

Hello. And welcome to the McKnight's webinar, "When COVID-19 and flu season converge: What to anticipate and how to prepare." This very important topic will examine what providers can expect during the upcoming fall, when the flu will be compounding COVID-19. We'll learn about how to fine-tune your infection-control programs and protocols for the task at hand. I'm McKnight's Long-Term Care News senior editor Liza Berger, and I'll be your moderator today. Our session's featured speaker is Nancy Losben, a consultant pharmacist and Chief Quality Officer for Omnicare CVS Health. I'll introduce her more formally soon, but first some housekeeping matters. Today's slides are available for download. Just click on the button on your screen to find a PDF of the slide deck to print out. If you're having audio problems with this broadcast, please first check the volume control on your machine. This is the most common cause of hearing problems. Also, we will have time for a Q&A session near the end of the presentation. There's a Q&A box on the left-hand side of your screen. If you have any questions for Nancy, please feel free to write them out and submit them directly to us, starting now. Those we don't get to in real time will be answered afterwards. Continuing education credits. This educational offering has been reviewed by the National Continuing Education Review Service of the National Association of Long Term Care Administrator Boards, or NAB. It has been approved for one clock hour. You need to stay tuned to this event in its entirety during the original broadcast to receive a certificate. If you have listened to this broadcast in its entirety, you will receive a certificate within five business days. If you provided a valid NAB ID number, your credit will be recorded on your behalf within five business days. We'd like to note that this program is made possible by support from Omnicare. Learn more about them at www.omnicare.com. Finally, this session is archived and available on demand shortly after the live broadcast. You can access it again or others can experience it for the first time by going to the registration page to enter the studio. The URL is mcknights.com/081320webinar. Now to our presenter. Nancy Losben is a consultant pharmacist and Chief Quality Officer for Omnicare CVS Health, a pharmacy-services provider serving over 2 million long-term-care admissions annually. She was the chair of the American Society of Consultant Pharmacists foundation from 2013 to 2018. A certified consultant pharmacist, she holds certificates in gerontology and in pharmacy regulation. She has won many awards, which you can look at in the bio section. She holds a pharmacy degree from Temple University in Philadelphia and has completed a consultant-pharmacy certification sponsored by Rutgers University. So, Nancy, I think we have a lot of listeners tuned in, and I think a lot of people feel very nervous about what's in store for them this fall. Do they need to be?

Well, Liza, I think that's a great question, and while I think they will still be nervous about the flu season converging with COVID-19, let's hope that, by the end of the hour, they're a little less worried and have a straight path forward in what their next actions will be. Hopefully, by the time 2:00 today rolls around, they'll start formulating with their teams what they plan to do. So, thanks so much for the great introduction. It's greatly appreciated. And good day, everyone. Thanks for joining us. I think what we can all agree on is that there was no one that had a written emergency-pandemic plan that would've met the needs of our residents and our facilities during the current situation. What this program is designed to do and what my intent is -- to have you apply all of the new knowledge you have and marry that to all of the wisdom that you've gained in the past five or

