Transcript: Long-term Care Respiratory Season Kick-off Webinar

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Good afternoon, everybody. Thank you for joining us today for our respiratory season kickoff webinar. We're happy you're all able to be here with us. We wanted to share a couple of different things from across MDH as far as some vaccination updates, some topics including Influenza, COVID, RSV, MIIC related topics, infection control, some about some survey process information, programmatic updates, and then we'll have time for Q and A and we're excited that you are all able to be here and take time to spend with us this afternoon. Next slide please.

A little bit about the cadence of this afternoon. I'm gonna just start relisting the topics. So, we will just go through a couple of housekeeping things. First, you should have access to the Q and A and the chat. If you don't have access to the chat, just please utilize the Q and A. As far as any questions, we will have time at the end to answer any questions that you have collected throughout the process. We're gonna start off talking about Influenza, first of all, today, talking about vaccination recommendations. We're gonna be talking about COVID-19, RSV, we'll have a MIIC demonstration, we'll have updates from the infection control team as well as about our survey processes and introduction to a new program entitled RespSafe. and again, at the end, time for questions. Next slide please.

My name is Phoenix, I will be here throughout this webinar sort of guiding things through. We're excited again having you all here today and we look forward to sharing this information with you. Next slide, please.

And I'll hand it off to Jeff.

Okay, thank you Phoenix, and hello everybody. My name is Jeff Sanders, Epidemiologist in the vaccine preventable disease surveillance unit. I'm just gonna start with an overview of Influenza, the outbreaks that we saw last year and some information about Influenza management during outbreaks.

So, to begin, a refresher that influenza is a respiratory virus that attacks the nose throat and lungs, and we typically say that there are four main strains. There are two that are influenza A, called H1N1 2009, which is the swine flu variant of 2009 pandemic. And then A/H3N2. There are also two influenza B viruses, and they are distinguished with a lineage of Yamagata or Victoria. However, it's interesting if you don't follow the flu surveillance is that Yamagata has not really been detected in the world since the CIVID-19 pandemic began around March 2020, so that is something that we are sort of considering extinct and the vaccines for Influenza of this season have been updated to reflect that this virus does not seem to be circulating anymore. The high-risk groups for Influenza are older adults who are older than sixty-five, young children less than two years, pregnant women, and those with a lot of different chronic health conditions, some of which are asthma, diabetes, and heart failure, and then the demographic of American Indian, Alaskan natives also are high risk groups. The illness of influences about four to seven days and it primarily spreads through close proximity in the form of droplets and these droplets can

remain on surfaces for up to twenty-four hours. Testing for influenza, it's always good to test when the results will influence clinical management such as antiviral treatment, and hospitals should test for flu upon admission of patients with flu likes symptoms. Give me the next slide.

Okay, so these are just some results from the long-term care outbreak reports that we received during the 2023 through 2024 season, we had 100 confirmed influenza and RSV outbreaks and 84 of those at the time of report reported that it was Influenza with sixteen outbreaks reporting that it was an RSV outbreak, and although our stats on the webs, the website did not reflect the different viruses being reported in the, in the report for that season, we are looking at, we're expecting that the, the graph for the upcoming seasons data will start to differentiate the virus reported based on what you enter on your report. And then among the eight, the eighty facilities who answered the question with influenza outbreaks, about ninety percent used antiviral treatment and about eighty seven percent were using antiviral prophylaxis at the time of report, and at the time of report, about thirty five percent of the facilities reported either in an RSV or an influencer related hospitalization. Can you go next slide?

Okay, so influenza management when you have an outbreak, if you, I don't think I I'd mentioned an outbreak is at least two confirmed cases of either Influenza or RSV within seventy-two hours, but in this case, Influenza management, we're following standard and droplet precautions for all residents with suspected or confirmed flu that is continuing for seven days after the illness onset or twenty-four hours after the resolution of fever, whichever is longer. And it's always recommended to treat the suspected and confirmed flu cases immediately, not waiting for lab confirmation per se, and it's best to receive this treatment within two days of symptoms and while there are four approved influenza antiviral drugs, only Oseltamivir has the data to support use during an influenza outbreak. The other end of antiviral management is giving prophylaxis in the form of oral Oseltamivir to eligible well resident in the effective ward. This is really meant for people that are, are exposed. So, you have some leeway perhaps and, you know, whether you want to do the whole, the whole facility or depending on how you are set up, just the effected places. You can also offer chemoprophylaxis access to your health care personnel or refer them to their provider. And next slide.

This is just to summarize the treatment and chemoprophylaxis doses of Oseltamivir during outbreaks. The treatment dose is seventy-five milligrams twice daily for five days and maybe considered longer treatment course for very severe illness. And then the chemoprophylaxis course is seventy-five milligrams once daily for a minimum of fourteen days continuing for seven days after the last known case was identified and always recommending to consult with your physicians for the residents for dosing guidance since they will need to be adjusted for kind of health conditions like renal impairment. I think that is it from myself. Is there someone to do this slide?

Yes. Thank you.

Thank you. So, my name is Caitlyn Stehlin. I am one of the nurses on the clinical team here in the vaccine preventable disease area here at MDH. I'm just gonna talk briefly about Influenza vaccination. I know that probably most of you are familiar with this, not many changes from last year, but ACIP did, reaffirm the recommendation for a routine annual flu vaccine for a person six months and older who do not have any contraindications. All the flu vaccines for this season will be trivalent. There as Jeff had mentioned in his prior presentation, there have been no influenza B or Yamagata component confirmed detections since March of 2020, so they did remove that component so it will be trivalent versus last year, which is a quadrivalent. Same as last year, September and October remained the best times for most people to get vaccinated, and then as always vaccinate as long as influenza viruses are circulating. As far as flu high

dose, again, seems last year recommended for persons sixty-five and older and it also, this year, does, well, new this year it is an option for persons, an acceptable option for persons for solid organ transplant recipients who are nineteen to sixty-five years old who are on immunosuppressive medication regimens CDC: ACIP Recommendations: ACIP Recommendations: Influenza (Flu) Vaccine (www.cdc.gov/acip-recs/hcp/vaccine-specific/flu.html), CDC: Vaccines & Immunizations: Adult Immunization Schedule Addendum (Addendum updated June 27, 2024) (www.cdc.gov/vaccines/hcp/imz-schedules/adult-addendum.html). Next slide please.

