen, you'll see, uh, the word chat and right next to it is three dots. If you click on those three dots, that will give you the option to open up the question-and-answer window. So, we ask that you please post your questions in the Q and A, rather than chat. This allows us to answer questions individually, rather than, um, than the chat. We will use the chat. Uh, the presenters will use the chat to post links and resources as needed. Next slide.

As I'm sure you're all aware, it's been a very busy respiratory season. There are several viruses circulating that are causing illness in Minnesota long term care facilities including COVID-19, influenza, RSV, and other viral pathogens. Since that COVID pandemic began in March 2020, influenza, and RSV have really had atypical seasonality particularly in that first and second year where disease activity was lower than we would have expected. This season. Um, I think we can all say that there has been a strong resurgence of both influenza and RSV, but since we have all been working on COVID for so long, we thought it would be helpful to have a webinar to review influenza and RSV epidemiology and management in long-term care facilities. Of course, there continue to be many resources for COVID-19 and long-term care on our website (<https://www.health.state.mn.us/diseases/coronavirus/hcp/ltc.html>), um, as well as in our monthly COVID-19 long-term care webinars. Next slide please.

So, the objectives for today's talk, if you can go back one, please, thanks, are to show current influenza and RSV trends in long-term care facilities. To review influenza and RSV virus facts and surveillance methods. To describe outbreak management and influence the antiviral use to describe infection, prevention, and control measures to reduce transmission of respiratory illness, and to review influence the vaccination recommendations and storage and handling recommendations for long-term care. Next slide.

So, with that, I'm gonna hand it over to Jeff Sanders, who will discuss influenza.

INFLUENZA AND RSV UPDATE FOR LONG-TERM CARE (LTC) TRANSCRIPT

Alright, thank you, Karen. Alright, so influenza activity in Minnesota began earlier this season around mid-October with laboratory data, showing that the number of positive molecular flu tests increased rapidly and hit a peak around Thanksgiving. From October to the end of the year long-term care facilities submitted about 76 illness outbreak reports, and these reports include outbreaks that are caused by either influenza or RSV. The graph at the right shows these outbreaks relative to the past influenza seasons. With the current season shown as the red line. ILI outbreaks in long-term care facilities also increased rapidly around the time of Thanksgiving and hit a peak that was similar to the 2019-2020 season, which was the season interrupted by the arrival of COVID-19. While there have been signs of decreasing flu activity, we have to remain vigilant because there's a lot of season left. Next slide please.

So, since influenza has been out of the spotlight for a few years, I just wanted to quickly review some features of the virus. Um, as we know influenza is a respiratory virus that usually circulates anytime from October to May, and there are four major strains of influenza that affect humans, and these are included in the annual influenza vaccines. Those at the highest risk of severe influenza are adults over the age of 65 years children, younger than 2 years, pregnant women, people with chronic health conditions, and the American Indian Alaskan Native population. The length of flu symptoms is typically four to seven days. It can be prolonged immunodeficient patients. Influenza is spread primarily through large particle droplets that require close proximity between the source and the exposed person. Flu may also be spread from contact with droplet contaminated hands or surfaces with transfer of contaminated hands to the nose mouth, and eyes. The incubation period of flu is about one to four days with a mean of two days, and people may be infectious one day before symptom onset and infectiousness typically ends within seven days. MDH recommends testing for influenza and the results will influence clinical management such as antiviral treatment and hospitals should test for influenza the upon admission of any patient with flu-like, symptoms. Next slide, please.