six months and apply it to the coming flu season. So, we still all have COVID. We know that flu is coming. That's a certainty. What we hope to do in this particular program and in the next 45 minutes is to help you be able to contrast and compare the symptoms of flu and COVID-19, which are incredibly similar. We want you to be able to formulate new approaches to achieve 100% immunization in the coming weeks for every resident and every visitor or every staff member who is eligible to receive a vaccination and consider the products you'll need, the finances, and the human resources that you're going to need to execute a really well-defined infection-prevention and treatment program during the coming flu season and, in addition to that, really leverage your Quality Assurance Committee to make sure that they drive infection prevention and control for you infection preventionist and assure that your facility is going to be as prepared as they possibly can be for the oncoming flu season. With that, when we start to plan for the future, there are usually two primary aspects that we look at as our plan, and one of them is, of course, our strategy that shapes the future, the data that we use to build it, the goal setting and the tactics or execution, assuring that all of the resources you need are available, and make a plan that is well-known and also embraced by your staff members. What we want to do is make sure that this year, perhaps more than ever, we take the proven steps that help us climb to success during the flu season. But we also want to ensure that you not only take a look at your strategic plan but that you begin some scenario planning. There are a lot of situations and unknowns that we will have to deal with and the uncertainties of the flu season, on how robust it will be or how weak it will be, the states that will be affected, the potential to have residents infected with both influenza and COVID and propose those "what-ifs" in a situation to prepare your scenario planning and do a deep dive into what you may need as you plan forward, because, quite frankly, what you know now is very different than what you knew in January of 2020, and I think that, by the end of the flu season, your knowledge, experience, and wisdom will be incredibly more enhanced and edified. So, let's do one thing. We certainly know that COVID's here, and we know that the flu season is coming. One of the big differences here -- there are systems in place that we all rely upon -- weekly reports from the CDC, for example -- that lets us know where the flu is, where it's growing, where it's trending. So, what I want you to sit back with your QA committee and start to think about are, "What are the scenarios that you and your team need to be ready for?" So I'm going to throw some hypotheticals out to you. Will staff be educated on the similarity between the symptoms of COVID and the symptoms of influenza, and are they so similar that they're going to have difficulty identifying the differences? Will you have enough flu vaccine, and will you know how to obtain more flu vaccine during the course of the year to keep up with your admissions as we see those new surgeries like knee and hip replacements come back into play and your census begins to grow as elective surgeries become more common again? If residents, staff, and family refuse influenza vaccine, do you have a plan to promote a change in attitude and exceed last year's numbers and move to a new and higher goal? If a COVID vaccine becomes available, there are things that you need to even think about -- will you have enough syringes and needles to even administer the vaccine should it become available to nursing facilities? What if other facilities hoard antiviral medications to treat influenza and you're out of product or your pharmacy is out of product? If staff is deeply focused on infection prevention and control, will it really divert our attention away from our residents' rights, resident falls and skin integrity and other very important care programs that you have worked on diligently since your last annual survey or through your five-star-rating processes? So, what we need to do, of course, is to identify, the best we can, the

differences between COVID and influenza and begin to teach our staff to recognize that. But teaching alone will not be enough. We can teach them to recognize that, if we do not teach them to communicate what they observe, all that education will be for naught. So, let's go ahead and take a look at the differences between COVID and influenza. The common symptoms that both COVID and flu have together, that may make it difficult for us to tell the difference, is that they both have fever or the feelings of being feverish and having chills. They both have a cough. There is shortness of breath and difficulty breathing. They cause fatigue and tiredness. They both can present with a sore throat or a runny or a stuffy nose. There's muscle pain and body aches, some of which past COVID patients still complain about feeling tired or having muscle weaknesses. With the fever, along comes a headache. Some people may have vomiting and diarrhea, although it's been seen more in children than in adults. And, of course, we know that both flu and COVID hit the high-risk patients, including older adults, and that both COVID and flu can have varying signs and degrees of symptoms, ranging from being asymptomatic to severe symptoms. And for both COVID and flu, it's possible for the virus to spread at least one day before experiencing any symptoms. In addition to that, what I want you to think about, too, is understanding that the common cold usually comes into play at this time of year. So, when you stop and you think about the common cold, you may want to jot this down to assure that you are building the signs and symptoms and that you are measuring them in sets of common cold, influenza, COVID-19. So, for the common cold, we'll often see that it's a gradual onset, while flu is a rapid onset. How many times have you yourself in your lifetime think, "I think I'm coming down with something. I bet I'm gonna get a cold." And that's that gradual onset that we see with just the common cold. Fever is rare in a common cold, but the aches are usually mild. Chills are uncommon, and the cough is usually mild to moderate. You'll get a stuffy nose. You may even have a sore throat, but headaches are rare, and there are usually swollen glands with a common cold. When you take a look at understanding the further differences, then, between influenza and COVID, you'll see that flu can cause mild to severe illness and varying degrees of signs and symptoms. No two residents really present the same. They typically develop in persons where they've been exposed or infected, and one to four days after the infection, you'll start to see those symptoms. Most people with flu are contagious for one day before they show their symptoms, and this is where your infection preventionist and his or her tracking capabilities will help you as a facility identify those who may have been exposed to influenza as our residents begin to commingle amongst themselves a little more as we move through the course of the year. In terms of understanding differences with COVID, there are other signs and symptoms that might include a change in or loss of taste, including a loss of smell. Now, one of the things that's most common is this pervasive symptom, and it doesn't necessarily go away immediately after the rest of the symptoms subside. Keep in mind, however, that there are many medications that also cause taste perversions, so please evaluate the medication regimen to determine if this is a new onset or perhaps may be caused by an anticholinergic medication. Typically, a person's going to develop symptoms of COVID about five days after being infected, but the symptoms can be as early as two days after infection and be as late as 14 days after they're infected. So the time range here isn't from one to four days after infected. It can come anytime, including up and past 14 days. If a person has COVID, they may be contagious then for a longer period of time than if they had the flu. And how long someone can spread the virus that causes COVID is still under investigation as we try to nail down the exact numbers. COVID-19 has also been observed to have more superspreading events than flu. What do I mean by superspreading? And I