So, then a quick, about data. So, immunization data are from the Minnesota Immunization Information Connection or MIIC and MIIC is Minnesota's statewide immunization information system or the IIS, and we'll share rates by age, which is calculated as of October 1, 2023, and rates by race and ethnicity are based on data submitted to MIIC by participating organizations, and then we'll share rates by region, which is based on health care coalitions Regional Health Care Preparedness Coordinators (RHPCs) (www.health.state.mn.us/communities/ep/coalitions/rhpc.html). Next slide please.

So, in the 2023-2024 influenza season, sixty five percent of Minnesotans over the age of sixty five received at least one dose of flu vaccine and this is below the healthy people twenty thirty goal of seventy percent vaccination against Influenza health.gov: —Healthy People 2030: Increase the proportion of people who get the flu vaccine every year (https://health.gov/healthypeople/objectives-and-data/browse-objectives/vaccination/increase-proportion-people-who-get-flu-vaccine-every-year-iid-09). When broken down by selected demographics, we see that flu coverage rates by or by race and ethnicity were lowest among black, non-Hispanic Minnesotans at seventy or at forty three percent and Hispanic Minnesotans at fifty two percent, and by age were lowest among sixty-five- to seventy-year-olds at sixty percent. Next slide please.

So, when looking by region, based on health care coalitions, we see that all regions are still below the healthy people, twenty, thirty goal, and twenty-three twenty-four flu rates were lowest in, Western Minnesota. And then next slide, please. And I will pass it to surveillance for COVID-19. Thank you.

Hello everyone, my name is Jared Shank, and I am an epidemiologist on the long-term care surveillance team within the COVID-19 section at the health department. Today I'll briefly discuss COVID-19 in Minnesota assisted living and skilled nursing facilities over the last year, as well as COVID-19 reporting requirements. Next slide.

While we have seen some movement towards seasonality of COVID-19 infections over the last year, there has been consistent activity in assisted living and skilled nursing facilities with more surges in the colder months and periods of lower activity in the warmer months. This is a little different than RSV and influenza. So, we will continue to monitor trends as we head into the fall respiratory season. However, the current signs and symptoms of COVID-19 are quite similar to both Influenza and RSV, which is why testing is important to identify which respiratory infection is circulating during facility outbreaks. Over the last month to six weeks, we've seen a late summer surge because of the newer flirt variance circulating both locally, here in Minnesota and around the United States. The good news with the newer variance is that they appear to cause similar respiratory symptoms and duration as previous variants, and the new vaccine coming out will provide specific protection for these variants as we head into the fall. Next slide, please.

One difference between COVID-19 in long-term care facilities compared to Influenza and RSV that I want to make sure that I spend a little time highlighting today are the reporting requirements. In the state of Minnesota, both assisted living and skilled nursing facilities are required by state law to report cases,

positive laboratory results, and deaths to the health department. On this slide, the three separate reporting requirements are separated by license type. And the link at the bottom of the slide will take you directly to the page where you can find more of this information COVID-19 Reporting Requirements for Minnesota Long-term Care Facilities (PDF) (www.health.state.mn.us/diseases/coronavirus/hcp/ltcreportrecs.pdf).

For skilled nursing facilities, aggregate weekly case counts should be reported to NHSN. Positive laboratory results for any rapid tests run on site under a clear waiver should be reported to either NHSN or simple report, and deaths in any residents with COVID-19 infection within ninety days of death should be reported to the MDH COVID-19 long term care report form. For assisted living facilities, aggregate weekly case counts and deaths in any residents with COVID-19 infection within ninety days of death should be reported to the MDH COVID-19 long term care report form. And any rapid tests run on site under a clear waiver should be reported to simple report. Because these reporting requirements are a little more involved and vary based on the license type, please feel free to reach out to the long-term care surveillance inbox with any additional questions or clarifications at health.LTC.covid19.MDH@state.MN.us, and thank you for all of your continued work on COVID-19 in long term care facilities. We really appreciate it. And that is all from me and I will pass it along for the COVID-19 vaccination update.

Thank you, Jared. This is Caitlyn back with you again. So, I'm just gonna go over, COVID-19 vaccine recommendations. FDA did approve the new 2024-2025 formulation last week, ACIP did recommend this new formulation for person six months and older, it was recommended that one dose of this new formula eight weeks after any previous COVID-19 vaccine dose. Additional doses were recommended for moderately or severely immunocompromised persons for them to receive an additional dose, at least two months after their last dose. However, it is not currently recommended for persons sixty-five plus who are not immunocompromised. And then people who had a prior COVID-19 infection, they do, I guess not recommend, but you may want to consider delaying vaccination by three months if you have had a recent prior COVID-19 infection. Next slide please.

And then in the 2023-2024, just to go over some data quickly here, fifty six percent of Minnesotans over the age of sixty-five received at least one dose of COVID-19 vaccine. And then when broken down by selected demographics, we see that COVID-19 coverage rates by race and ethnicity were lowest among black and non-Hispanic at forty percent and Hispanic residents at forty four percent. And by age, we're lowest among sixty- to seventy-four-year-olds at fifty percent. Next slide please.

And then when looking by region based on health care coalitions, we see that all regions have lower COVID-19 rates compared to Influenza, and similar to flu, COVID-19 rates were lowest in western Minnesota. And then the next slide please. And I will pass it to Erica to talk about RSV. Thank you.

Yeah, thanks so much Caitlyn. My name is Erica Mumm, I'm the RSV hospitalizations surveillance officer at MDH. And I'll just be giving a brief overview of RSV disease reporting and general trends. Next slide please.