Alright, so these symptoms may include fever or chills, cough, sore throat, body aches, headache, and fatigue, vomiting and diarrhea may occur, but these are not usually the only symptoms. It's important to note that some people, including the elderly, may have atypical symptoms such as not having the fever, or having a sudden behavior change. Starting in January of 2023 outbreaks may be defined as having at least two laboratory confirmed influenza identified within 72 hours of each other in residence on the same unit. This is a new definition, but when in doubt just report and we will do a review of it. So, you may get a follow up call or email if we have some additional questions. On MDHs flu long-term care page, we provide a line list tracking tool (<https://www.health.state.mn.us/diseases/flu/ltc/linelist.pdf>) to help with monitoring and management. Um, this tracking tool does not need to be submitted to MDH. It is just a resource for you. But what you should report to are influenza hospitalizations, deaths, and outbreaks. Hospitalizations and deaths may be reported by sending an MDH Disease Report Card (<https://www.health.state.mn.us/diseases/reportable/forms/reptcard.pdf>) or calling either of these phone numbers, and the outbreaks may be reported using a REDCap survey. On the MDH long-term care influenza page (<https://www.health.state.mn.us/diseases/flu/ltc/index.html>) you want to click the link for LTC Facility Influenza and RSV Report Form. This survey link will be changed annually so be sure to update any bookmarks. Next slide. Please.

So, later in the presentation my colleagues will go over aspects of disease control, more in depth. But here are some initial guidance with a focus on influenza and antiviral use. Before an outbreak provide and promote influenza of vaccinations, all residents and health care personnel. And also have a plan for testing, treating, and providing chemoprophylaxis to residents. For example, having pre-approved antiviral orders may expedite the administration of the medicine. When there is influenza in your local community, monitor residents, healthcare personnel, and visitors for flu illness daily. Test for influenza and any resident with signs of acute respiratory illness or influenza illness since tests results will guide clinical management. Next slide.

When an outbreak is identified, follow standard and drop of precautions for all residents with suspected or confirmed flu and apply these precautions for seven days after illness onset or 24 hours after the resolution of fever, whichever's longer. It is recommended to treat suspected influenza cases immediately, and that wait for lab confirmation. Influenza antivirals work best within two days of symptoms, but they can still have some benefit beyond that. At a minimum it is recommended to promptly give antiviral, antiviral chemoprophylaxis to well residents in the infected ward or unit. Facilities may decide to extend chemoprophylaxis to residents in uninfected areas based on their judgement and can consider offering chemoprophylaxis to healthcare personnel. Next slide please.

Alright, um, so, while other influenza antivirals exist for treatment, Oseltamivir, or Tamiflu, is the only antiviral recommended for chemoprophylaxis during institutional influenza outbreaks. So, if using for treatment Oseltamivir should be good at 75 milligrams, twice daily for 5 days, but you may consider a longer treatment period in patients that are, um, are still severely ill after 5 days. For chemoprophylaxis, give 75 milligrams once daily for a minimum of 14 days, continuing for 7 days after the last known case was identified. Lastly, be sure to always consult the resident's physician for the appropriate dosage because patients with renal impairment may require lower doses. Next slide.

Um, thank you, that was the end of my update. Um, here are these links referenced in my slides (<https://www.health.state.mn.us/diseases/flu/ltc/index.html>, <https://www.health.state.mn.us/diseases/flu/ltc/linelist.pdf>, <https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm>) and I will think I'll also put these in the chat if they have not already and I'll pass the mic back to Karen.

Thanks, Jeff. This is Karen Martin again, and I will be reviewing RSV activity and recommendations. Next slide.

So, as mentioned before, uh, RSV activity this season has been unusually high. The season started early and is still going strong. By the end of the calendar year 2022 eighteen long-term care facilities in Minnesota had reported RSV with 1,338 hospitalizations of seven-county, Metro residents since October 1. It's important to note that testing for RSV, especially in the adult and elderly population is not widespread. So, RSV is generally, uh, under tested and under recognized, um, in the adult and elderly population. Peak RSV activity happened in early November, um, which is typically earlier than we see, uh, and has been decreasing since then. Um, but even the levels that we're seeing now, um. Still, uh, at the level that we would expect to see, um, in peak activity, during a, a quote, unquote, regular season. So, even though things have been decreasing, there's still a significant amount of RSV circulating. Next slide. Please.

