Gearing Up for Fall Immunizations

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Introduction

Importance of Fall Immunizations

- Staying up-to-date with immunizations is of paramount importance for several reasons:
  - Disease prevention
  - Community immunity
  - Preventing outbreaks
  - Protecting vulnerable populations
  - Public health and healthcare system resilience

Fall Immunization Overview

- COVID-19
- Influenza
- Pneumococcal
- Respiratory syncytial virus (RSV)

COVID-19 Vaccinations

- Efficacy and safety data
- New booster approval
- Variants of concern and their implications
  - BA.2.86 variant
- Evolving guidelines for health care professionals

COVID-19 Vaccine Recommendations

- Everyone aged 6 years and older should get 1 updated Pfizer-BioNTech or Moderna COVID-19 vaccine to be up to date.
- People aged 65 years and older may get a 2nd dose of updated Pfizer-BioNTech or Moderna COVID-19 vaccine.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html#atrisk

Influenza Vaccination

- The unique role of health care professionals in preventing the spread of influenza

Influenza Vaccination

- Strategies for promoting influenza vaccination among health care workers and residents

Pneumococcal Vaccination

Available pneumococcal vaccines

Pneumococcal Vaccine Timing for Adults

Make sure your patients are up to date with pneumococcal vaccination.

Adults ≥65 years old
Complete pneumococcal vaccine schedules

Prior vaccines	Option A	Option B
None*	PCV20	PCV15 → ≥1 year† → PPSV23
PPSV23 only at any age	≥1 year → PCV20	≥1 year → PCV15
PCV13 only at any age	≥1 year → PCV20	≥1 year† → PPSV23
PCV13 at any age & **PPSV23** at <65 yrs	≥5 years → PCV20	≥5 years§ → PPSV23

* Also applies to people who received PCV7 at any age and no other pneumococcal vaccines
† Consider minimum interval (8 weeks) for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak (CSF) leak
§ For adults with an immunocompromising condition, cochlear implant, or CSF leak, the minimum interval for PPSV23 is ≥8 weeks since last PCV13 dose and ≥5 years since last PPSV23 dose; for others, the minimum interval for PPSV23 is ≥1 year since last PCV13 dose and ≥5 years since last PPSV23 dose

Shared clinical decision-making for those who already completed the series with PCV13 and PPSV23

Prior vaccines	Shared clinical decision-making option
Complete series: PCV13 at any age & **PPSV23** at ≥65 yrs	≥5 years → PCV20 Together, with the patient, vaccine providers **may choose** to administer PCV20 to adults ≥65 years old who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of 65 years old.

cdc.gov/pneumococcal/vaccination.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Pneumococcal Vaccination

- Strategies for integrating pneumococcal vaccination into routine clinical practice

RSV Vaccination

- RSV and its impact on the elderly population
- RSV vaccine recommendation
- Availability of vaccines

Addressing Vaccine Hesitancy

Effective communication strategies to address vaccine hesitancy among residents and colleagues

- Active listening
- Empathy and respect
- Provide accurate information
- Use visual aids
- Share personal experiences
- Answer questions
- Highlight vaccine benefits
- Discuss risks in perspective

Addressing Vaccine Hesitancy

Approaches to counter common vaccine myths:

- Provide accurate information
- Address myths directly
- Use trusted sources
- Cultural competency
- Listen and empathize

Vaccine Administration and Safety

- Vaccine storage and handling, including temperature requirements
- Proper vaccine administration techniques, such as injection site selection and needle length
- The importance of documenting vaccine doses and adverse events reporting
- Managing common side effects and adverse events

Public Health Measures

- Importance of other preventive measures, such as mask-wearing, hand hygiene, and social distancing, especially in the context of COVID-19
- Updating policies for outbreak response within your facility including testing strategies

CMS Core Principles of COVID-19 Infection Prevention (1/3)

- Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control)

https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

CMS Core Principles of COVID-19 Infection Prevention (2/3)

- Hand hygiene (alcohol based hand rub)
- Face covering or mask (covering mouth and nose) in accordance with CDC
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)

CMS Core Principles of COVID-19 Infection Prevention (3/3)

- Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of PPE
- Effective cohorting of residents
- Resident and staff testing conducted as required at 42 CFR § 483.80(h)

Face Coverings

- Source control refers to use of respirators or well-fitting facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. People, particularly those at high risk for severe illness, should wear the most protective mask or respirator they can that fits well and that they will wear consistently.
- Even when a facility does not require masking for source control, it should allow individuals to use a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