So respiratory syncytial virus causes acute respiratory illness in people of any age, and it's one of the most common diseases of early childhood. It's a disease that we're concerned about because I can cause severe illness such as bronchiolitis, which is the inflammation of the small airways in the lung and pneumonia infection of the lungs. High risk groups do include older adults. Anyone over sixty is recommended to, you know, consider a vaccine with their provider as we'll talk about later. But particularly we'd be concerned about those older adults seventy-five and older. Other groups at high risk

include infants, those with chronic health conditions and members of the American Indian, Alaska native community. The incubation period for RSV is about four to six days and transmission can occur by director closed contact with contaminated secretions. RSV is a little bit more fragile than the flu virus, for example, but it can survive on environmental surfaces for several hours and more than thirty minutes on hands. Next slide please.

Currently in Minnesota, RSV is only required to be reported for hospitalized cases and deaths. New as of last year, this is for any Minnesota resident, it was previously just for those who were residents of the seven county Metro area, but it's expanded now to be any Minnesota resident who has a positive RSV test by any method, and is then either admitted or observation status within fourteen days of the positive test or has a death in that patient within sixty days of the positive test. And thus, do not need to be hospitalized to be reported, and this can be reported via the MDH disease report card. Next slide please.

And just a little overview of general trends and RSV, we can see that in the 2020-2021 and 2021-2022 seasons, we had a little bit of atypical seasonality, but we've moved back to our regular, you know, normally only seeing high RSV activity peak RSV activity between October through April with the peak usually being in December or January. Next slide please.

And we can see that in the 2022-2023 season, we saw our highest number of RSV cases in the metro than we've seen for the past six years and cases did go down a little bit in 2023-2024, but activity did remain high. Next slide please.

And then this is just a, a quick overview of the hospitalized cases by age that we saw for the last season. So, you can see that we see most of our cases in, infants under one year old, but our next highest group that we see hospitalized is those sixty-five years and older. Next slide and I think I'll pass it over to our vaccination team. Thank you.

Thank you, Erica. This is Caitlyn again. I'm just gonna go over some RSV vaccine current recommendations for older adults. So ACIP did recommend an RSV vaccine for everyone, ages seventy-five and older and ages sixty to seventy-four at increased risk of severe RSV. So, adults sixty to seventy-four who are at increased risk include those with chronic heart or lung disease, certain other chronical medical conditions, and those who are residents of nursing homes or other long term care facilities, RSV Vax, the vaccine is not currently an annual vaccine. So, in other words, if someone has already received the vaccine, they don't need to get another one at this time. And the best time to get vaccinated is in late summer or early fall. So, right now, I've also, at attached the link, for more detailed recommendations CDC: RSV (Respiratory Syncytial Virus) Immunizations (www.cdc.gov/vaccines/vpd/rsv/index.html). Next slide please.

And then, just some RSV state wide rates. So, this summer the RSV recommendation was adjusted to recommend that all individuals, seventy-five and older receive at least one dose of RSV vaccine. And so, this is a good opportunity to see what our current coverage rates are in the seventy-five plus population to identify, you know, opportunities to increase RSV vaccination, and as of July 2024, twenty six percent of Minnesotans over the age of seventy-five received at least one dose of RSV vaccine. And then when broken down by a selected demographics, we see the RSV coverage rates by race and ethnicity were lowest among black, non-Hispanics at eight percent and Asian Pacific Islander Non-Hispanic at fifteen percent in Hispanic residents at seventeen percent. And by age we're lowest among eighty-five plus at twenty three percent. Next slide please.

And then when looking by region based on the health care coalitions, we see that all regions have an opportunity to increase their seventy-five plus RSV rates after the new age-based recommendation was approved this summer, and currently again, RSV rates are lowest in Western Minnesota. And then next slide please. I am going to toss it to MIIC with Jenevera and Maureen. Thank you.

Hi, thank you. My name is Jenevera I'm with make operations and Maureen is here with me as well. I'm just real quick gonna go over, you kind of heard what MIIC was and I'm just gonna show you how to log in and look up a record for anyone who is not familiar. If you don't know if you have access to MIIC yet, you can always email the help desk. I will put that address in the chat, and then I'll put the web link to the web pages as well health.miichelp@state.mn.us, Minnesota Immunization Information Connection .. [Login] (https://miic.health.state.mn.us/miic/psp?cmd=SplashHandler). Next slide.

So, as was mentioned before MIIC is it's, it stands for Minnesota Immunization Information Connection. It's a statewide IIS created in 2002. It's a confidential system that stores electronic records for clients, in this case client would mean your patients. It combines a person's immunization record into one single record, even if they were given by different providers from all over the state. And it does, it's used to support practice monitoring and improvement in Minnesota. Next slide.

And then I'm gonna try to navigate to my screen here. So, this is the MIIC login screen. This is the test environment. Can you not see it? Whatever, nope.

Go to the bottom to share and hit the share button and then share your screen.

That's what I did. Okay. Share entire screen. Window. Okay, I can figure it out guys. Why is this not working? Okay. Can you see it now?

Yes.

Okay. Okay, so this is the MIIC web login screen. This is the test environment, so just so everyone knows these are fake clients. None of this information is real, but it does work the same as the real. So, when you get a login to MIIC, you'll need an organization code, a username, and a password. You'll notice on this screen that, in this little box down here, we do have an email address that if you don't know what to do when you get to this page, you can email us. There's also a little light bulb up here on the top right side and that'll get you more information on our webpage. For now, I'm just gonna log in, which is always fun to do in front of people.

Okay, so this is the MIIC, this is what MIIC would look like. I am logging in as a typical user. This yellow ribbon will tell you what organization you're under, your, your name, and then your role MIIC. On the above that, there's this manage my account. This is where you would go to edit any of your information, including your name. Like if you have a name change, you change your password here and this is where you set up security questions. If I click on home, it takes me to that same screen. You can also click on this help desk icon, and it should generate an email, which it might not show here. It should generate an email to the MIIC help desk from this screen. And then this little light bulb like I mentioned, will navigate you to our MIIC user guidance and training resource page MIIC User Guidance and Training Resources (www.health.state.mn.us/people/immunize/miic/train/index.html). This is a really useful page. It tells you a lot of information about the application, and it also gets you to how to participate in MIIC on this page.