So, now we'll go over some of the basics about RSV. RSV is a common respiratory illness and people of any age. Um, it's a common early childhood. It can cause severe illness, such as bronchiolitis and pneumonia and below are some resources, um, for more information on RSV (<https://www.health.state.mn.us/diseases/rsv/index.html>, <https://www.cdc.gov/rsv/clinical/index.html>). Infants', young children, and older adults are at most risk for severe disease, and as I mentioned previously, RSV is under recognized in the adult and elderly age groups. People with RSV are usually contagious for three to eight days after symptom start but can be contagious for longer especially if they have, uh, a condition which compromises the immune system. Standard and contact precautions are recommended for RSV, uh, with some facilities, choose to use droplet precautions. If that's the case, ensure that your facility policy is clear on what is required. And that staff have been educated. Precautions should be in place for the duration of the illness and it's best to have a private room if it's available for those with residents with RSV and you can cohort ill residents with the same diagnosis. Next slide.

So, the first symptoms of RSV are gonna present, uh, like, many other respiratory viruses. Uh, but the signs and symptoms that you want to look out for include, uh, those that are more severe, such as difficulty breathing, wheezing, lung congestion uh, particularly in those who are at high risk for complications and including those with lung disease, heart disease, and those with weakened immune systems, which, I'm sure, um, represent many residents in your facilities. Uh, when a single case of RSV is detected in the facility, that's when you should really increase surveillance, um, have a low threshold for testing. So, test residents for RSV with new onset of respiratory illness. Um, and when you have two cases of laboratory confirmed, RSV identified within 72 hours of each other in residents in the same unit or area. That's when you can report it to MDH. And we keep the definition, the same for RSV and flu, um, to make it, uh, easier for you. Um, and the reporting page is also the same and that's the link here, which is Long-term Care Facility Influenza and RSV Report Form, 2022-2023 (<https://redcap.health.state.mn.us/redcap/surveys/?s=77K8YPJKDEPEMYTY>). And as Jeff mentioned that case definition, or I'm sorry, the outbreak definition did recently change to be two laboratory confirmed in a single unit within 72 hours. Um, and previously it was one confirmed with, uh, other respiratory illness, uh, in the facility. Um, if you're confused or in doubt, just go ahead and report it. And as Jeff mentioned, we'll give a call and follow up with more information if we need it. And finally, there are, uh, some individual cases of RSV that should be reported in Minnesota, and those include hospitalizations that happen within 14 days of a positive test. And that would be just for residents in the seven-county Metro area. Um, and for the entire state depth in individuals within 60 days of a positive test Those hospitalizations and death can be reported with the Minnesota Disease Report Card. The link is there (<https://www.health.state.mn.us/diseases/reportable/forms/reptcard.pdf>) or by calling our main infectious disease number. Next slide.

And finally, here's just another reminder that the prevention strategies for RSV are also effective against flu and COVID and other viruses. And so, uh, that includes washing your hands. Uh, keeping your hands off your face, avoiding contact with sick people. Um. Bring your coughs and sneezes, and cleaning and disinfecting surface disinfecting surfaces and for more information, the CDC does have this resource on RSV in older adults and adults with chronic medical conditions uh, which may be beneficial, uh, for you to read (<https://www.cdc.gov/rsv/high-risk/older-adults.html>). Next slide please.

And with that, I will hand it over to Tammy Hale to talk about infection prevention and control.