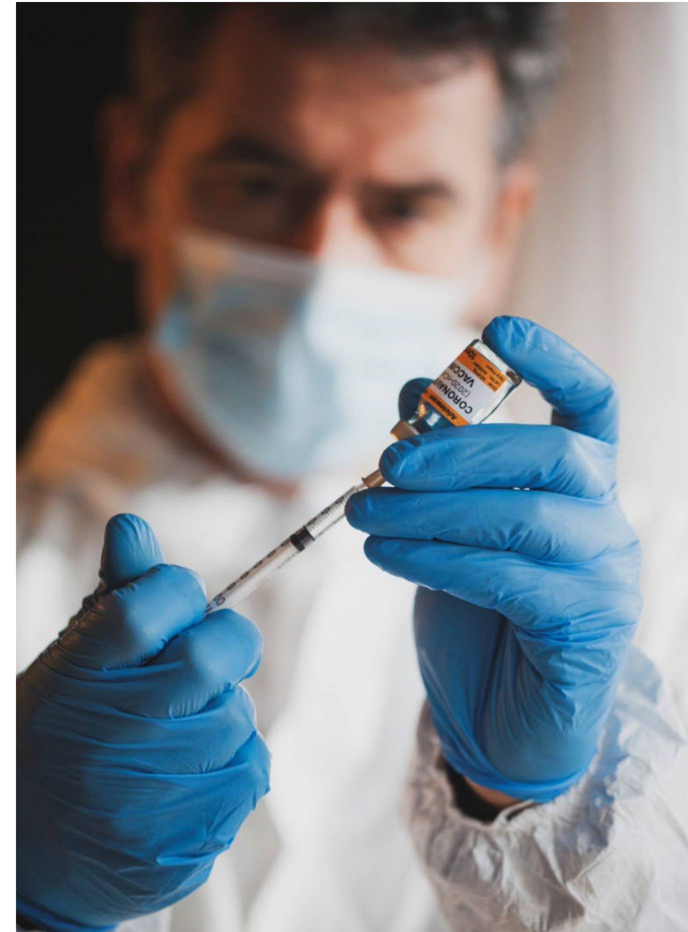
Source Control Recommendations

Recommended in facilities:

- By those residing or working on a unit or area of the facility experiencing a COVID or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of COVID infection have been identified for 14 days)
- Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas or patient populations (e.g., when caring for residents with moderate to severe immunocompromised) during periods of higher levels of community COVID or other respiratory virus transmission
- Have otherwise had source control recommended by public health authorities

COVID Vaccination Reporting

- During PHE: Facilities are required to report the COVID-19 vaccination status of residents and staff through NHSN.
- After PHE: Facilities are required to report the COVID-19 vaccination status of residents and staff through NHSN.



COVID Vaccination Education

- During PHE: All long-term care (LTC) facilities are required to educate residents and staff on the COVID-19 vaccine and offer to help them get vaccinated.
- After PHE: This requirement will remain in effect until May 21, 2024, unless additional regulatory action is taken.

COVID Testing

- During PHE: LTC facilities are required to perform routine testing of residents and staff for the COVID-19 infection.
- After PHE: LTC facilities must conduct COVID-19 testing in accordance with accepted national standards, such as CDC recommendations. Noncompliance with this expectation will be cited at F-880 for failure to implement an effective Infection Prevention and Control Program.

Table 1: Testing Summary

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, regardless of vaccination status, with signs or symptoms must be tested.	Residents, regardless of vaccination status, with signs or symptoms must be tested.
Newly identified COVID-19 positive staff or resident in a facility that can identify close contacts	Test all staff, regardless of vaccination status, that had a high-risk exposure with a COVID-19 positive individual.	Test all residents, regardless of vaccination status, that had close contact with a COVID-19 positive individual.
Newly identified COVID-19 positive staff or resident that is unable to identify close contacts	Test all staff, regardless of vaccination status, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g. unit, floor, or other specific area(s) of the facility).	Test all residents, regardless of vaccination status, facility-wide or at a group level (e.g. unit, floor, or other specific area(s) of the facility).
Routine testing	*Not generally recommended*	Not generally recommended

https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf

Questions?

Resources and Continuing Education

- CDC COVID-19 Vaccine Page
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html
- CDC Influenza Vaccine Page
https://www.cdc.gov/vaccines/vpd/flu/hcp/index.html
- CDC Pneumococcal Vaccination Page
https://www.cdc.gov/vaccines/vpd/pneumo/hcp/index.html
- CDC RSV Vaccination for Adults 60 years and older
https://www.cdc.gov/vaccines/vpd/rsv/hcp/older-adults.html#vax-rec
- You Call The Shots Web Based Training Course
https://www.cdc.gov/vaccines/ed/youcalltheshots.html
- Immunize.org https://www.immunize.org/

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