Now real quick I'll just look up a fake client and then I'll send it on over to Maureen. There's a lot of ways to look up clients. You want last name, first name and birth date or some part of a combination of those three. So, I'm just gonna look at it. It does depend on how unique they'll name is and the last name and

first name. So, I know that Rainbow Bright is in here, so I'm just gonna put her last name in first name. So, this is what's called, I'm sorry, I should go back. You're gonna go to manage client and type in the information. So, I'm gonna put in Bright and Rain and hit find and you'll see that there's two Rainbow Brights in here. This client has an AKA on their record. That means that somebody changed their last name first name or birth date at some point. And you'll see on this screen that the AKA was how Rainbowed Bright's last name was spelled previously. This is a demographics page. This is everything that MIIC has for this client. So, last name, first name, and birthday are the minimum information we need to have a client in MIIC. If you have mother's maiden and last name and mother's first name, we want that. If you have any of this other information, we'd love that information. If you have street address and phone number, we would also love that. And then from here you can click on immunize and it'll take you to what we have on Rainbow Brights immunization record. So, I'll just scroll down a little bit before I send it over to Maureen and then she can kind of explain the forecaster part. So right here, is all the information we have for Rainbow Bright for all the immunizations, and then this bottom part, I believe is what this group is interested in that is the forecaster. So, I'm gonna stop sharing unless it's easier for you to just take it. I'll just stop sharing.

Great. How about now?

Okay sorry we had to deal with some audio problems here in the room. Alright, so we're taking a look at an older gentleman here. It's been a while since I used Webex folks. All right, so we have here the immunization screen for a different test client than the one Jenevera was showing you. This one is an older gentleman that I pulled together for the long-term care kind of community. We just sort of have our different columns here for each immunization that this person has received, I only I kept it to four just to sort of keep things nice and simple. There's a little, demographic blurb up here to sort of remind yourself who you're working on and how old they are. Their date of birth is calculated into an age down here, which is pretty useful. For each immunization that they have received, we have the vaccine group that it's sorted into. If they have received a vaccine, like a combination vaccine, it would appear multiple times in this area. So that you can look by vaccine group and not have to guess which group it has been put into. We also have the date administered column that gives the specific date on which the vaccine was given, if you'll notice it's highlighted as a blue link here, if you ever want to click on that, you can click and a small window should pop up, information on the schedule that MIIC is using for that, that vaccine group. So, for the zoster 2 dose series shingles, it gives the minimum age, and the minimum valid interval between the doses.

Next is the series column, so you know of course depending on what type of vaccine it is, there might be multiple doses in the series or just one, for example, right now we just have one for Covid routine. But hopefully that will show up the next dose that this person gets to this season will show up as a booster. Information on the vaccine type and then in square brackets we have the vaccine trait name. We don't always have trade name information if it's not sent to us by an organization, we're not going to have it. And then if you have the right permissions, you can click the edit button on a vaccine and there is some information that you're able to change if necessary if you are the, the organization that entered the vaccine. But this is also useful if you scroll down to see. Which organization owns it. So, if you have a question, about why a vaccine was given for an example or if there may be either you have a concern about the date, and you're not sure if it was correct or not and you have questions about the pro, not with the provider, but the vaccine, this should give the contact information for the organization that entered it. So, we'll escape from there.

Down here at the bottom we have the, the forecaster, which predicts which vaccines this client is due for by vaccine group. Only vaccine groups that are appropriate for this person's vaccination history and age will be shown. So, for example, this is a, a seven-year-old client. So, it's not telling you, hey, maybe, maybe you could go back and give them the chicken pox vaccine. It's their, they're a little beyond that. Same for example for the meningitis vaccine or HPV. MIIC bases this recommendations on the ACIP recommended schedule. We aren't unable to take into account recommendations for people with particular medical conditions. This is just the standard recommendations for these for based on age. So, as you can see, we have updated the COVID routine schedule, so it is predicting, its recommending we're gonna do it the same as flu, so the quote on quote COVID season will start in July just like flu, and so it's predicting by based on seasonality that they should be getting a flu shot and a new updated COVID shot this fall. It also has that information; this person never got a hepatitis B series; they should probably look into that. Same for the pneumococcal conjugate vaccine, and they need a tetanus shot.

For vaccine groups where they have completed the series, it'll just show complete. So, no dates necessary for this one as they have had both doses and there's no need for them to receive any more at this time. Alright, so that's a quick look at the MIIC immunization screen and MIIC forecaster as Jenevera says, we're gonna kind of hammer that point home over and over again, if you ever have a question about any of the items in here, the vaccine groups, this series numbers, if something shows up not valid, the different vaccine information, please feel free to contact the make help desk health.miichelp@state.mn.us.

Okay, good afternoon, my name is Brenda Fischer. I'm a nurse and I'm one of the regional operations managers here at MDH and I oversee the federal teams. What we're gonna talk about today is going to be the long-term care survey process regarding immunizations. So next slide please.

Okay. So, part of long-term care, there is immunizations that are part of the regulatory process. So, we're gonna over review Influenza, which the flu influenza season starts on October 1 to March 31. And I just have a reference underneath here that is underneath the F883 three that's the regulation, and then we're also gonna talk about the COVID-19, then there's the CDC guide guidance as Caitlyn had identified earlier, and the regulatory aspect underneath this is under F887 and that talks about residents and staff, and then the pneumovax. And we're not gonna talk about the pneumovax today and you're just to follow the guidance under that F883 regulation and then the RSV. RSV is really not identified in our state operations manual or in any QSO memo. So, CMS is not directed the survey teams to be reviewing these at this time. So next slide please.

So, what we're gonna talk about is underneath the immunizations for F883, and it talks about Influenza and that the facility must develop policies and procedures and they need to be offering the influenza immunization for each resident or the representative along with receiving education regarding the benefits and the side effects of this immunization. And that we the survey team looks that the facility did offer this during this influenza season. So again, October 1 through March 31 annually, we look at unless the immunization is medically contra indicated or that the residents have already been immunized during this time frame. So next slide please.