Thank you, Karen. Facilities can use the concept of identify, isolate, and inform when responding to any type of outbreak. So, let's explore this each component a bit further. And we'll begin with the concept of identify. Facilities should keep staff informed on the types of illnesses circulating in the community. There are multiple resources available that you can use to assist with this process. For example, Minnesota Department of Health sends out a respiratory illness report weekly and so some of my colleagues highlighted some graphs and some data from that report. And so that's one piece of information that you can communicate with your staff, what's occurring in your community. Facilities should also educate their staff on steps to take when a residence condition changes. Such as a fever, or a new cough. Education should include all staff, for example, activities, housekeeping and dietary, as we know these staff all interact with your residence on a frequent basis. For example, a housekeeper who might be interacting with a resident while they're cleaning the room might hear a resident state, "I'm not feeling well, today". That type of comment should be reported. And so, staff should know who to report changes to, for an example, the unit RN. Reminders or reeducation should occur with increased number of cases both in your community, or within your facility. As we are seeing increased number of respiratory illnesses throughout the state of Minnesota, it's advised that facilities, increase surveillance, assign a designated person. Usually, your infection preventionist to monitor for increased number of cases in your facility. It is also important to have a backup person to monitor for cases as needed and be sure to monitor, for cases across all units. Monitor for cases in both residents and staff. Facilities to consult with providers to determine what testing is appropriate when changes and resident conditions occur. This is done to identify a specific pathogen. Next slide please.

It's really important to identify the pathogen that's causing illness. When we identify the pathogen, we can better determine the length of isolation for the resident and the type of PPE to use. So, as highlighted in previous slides, PPE will vary, depending on if the resident has illness caused by influenza, RSV or as, you know, you need to use full PPE if COVID is identified. Identifying the pathogen will also help better determine the treatment options for the treatment potential and consultation with your providers. Identifying the pathogen will also assist with contact tracing. It may identify incubation periods length of illness and better determine which residents may have been exposed. Facilities should also determine the threshold at what point, to consider cases to be an outbreak and determination of an outbreak might depend on the type of illness. Now, consider that sometimes one case constitutes an outbreak. Facilities may also want to increase surveillance as cases of respiratory illness increase within their facility. You should preplan for how this will occur. For example, you may want to actively monitor your residents daily, twice a day, or three times per day. This may also vary based upon the type of unit, for example, memory care units. You may choose to increase surveillance more frequently if residents are unable to verbally communicate, any changes in conditions. Facilities should also consider increase surveillance of staff and visitors. Next slide please.

The next step now that we've identified a resident with a change of condition or identified a pathogen is we need to isolate those residents. So, place residents in transmission-based precautions as appropriate. Please know that you do not need to confirm a diagnosis to place a resident with new signs and symptoms of respiratory illness into precautions. The CDC has resources that can assist you in the type of transmission-based precautions to implement for different types of change in conditions, including not only respiratory illness, but GI as well. Educate staff on who can put a resident into transmission-based precautions. You should review your policy and procedures with staff upon hire, annually, and as needed. Facilities should also have resources and tools such as an isolation cart,

readily available. When a resident change in condition occurs, you don't want staff searching for supplies, such as gowns or gloves or masks. Be sure to also review your signage to ensure it clearly communicate expectations to staff who are entering resident rooms. Please note the CDC has standardized signs, which can be used, and I've included some examples here and some screenshots of the signs that the CDC has available. Facilities should implement other infection control and control practices as appropriate, for example, increasing environmental cleaning and disinfection may also be warranted. Next slide please.

In regard to isolation, be sure to provide education on PPE use to all staff. Resources and tools on donning and doffing should be readily available. And here's an example by the CDC of how staff can put on PPE. The order. They also have on the flip side of this instructions, for how to take off PPE. It's very important that your staff know how to appropriately don and doff PPE. You should also preplan for resources to utilize such as the MDH Project First Line. There are recorded webinars and resources on the MDH Project First Line website that you can utilize and assist with education of your staff. Facilities should also audit compliance with PPE and hand hygiene to identify any gaps, for example, as your auditing compliance with PPE you might observe that the isolation cart is small and you're frequently running out of gowns. It's important that staff restock gowns. If they take the last gown as a staff member coming to enter that resident's room may now not have the equipment they need. This is very crucial, especially if they need to enter the room urgently. So, audit the compliance with PPE, identify gaps and share those results with your staff. In addition, be sure to audit compliance with hand hygiene and ensuring that staff are performing hand hygiene prior to donning and after doffing PPE. Facilities should also ensure they have enough supplies on hand, utilize a standardized tool, such as a PPE burn rate calculator, ensure that you have enough PPE on hand, even when you only have one or two cases, because, as, you know, that can quickly escalate to say, 10 or 15 cases. Significantly impacting the amount of PPE that you have on hand. Next slide please.

So, now that we've identified a resident with a change in condition, the resident is now isolated now, think about who to inform both internally and externally. Determine who you need to inform a unit level, on a facility level, and also, with external. Such as the provider or providers of the residents with the change in condition, or your medical provider be sure to include information to staff. Not just nursing staff, but think about physical therapy, occupational therapy, or any other individuals who might be entering that resident care area. Also use a standardized tracking tool to track illnesses and ensure appropriate internal staff have access as well as a backup. Have a standardized tool to also communicate resident condition changes during transfers. Communicate with staff who transport residents as well, as receiving facilities. Here's an example of a CDC resource, and you'll note that it does have clearly outlined identified NDROs, but on the bottom portion, it also lists signs and symptoms that you can check to clearly communicate externally. Next slide please.

Also, preplan the frequency and the process for communicating updates. So, as the situation evolves, or as you have more residents developing signs and symptoms of illness, preplan for how you will communicate either via email, team huddles or memos. Also think about who is receiving that message, for example, if you're sending out emails to your housekeeping staff, be aware that they may not be checking emails frequently throughout their day. If they're not on a computer as frequently as other staff. Also know when to update external partners such as the Minnesota Department of Health, or your local public health jurisdiction. It's best to inform external partners early. I'd also just like to

remind facilities that we do have an ICAR team, and we can provide assistance with infection prevention and control questions as they come up. Also, preplan when to inform residents, families, and visitors, and once again, determine the frequency and the method of this communication. Next slide please.

I also wanted to call out some information that we have on source control, so you'll see a link here to our covert source control, masking, PPE and testing grid (<https://www.health.state.mn.us/diseases/coronavirus/hcp/ppegrid.pdf>). This was updated in the fall of 2022 after the last updates by the CDC to the infection prevention control interim recommendations, this resource provides assistance to facilities with when to mask, what PPE to use and some test testing considerations, particularly around COVID-19. Some of these concepts can be applied to other types of respiratory illness. This resource also provides considerations for uncontrolled COVID-19 outbreaks. So, I hope these infection prevention and control concepts help you navigate, especially as you may be facing different types of respiratory illnesses within your facility.

And with that, Here's some resources. Infection prevention and control, and I can turn it over to Sarah. Thank you.

- [CDC Transmission Precautions | Appendix A | Isolation Precautions \(www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/transmission-precautions.html\)](https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/transmission-precautions.html)
(Clinical Syndromes or Conditions warranting Empiric TBP)
- [CDC Prevention | Isolation Precautions \(www.cdc.gov/infectioncontrol/guidelines/isolation/prevention.html\)](https://www.cdc.gov/infectioncontrol/guidelines/isolation/prevention.html)
- [CDC Transmission-Based Precautions | Basics \(www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html\)](https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html) (links to signs)
- [CDC Isolation Precautions \(www.cdc.gov/infectioncontrol/guidelines/isolation/index.html\)](https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html)
- [CDC Precautions | Appendix A | Isolation Precautions \(www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html\)](https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html)
(Types and Duration of Precautions)
- [Minnesota Antimicrobial Stewardship Program Toolkit for Long-term Care Facilities \(www.health.state.mn.us/diseases/antibioticresistance/hcp/asp/ltc/index.html\)](https://www.health.state.mn.us/diseases/antibioticresistance/hcp/asp/ltc/index.html) (Note Appendix L)
- [CDC Inter-Facility Infection Control Transfer Form for States Establishing HAI Prevention Collaboratives \(www.cdc.gov/hai/pdfs/toolkits/Interfacility-IC-Transfer-Form-508.pdf\)](https://www.cdc.gov/hai/pdfs/toolkits/Interfacility-IC-Transfer-Form-508.pdf)

Thanks Tammy. Hi everyone, I'm Sarah Spah, I'm a Nurse Specialist in the Vaccine Preventable Disease section of MDH. I'll be talking a bit about influenza vaccine as it relates to adults and more specifically regarding long-term care, residents, and staff. Next slide please.