In addition, the regulation does talk about the residents and the representative had the opportunity to refuse this immunization as well. The, so what we would look at is the resident's record that includes documentation that indicates at a minimum the following here that a resident or the representative was provided that education regarding the benefit and potential side effects of the influenza immunization and that the resident either received the influenza immunization or did not receive the Influenza

immunization due to medical contradictions or refusal. This is really an area that we do look at when we are doing our survey for this. So, just make sure that all that is documented. So next slide please.

And part of our regulations is typically an intent and really the intent of this regulation is to minimize the risk of residents acquiring and transmitting or experiencing complications from either influenza or the pneumococcal disease in ensuring that the residents are informed of the risk and benefit of these immunizations. They have the opportunity to receive the immunization as well, unless medically contract indicated as we identified earlier, and also is to ensure that documentation is in the medical record for that information as well. So, that's really the intent of this regulation. So, next slide please.

What we're also gonna do is we're gonna review the infection prevention controlling immunization pathway. This is the pathways that the surveyors use when they're making a determination of compliance. So, we're gonna be going through this, which really gives the direction of the survey team of how to investigate it. What they're gonna do is they're gonna review at least five records. They're gonna review for influenza, pneumococcal and COVID-19. So, they're gonna choose five residents from different areas of the facility to make sure they have a stratified sample. They're gonna review residents from the current fly season if they're in one, any new admissions they may look at those along with the previous flu season. Just to make sure that the facility system is, is accurate and it's being implemented. They're gonna also look at screening and eligibility to receive the vaccine if the individual is eligible or not, they're gonna look for education related to influenza and the COVID-19 vaccines. If they have a benefit and the potential side effects have been identified in there as well. The administration of vaccine is in accordance with the national recommendation, which includes doses administered and they must follow the CDC and then the advisory committee on immunization practices recommendations for these vaccines. And as always, allowing the resident or representative to accept or refuse these vaccines for influenza, pneumococcal, and COVID. And if they haven't provided them, I'm really, they need to identify document why as well.

So, as we continue on this pathway, looking for surveys occurring, like I said during influenza season, we're gonna look to see if, if there was any time when it was unavailable for the influenza or COVID-19 vaccine or if there was a limitation to supplies. If this occurs during this time frame, the facility really needs to demonstrate that the vaccine has been ordered and the facility received confirmation of the order, and again the vaccine has been shipped or that the product is not available but will ship when a supply is available. And any plans are to develop and how they're gonna administer that vaccine once they receive it. Really the facility is responsible for communicating with the pharmacy for the supply when it's coming in and really that ongoing communication they really need to have. So, next slide please.

And the pathway continues, and it talks about that the facility must develop the influenza, pneumococcal, and COVID-19 policies, and procedures for their residents and along with reviewing the policy, they're gonna interview facility staff and residents and representatives to a determine if the residents or the representative received the education on the benefits and side effects before the vaccine was offered. If multi doses are required, how are residents and representatives will again receive that education on the benefits and the side effects before the vaccine is offered along with how screening is conducted for eligibility, are they looking at the medical contraindications, previous vaccinations, and if the vaccines are offered in the consent of refusal is obtained. Next slide, please.

And then when you get down towards the end of the pathway, it gives a surveyor a couple questions which they have to identify a yes or no, as part of their investigation. So, the first question based on

their investigation, they're gonna be asked, did the facility provide influenza and or pneumococcal immunizations as required or appropriate for the resident that they're reviewing. It's either a yes or a no, that's no, then they would cite with their information F883. The other question that they'll answer, did the facility educate an offer the COVID-19 immunizations or required or appropriate for the residents, either a yes or no. Again, if they answer the no, then they would issue that F887 citation for that time, for those residents. So next slide please.

In addition, on that pathway, it does talk about educating and offering the COVID-19 immunizations for your staff as well. Again, the, the surveyor will pick a stratified sample of staff that are new who then there for a couple of years and then across different areas of the facility. They really are gonna focus on the facility system to make sure that it is accurate and that is being implemented. They're gonna look for during that sample of staff if they've had evidence of that screening and eligibility to receive a vaccine. If they've been provided the education regarding the benefits, the risks and side effects associated with that vaccine for the co COVID-19, and if they're being offered the vaccine or provided information at obtaining the vaccine. And if, if they have the availability, the administration of the vaccine if it's accepted. As always, the staff can accept or decline that vaccine as well. So next slide, please.

Along with this and just as a residents, they're going to look at the policies, they're going to interview staff and determine how staff are educated on the risks and benefits of the side effects, how staff vaccines status is documented and again, the screening for eligibility, and if the facility provided information to the staff obtaining that Vaccine, if it is not available in the facilities. So, they're gonna look at all those components. Next slide please.

Then as before, this is a question that the surveyor will answer as well, did the facility maintains staff documentation of screening, education, offering and current COVID-19 vaccination status, they will answer yes or no for that, as well. And so next slide please.

And just to give you some resources about the information we just discussed in all these areas.

- cms.gov: QSO-21-19-NH (www.cms.gov/files/document/qso-21-19-nh.pdf).
- eCFR :: 42 CFR 483.80 -- Infection control (www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.80).
- cms.gov: SOM - Appendix PP (PDF) (www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf).
- CMS: Nursing Homes (www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes).

I'm going to hand it off to Kari who'll discuss infection control. Thank you.

Thanks Brenda, so my name is Kari Bergman and I'm a nurse specialist with the MDH ICAR unit, which stands for Infection Control Assessment and Response. And today I'll be discussing how implementing infection prevention and control measures can help protect residents and staff from respiratory viruses this season. Next slide.