So, CDC says that everyone 6 months of age, and older should get a flu vaccine every season. It's especially important for people at higher risk of flu complications, such as those that are 65 years and older people with chronic health conditions, and people who are pregnant. People with asthma, heart disease, diabetes and a number of other chronic health conditions are at higher risk of developing potentially serious flu complications that can result in hospitalization or even death. In fact, in the recent flu season, nine out of ten people hospitalized with flu, had at least one underlying health

condition. That's why getting an annual flu vaccine is especially important for people, especially those with certain health chronic conditions. This is not only a great point when encouraging residents to get vaccinated, but also something to share with your staff and, of course people who live with or care for those at high risk and those who work in health care settings, as, you know, are also recommended to get vaccinated. Next slide please.

All influenza vaccines are now, quadrivalent, trivalent vaccines are no longer available. The Advisory Committee on Immunization Practices or ACIP recommends that people, 65 years of age and older preferentially receive any high-dose or adjuvanted influenza vaccine. This includes the quadrivalent, high-dose inactivated vaccine, the quadrivalent recombinant influenza vaccine or quadrivalent adjuvanted inactivated, influenza vaccine. However, if none of these three vaccines are available at the time of vaccination than any other age-appropriate influenza vaccine should be used. There is no recommendations for administering a second dose to adults, even if they receive the vaccine early in the season. And as a good reminder, COVID-19 and flu vaccines can be given at the same time including COVID-19 bivalent boosters. According to CDC's, Weekly US influenza Surveillance Report on January 6, the majority of influenza viruses tested are in the same genetic subclade as, and antigenetically similar to the influenza of viruses included in this season's influenza vaccine. Basically, meaning the vaccine is a good match and so that's a good sign this year. Next slide please.

One of the most common issues that arise with flu vaccine are questions about storage and handling. Proper storage and handling of influenza vaccine is critical to maintain its effectiveness and viability. In many instances, vaccine is not stored properly and actually needs to be discarded. Even with small amounts of vaccine that loss can add up to thousands of dollars, and if non-viable vaccine was administered, people will not have adequate protection and may need to be revaccinated and trust me those calls are not fun to make. A common myth with vaccine storage comes from the term cold chain. But, in fact, colder is not better. In inactivated vaccine. When exposed to temperatures below freezing becomes non-viable. Therefore, monitoring the temperature of all vaccine is vital. The parameters for storage of vaccines are very specific. Don't assume that your refrigerator is doing the job. CDC recommends the ideal temperature for flu vaccine storage is 40 degrees Fahrenheit or 4.4 degrees Celsius with a range from 36 to 46 degrees Fahrenheit or 2 to 8 degrees Celsius. There's several options for monitoring vaccine temperatures but ensure that you have a calibrated non-expire device, make sure that the temperature is checked and documented twice a day by a person. Therefore, you can detect if anything isn't right before the temperature goes out of range. We linked to several storage and handling resources from our website, and I'll show you where to find them at the end of the segment. Next slide. Please.

So, here, you're going to find the vaccine storage guide, and it's a very basic resource that any facility storing vaccine should have. You can order it at no cost from, or print it off on your own and the order form can be found in our website (<https://www.health.state.mn.us/people/immunize/ordermat.html>) and again, I'll show you that place at the end of the segment. Next slide please.

A vaccine information statement or VIS must be presented to all patients before they get vaccinated. Usually, this is done at registration or screening. This is a federal law. You must also provide the current addition for the vaccine you are administering. VISs are not typically updated every year, and for the influenza, the current edition is August 6 of 2021. The person getting vaccinated must have the option of taking a copy with them if they choose to, but you may also present them with a laminated copy to

read at the vaccination clinic. You may also have the patient download a copy on their Smartphone or mobile device, if they have one, and if they prefer. To find the most current addition, you can go to current on CDC's homepage at the following link (<https://www.cdc.gov/vaccines/hcp/vis/index.html>). And influenza are also available in several languages, and you can find the links to these at the Immunization Action Coalition or Immunize.org (<https://www.immunize.org/vis/>), or in our MDHs fall flu guide. And again, I'll show you that at the end of the segment. Next slide please

Another pretty common question for long term care facilities is about documentation. Documentation of vaccines is just slightly different than documenting any other medication in that you also need to include information about the VIS, and the person administering the vaccine. There are many ways this can be accomplished, depending on your facilities, medical records, and resources. And as you can see on this slide, what's required by federal law is the published date of the VIS, the date the VIS was given to the patient, the name, address, office address, and the title of the person who administers the vaccine, the date the vaccine is administered, and the vaccine manufacturer and lot number of each administered dose. What is good practice is also to document the site and the route of the vaccine administered. One of the more common issues is that information isn't always collected or maintained for vaccine given to health care workers. Federal law does require that this information is available for any vaccine that's administered. Not just to the residents and patients. Next slide please.

So, MDH has developed an influenza screening form template that is available in Microsoft Word and can be found on our flu webpage. You can modify this template to your agency's policy. It also contains the required documentation elements that we just spoke about. You can choose to complete the forms and keep them for documentation requirements. Next slide please.

Here we're going to talk a little bit about the vaccination of your residents. Optimally vaccination should occur before the onset of flu activity in the community. However, vaccination should be offered as long as flu viruses are circulating, and unexpired vaccine is available. Therefore, it's not too late. And there's still benefit to vaccinating throughout the season. Generally, by January, we see vaccination efforts decrease, however, make sure that any of your residents that come into the center, who haven't been vaccinated or those who declined earlier, but now want to get a flu shot can get vaccinated. Also, as it gets later into the flu season you may not have access to your first choice of flu vaccine product. So, give what you have on hand, as long as it's within the license age indication, and the patient has no contraindications. Make sure you're using the proper needle length of needle when administering flu shots, especially for residents who are frail or obese as they may need a different needle length, for example, frail patients may require bunching or a shorter needle length for intramuscular administration. For obese patients, they may require a longer needle length. Immunize.org has a good article on consideration for choosing the proper needle length for vaccination. So, I encourage you to take a look at that as it's a good resource for you. The Minnesota Immunization Information Connection, or MIIC, has a client follow up reminder recall tool that can assist you in determining which residents still need a flu shot. You can find the tool on MIIC's web page at the web address there (<https://www.health.state.mn.us/people/immunize/miic/train/followup.html>). Next slide please.

For health care personnel continue to vaccinate. Make sure that new employee has the opportunity to get vaccine and that people who have previously declined, have an option to get vaccinated. If at any point in the season, your out of vaccine for employees refer them to be vaccinated at a pharmacy,

clinic, or community vaccinated. It's not uncommon for people employed and long-term care to be uninsured, depending on their work hours, etc. So, keep in mind that we have Minnesota's Uninsured and Underinsured Adult Vaccine program to provide vaccines for those without insurance (<https://www.health.state.mn.us/people/immunize/basics/uuavsearch.html>). To assist in finding locations use the flu and COVID-19 vaccine locator (<https://www.vaccines.gov/>) for clinics offering vaccination. And consider your educational resources when promoting flu vaccination. Remember to tell your message to a lay audience as your staff may not all have the clinical background. Promote messages in languages your staff commonly speak or read, even if they're proficient in English or even seek out interpreters. Also, using informal leaders to promote vaccination has been proven to be successful and lastly use the client follow up tool in MIIC (<https://www.health.state.mn.us/people/immunize/miic/train/followup.html>) only if you're the vaccinator of your staff. Next slide please.