So, preventing the spread of respiratory viruses and nursing homes requires a comprehensive approach that includes not only vaccination but also testing, treatment, and the implementation of proven infection prevention and control measures. Taking together these actions can protect residents and staff from respiratory viruses. So, identifying cases early, isolating and then informing transferring facilities of a resident's infection status are three main ways to reduce transmission. So, for identify, we want to

ensure everyone, including residents, visitors, and health care workers, are aware of a recommended IPC practices in the facility, including when specific IPC actions are being implemented in response to new infections in the facility or increases in respiratory virus levels in the community. This education can include what steps to take if a resident's condition changes such as developing a new cough or fever, and who to report those changes to. And as new cases continually developed reeducating staff on infection prevention and control measures. We want to encourage staff to recognize when they signs and symptoms of our respiratory infection and reinforce sick leave and work restriction policies, including circumstances when they should not report to work. Staff must understand how respiratory pathogens are transmitted and measures to prevent their spread in order to effectively model and communicate this information to residents and visitors. This can include respiratory hygiene and cough etiquette and hygiene PPE donning and doffing, and environmental cleaning and disinfection. It's also important to increase surveillance in the facility as this helps to identify new cases and residents and staff and to develop plans to provide rapid clinical evaluations such as testing and intervention to ensure residents receive timely treatment when needed. Next slide.

So, testing results can inform recommended treatment in IPC actions. Testing can identify the pathogen causing illness which informs you of the length of isolation, the PPE that is needed and the treatment options. When an acute respiratory infection is identified in a resident or health care worker, it's important to take rapid action to prevent the spread to others in the facility. While decisions about treatment, prophylaxis and the recommended duration of isolation vary on the pathogen, IPC strategies such as placement of the resident in a single person room if available, use of face mask for source control and physically physical distancing are the same regardless of the pathogen. There are several triggers that should prompt investigation on whether an outbreak is occurring in your facility such as an increase over baseline infection rates or a sudden cluster of infections occurring in a common location such as a unit or floor or during a short period of time may also signal and outbreak. The purpose of an outbreak investigation is to stop transmission of pathogens and prevent additional infections and residents, staff, and visitors. Early identification of an outbreak in implementation of IPC measures are critical to reducing transmission. On this slide, there's a link to the viral respiratory pathogens' toolkit for nursing homes for more information. It's also included on the resource slide as well CDC: LTCFs: Viral Respiratory Pathogens Toolkit for Nursing Homes (www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html). Next slide.

So, to prevent spread, we want to apply the appropriate transmission-based precautions for symptomatic residents based on the suspected cause of their infection. Diagnosis of many infections requires laboratory confirmation. Since laboratory tests can take some time to result, transmission-based precaution must be implemented while test results are pending based on the clinical presentation and likely pathogens. Use of appropriate transmission-based precautions at the time a resident develops symptoms reduces transmission opportunities. It's also important to educate staff on who can put a resident into transmission-based precautions and what supplies are needed and how to access them. Signage should be placed at room entry and CDCS standardized signs, which I did include in the resource page. PPE supply should be well stocked and easy to access prior to room entry and medical equipment such as stethoscope should be dedicated to a resident on isolation if possible. Alcohol based hand sanitizer should be readily available for health care workers to clean hands and a waste receptable should be readily available for doffing PPE. Supply should be monitored regularly by designated personnel and restocked as needed. And we want to implement other infection control measures to reduce spreads such as source control, consider limiting or ceasing group activities in communal dining, halting new admissions to the affected units, reinforcing sick leave policy and monitoring absenteeism

due to respiratory symptoms. We also want to emphasize the importance of hand hygiene for staff and residents, respiratory hygiene, and cough etiquette, as well as enhanced cleaning and disinfection measures. Next slide.

So, continuing on with isolation, we want to provide education on how to don and doff PPE and pre plan for resources to utilize. Project first line is a partnership between CDC and MDH that provides infection control education for all frontline health care workers, staff, and members of the public health workforce. The goal is to understand and confidently apply infection-controlled principles. Project first line has specific trainings regarding respiratory illness and PPE that you may be interested in for staff education. And lastly, to provide additional training and response to recognize lapses and adherence, the MDH ICAR team has developed a suite of infection prevention audit tools to help collect and analyze audit data Project Firstline Training and Resources (www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pfl/training/index.html), ICAR Infection Prevention Audit Tools (www.health.state.mn.us/facilities/patientsafety/infectioncontrol/icar/res/audit.html). Next slide.

And the final action to reduce transmission is to inform both internally and externally. Who to inform on a unit level such as notifying staff, at the facility level such as the director of nursing, and external partners such as providers to ensure appropriate follow up and treatment of residents. Utilizing a standardized tool to track illness can help facilities monitor infections in their facilities and inform surveillance measures. And during resident movement, strict adherence to IPC practices must be followed to ensure additional transmission does not occur. If the resident is to be transferred out of the facility, it's important to communicate their infection status with other health care facilities prior to their transfer. Next slide.

It's also important to pre plan the frequency and process for communicating updates for staff. This could be in team huddles or by emails or memos. It's also important to pre plan communication with residents, families, and visitors. As we enter a respiratory season, you could consider sending out letters or handouts to residents and families educating about vaccinations, risk of visiting residents when ill and what your policies are and the importance of respiratory hygiene and cough etiquette. And lastly, know when to update the state or a local public health department. When respiratory viral outbreaks are suspected or confirmed, a rapid coordinated response is necessary to prevent further transmission. Next slide.

And here are some additional infection prevention and control resources, and with that I can turn it over to the next presenter.

- CDC: Appendix A: Table 2. Clinical Syndromes or Conditions Warranting Empiric Transmission-Based Precautions in Addition to Standard Precautions (www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-table-2.html).
- CDC: II. Fundamental Elements Needed to Prevent Transmission of Infectious Agents in Healthcare Settings (www.cdc.gov/infection-control/hcp/isolation-precautions/prevention.html).
- CDC: Transmission-Based Precautions (www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html).
- CDC: Isolation Precautions Guideline (www.cdc.gov/infection-control/hcp/isolation-precautions/).
- Project Firstline Training and Resources (www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pfl/training/index.html).