Here are a few helpful ways to talk about the benefits of flu vaccine with your employees. And even your own friends and families if they ask you. These main points on the benefits of influenza vaccination are from selected publications as listed on CDC's flu webpage (<https://www.cdc.gov/flu/prevent/benefit-publications.htm>). Vaccination reduces hospitalization in death. The flu vaccine for children cannot be overstated. Kids that are vaccinated have much better outcomes when they come down with the flu than those who do not. This goes for healthy children, especially. Flu vaccination reduces the severity of illness and keep people out of the ICU. If they do not if they do end up hospitalized, especially relevant for your residents, flu vaccination helps prevent the most severe outcomes that could impact their independence. Another group for which we strongly recommend vaccine for is pregnant women. Pregnant women experience a much higher rate of hospitalization. If they get influenza vaccine can reduce illness by 50%. And these can be found again at CDC's benefits of influenza vaccination. Next slide please.

So, how do we help message flu vaccine? First keep it simple. You don't need to get into the details right away. Let people know that flu is a serious disease and causes harm both to the high-risk groups listed here, but also to healthy adults. It's important to acknowledge that flu vaccine is less effective than we once thought. And then it will not prevent every case of the flu. The main message comes back to a strong recommendation and communicating that flu vaccine is a standard of care and you were offering it to protect patients and one another. Next slide.

So here is where I'm going to show you how to find the flu materials on our website when you type in www.mdhflu.com, you'll be taken to this page. Look at For Health Professionals section and that's in that red circle. That top red circle, you'll find information on testing, rapid testing vaccine, antivirals, infection control and reporting on this page. To find the flu guide click on Vaccine. Next slide please.

So, once you click on vaccine this, you're going to be taken to our influenza vaccine page where you will find the flu guide at the top. We recommend you bookmark or print this and keep it handy throughout the vaccination season. Occasionally, we're going to need to update this piece mid-season and if we do, we'll send out a notification via the GovDelivery list for Health Professionals, you can sign up for that GovDelivery and to receive these updates by clicking the box at the top of the page. And we kind of indicate that with that red arrow there. Next slide please.

Our influenza vaccine page also is a lot of resources for you to check out, including vaccine administration. And this is where that influenza screening form template is located that I spoke about

INFLUENZA AND RSV UPDATE FOR LONG-TERM CARE (LTC) TRANSCRIPT

earlier. The influenza vaccine page also includes information on storage and handling vaccinating healthcare workers. How to use the Minnesota Immunization Information Connection or MIIC and more. Next slide please.

And we do have a new inbox specifically for clinical vaccine questions. It is health.vaccineSME@state.mn.us. This is not for the public, but rather for you, and other clinical staff to ask questions on vaccine and on current recommendations. I'll now turn it over to Karen.

Thank you so much Sarah. Finally, we just have some contact information for you here. Um, we have infection prevention and control questions can go to health.icar@state.mn.us. Clinical vaccine questions again, this is for not for the public, but for providers can be sent to health.vaccineSME@state.mn.us and then infectious disease questions. Um, including influenza and RSV can go to our main disease number, which is 651-201-5414 or toll free and with that next slide please.

I just want to thank everyone for coming today. Um, I'm hoping that, uh, that things in the in the respiratory world are settling down, although, um, as we've seen from the data, there are still quite a bit of, uh, viruses out there and activity is still high. Um, but we hope that, um, some of the information, at least today provided was helpful as mentioned in the chat, this, uh, webinar is being recorded and a transcript and access to the slides will be available on our website soon. So, I hope everybody has a wonderful day. And thanks again.

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01/11/2023

To obtain this information in a different format, call: 651-201-5414.