- CDC: Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions (www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html).
- Minnesota Antimicrobial Stewardship Program Toolkit for Long-term Care Facilities (www.health.state.mn.us/diseases/antibioticresistance/hcp/asp/ltc/index.html).
- CDC: Inter-Facility Infection Control Transfer Form for States Establishing HAI Prevention Collaboratives (www.cdc.gov/healthcare-associated-infections/media/pdfs/interfacility-ic-transfer-form-508.pdf).
- ICAR Infection Prevention Audit Tools (www.health.state.mn.us/facilities/patientsafety/infectioncontrol/icar/res/audit.html).
- CDC: Viral Respiratory Pathogens Toolkit for Nursing Homes (www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html).

Alright everyone, my name is Phoenix. I'm going to take a pause before I get into the section of the presentation that I will be given for Caitlyn to jump back in and answer some of the vaccine related questions. So, Caitlyn, please, please feel free to answer some of those questions you've been receiving.

Yeah, for sure. Thank you, Phoenix. And so, yeah, I was just going through the chat, and I wanted to address some of the questions here. So, Brenda and feel free to come off of mute or chat me something, if, if that would be, you know, more helpful or you need more clarification, but, Brenda, I'm just, apologies here. I'm just trying to get to your question here, Brenda. Yep, I apologize. One second. Talking about actually don't Tammy was just right before Brenda, so if long term resident received the 2023-24 for formula in May is not immunocompromised, should they be offered the new?

So yes, technically, so, if it's been at least, eight weeks or two months since their last dose, they absolutely, they could qualify that. As far as someone I know that there was another question in the chat about someone who was immunocompromised, I would definitely have them reach out to their health care provider, but it does in the clinical considerations say eight weeks from the last dose. I know another person asked if someone had a recent COVID infection and they're immunocompromise, should they possibly get, that dose sooner?

Here again that would be a discussion between the, that person and their health care provider. The reason why they say that amount of time with a recent COVID infection and then something that they might want to consider just delaying vaccination a little bit is because research has shown that they probably have a good amount of protection against COVID disease and infection after a recent infection, and so that's why they say you might want to delay vaccination, for that time period, but I would definitely encourage that person to reach out to their health care provider and that be a decision that is made, between that person and that that health care provider. So, I think I've answered the questions in the chat if I've missed something, please let me know. I will keep an eye on the chat while I pass it back to Phoenix and, can come back on if, if, if needed. So, if anybody needs more clarification or has more questions, please feel free to throw something in the chat or, unmute when Phoenix is done, and I can hopefully clarify something. Thank you.

Thank you, Caitlyn. Hello, everybody. My name is Phoenix Borowski. I'm the long-term care immunization coordinator and the outreach and partnerships unit and the vaccine present preventable disease section, and I'm here today to give an introduction to a new program that we are launching this respiratory season entitled RespSafe. Next slide please.

To give a little bit of background information about what exactly RespSafe is going to be, specifically some of the things that I'm gonna talk about today are the program goals and who is eligible to participate, and I'll give some background knowledge as well as to how RespSafe came to be. So, the main overarching goal of this program is to track the coverage rates for both flu and COVID-19 vaccination uptake IN staff, really to understand which staff are vaccinated and which staff are choosing not to get vaccinated for personal reasons or for a medical reason. And then this program specifically, we are aiming to improve coverage rates in our health care personnel in long term care facilities and hospitals. And part of this program is to give strategies to encourage vaccination and we are asking participants to implement at least two best practice strategies, and I'll give some examples of that a little bit later as well. But the goals that we are asking facilities to hit to meet some of the tiers in this program specifically are an eighty percent coverage rate for COVID and then eighty percent coverage rate for flu, and I'm gonna talk about data in a little bit too and I understand that these are lofty goals, and we understand that vaccine fatigue is real and we understand that the last couple of years during the pandemic response have been really trying and really troubling, and that's something that this program recognizes and understands and we want to support long term care facilities to the best of our ability to really still encourage the importance of vaccination.

And to give some context as well as who is going to be considered eligible to participate, our program goals are going to align with the NHSM as far as personnel that are considered to be participants, so those are paid employees, license independent practitioners physically present in the health care facility for at least one working day from October 1 through March 31. So, these are people who would be considered to be eligible as participants in this program when we're thinking about health care personnel. Next slide, please.

I want to give some context to the birth of this program as well, so I'm gonna talk a little bit about the FluSafe program and some of you may be aware of the FluSafe program that started in 2010, and this was a program that ran and recognized long term care facilities in hospitals for high flu immunization rates. Those rates being ninety percent amongst staff. So, how this program had previously worked is that facilities were registered, they would enter employee immunization data and then were recognized in the fall following the flu season for those high immunization coverage rates. But since the onset of the COVID-19 pandemic in 2019-2020 that flu season, this program was indefinitely paused and something that has transpired between the posing of this program and the onset of this program that we are rolling out this coming respiratory season is a lot of feedback was collected from previous FluSafe participants, really trying to understand what this program did well, what things were liked about this program and what were areas that could potentially be improved upon. And that was something that was really important in, in the new version of this program entitled RespSafe. It was really understanding what were things that fell short, what did we need to change in the future to make this program accessible and make this program something that long term care facilities and hospitals wanted to participate in. And so, a lot of our goals are based on the feedback that we have received from participants in the surveys. So, I just wanted to highlight that as well, that this program has really been a culmination of efforts from our clinical team, from external participants, subject matter experts, really trying to understand what we can do at MDH to help our long-term care facilities and hospitals with impro improving vaccination uptake. Next slide, please.

Wanted to give some context to this data as well that I'm going to be sharing, and as far as our coverage rates that we have selected to be the goals for RespSafe. So, from the 2023-2024 flu season in long term care facilities, the average coverage rate for health care persons and all those forty two percent in

Minnesota, and COVID coverage rates were 20.6 percent, and that data is from the 2022-2023 season, and I wanted to give some context to this data as well. We're considering Covid coverage to be an up to date COVID-19 vaccination. So, having a bivalent COVID MRNA vaccine dose or a completion of a primary series within the preceding two months. But I also want to say that within RespSafe, we are not going to be looking at primary series doses. We are going to be looking at whether or not participants received that season's specific dose. And then within our hospitals, there was a seventy five percent flu coverage rate and a twenty four percent COVID coverage rate. And I think we understand that there's a lot of vaccine fatigue happening out in communities, out in our facilities, we really understand this to be the case, and we really understand that there are a lot of barriers in place preventing people from getting vaccinated or just feeling discouraged in general, and that's something that we have taken to heart when we are thinking about how this program is going to work going forward, but also still trying to encourage the importance of vaccine and preventing long term illness and even death within our health care facilities within our patients and we understand that one of the best ways to protect ourselves and to protect our patients is through vaccination CDC: MMWR: Influenza and Up-to-Date COVID-19 Vaccination Coverage Among Health Care Personnel — National Healthcare Safety Network, United States, 2022–23 Influenza Season (www.cdc.gov/mmwr/volumes/72/wr/mm7245a5.htm). Next slide please.

Some of the best practice strategies that we have laid out are, as seen below, we have four main categories that we are listing these strategies that we are asking facilities to implement, and those four categories are assessments, communication, education, and promotion, and in the coming weeks there will be access to a much longer document with specific strategies on our website for you all to access as far as opportunities for you to really work together with staff within facilities, with each other to try to encourage vaccination and uptake, but also just backs best practice strategies in general. And so, some of these examples specifically have been based on conversations with health care personnel and staff, our clinicians, really trying to understand what is preventing people from getting vaccinated. And some of the things that we have come to understand is really understanding where people are at, specifically identify identifying perceptions, motivations, and barriers to vaccination, also promoting employee's awareness of their own immunization history through accessing their own records. These are two examples of assessment strategies that can be implemented.

Communication, developing a communication plan, and also utilizing trusted leaders, peers, or community members who can be vaccine and advocates to relate information. When it comes to education conducting and in service for staff on the benefits and the considerations of vaccination, using supported and trusted leaders or peers through a feedback loop when it comes to promotion making vaccines accessible, providing them during all shifts and offering vaccine events multiple times throughout the respiratory illness season, and then also promoting vaccination resources for uninsured or out of network, insured employees. Next slide please.

So, some of the guidelines that this program encompasses to our reporting season is going to be the same as the NHSN reporting season. So, it's going to start October 1 through March 31 and Vax check, which is a MIIC supported application will be the way that participants are able to register and enroll in this specific. And I just wanted to highlight that this program in particular Vax Check is different than the program that was previously utilized. So, during Flu Safe participants were required to fill out spreadsheets and manually upload them to MIIC or send them to MIIC and that was a really tedious process and proved to be really difficult. And so going forward we wanted to make this really as easy as possible. So, what will happen is facilities will be able to enroll and more information will come out on

this in the coming weeks and months, but this will give everybody the option of sharing their immunization history or not, and then MIIC will be utilized to pull that data together on their behalf. As far as our recognition tiers go for rest safe, bronze is going to be that facility participated in implemented two strategies, silver, is that an eighty percent coverage goal was met for flu or COVID along with the implementation of two best practice strategies, and then the gold tier level is that the facility met the eighty percent coverage goal for both flu and COVID along with implementation of strategies. So again, along with all of these tier levels, we are asking for the strategies at least two to be implemented in each, but really trying to give credit where credit is due to facilities trying to encourage vaccination. We understand that this is really difficult. We understand that people are very tired, but we want to make sure that we are paying a homage to people really doing their best to try to encourage vaccination especially during times where vaccination has become so polarizing. And stay tuned because we're going to have a website and much more information to come. Next slide please.

That is all I have today, and we have plenty of time for questions, so please feel free if you have questions for me or for any of our other presenters to pop those in the chat and I'm happy to moderate or hand those off to those who are able to answer those questions, but I wanted to thank you all for being here with us today as well.

Oh, hi Phoenix, I just wanted to hop on and address one of the questions from Heidi. And it looks like you got an email from MDH, about COVID, contacting you for COVID vaccine and you said this is the first time that you've been contacted regarding this and so I'm gonna shoot our SME inbox email address in the chat. So, if we could just follow up with you cause I will be honest I'm not quite sure what this is regarding, but if you can email us, I will put our email in the chat just so we can get some more details and, and help you out with that.

And also, in the chat you will see that there is a link to a survey to obtain the CEU for today's presentations Respiratory Season Kickoff Webinar Evaluation (vovici.com) (https://survey.vovici.com/se/56206EE315F10309). Just complete the survey at the link and then once you hit submit, your certificate will pop up on your screen, so save that somewhere or print it out immediately so you have access to it. But the survey link is in the chat, and I will post it one more time.

And I know a lot of our presenters especially Brenda has been answering questions in the chat, if any other presenters see a question that they may have answered but they want to call out, please feel free to just ask and answer the question live. Go ahead and unmute yourself, we'll give it a few more minutes to see if anybody else has anything else to say and then we will end the call.

There is a question about will the slides be available?

And I do not believe the slides specifically will be available, but resources and or the recording of today's training will be posted online. And again, to receive a CEU for the webinar, I'm putting the survey link in the chat, complete the survey, and once you hit submit on the survey evaluation, you will receive a certificate for today's presentation Respiratory Season Kickoff Webinar Evaluation (vovici.com) (https://survey.vovici.com/se/56206EE315F10309).

So, if you have a question, please put it in the chat.

Brenda to answer your question, this new program is entitled RespSafe. That is what is replacing the previous FluSafe program.

There's a question from Andrew in the chat. I'm going to read out loud for anybody to be able to answer. Is documentation of a vaccine refusal considered acceptable for a lifetime or do we have to reach out with each new formula? If somebody is able to answer that question, that would be greatly appreciated.

This is Brenda. I think that's directed for me for long term care. So, really because the risk and benefits and the side effects change each of the times, they really need to have that every time and every flu season if they're looking for that piece along with the COVID because they do keep changing. Thank you.

Thank you all so much for joining us today. We appreciate you being here with us as we start this webinar for the kickoff to the respiratory season, we hope that you found this information helpful and please feel free to let us know if you have any other questions. This webinar is being recorded and will be accessible in our website soon here. Again, thank you for being here with us. We really appreciate your time and attention and all of the questions and all of the work that you are doing, and we hope that you have a wonderful rest of your day.

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