think that this is a term that is being used too loosely both amongst ourselves and in the news. Superspreading really means that this COVID virus can more quickly and more easily spread to more people and result in contagious spreading among others as it progresses. I think you can recall that there was a time where they said, in the state of New York or New Jersey, where one person was infecting five others. That's the true definition of a superspreader when it comes to COVID. So keep an eye on hot spots. And I would say to you that, if this were my facility, I would really interview my residents and my staff and talk to them about their specific symptoms that they've had if they were infected with COVID. I think that you'll find that there are very distinct descriptions that patients of COVID-19 can describe to you, and I think that there anecdotes and their stories are well worth learning and listening to help our staff further identify the differences between flu and COVID-19. Also, I want to bring your attention to the fact that there is a DEAR assessment form available. However, what it really looks at is the common cold versus flu-like illnesses. I find it to be very valuable, but of course it doesn't yet tease out the differences between flu-like illness and COVID-19. More investigation should be done, but I would recommend that your team and your infection preventionist take another look at the DEAR criteria for the common cold and flu-like illnesses. We know that the common mode of transmission between COVID and flu is person-to-person contact when enclosed, especially when they're within 6 feet of one another. And it spreads mainly by droplets when people with the illness either cough hard, sneeze, or even speak loudly. As you can realize, because of how it spreads with these droplets is one of the main reasons that sports are cancelled. It's not just the contact among the players, but sitting in an arena where someone is screaming for their favorite team on the field is a great way to go ahead and spread COVID amongst us. So, when we look at the complications of flu and COVID, I want you to take a look at influenza on the left side of the screen. Recovery is a few days, but definitely less than two weeks if it's an uncomplicated influenza. But we also know that we have vaccines available. There is going to be all quadrivalent vaccines available for us to use, and that there are also several prescription influenza antivirals that we can use, that are all FDA-approved to treat flu, and if identified early and treated soon enough, certainly lessens the symptoms and the duration of the influenza infection. On the right side of your screen, let's take a look at what COVID has specifically in terms of some of these complications that you will not see with influenza, and that's the blood clots in the veins and arteries of the lungs, of the heart, the legs, or the brain. How many early COVID patients were diagnosed with a heart attack when perhaps they actually had a pulmonary embolism that was caused by COVID-19? Also, COVID-19 causes multisystem inflammatory syndrome in children. I certainly don't want to leave out those of you who have a practice where you care for long-term-care children in your practice. We certainly have no proven treatment right now and certainly no vaccine. And I will talk about preparing for a vaccine when it becomes available later in the session. Now turn your eyes to the center. This is where flu and COVID collide in terms of complications. They can both cause a viral pneumonia. They cause respiratory failure, especially in those who have COPD or other comorbidities. They can cause acute respiratory-distress syndrome or sepsis or worsening of chronic conditions, including diabetes and heart disease, and they can also cause a secondary bacterial infection. And, again, you can go back and evaluate and review with your staff the differences between bacterial infection and how it presents from viral infection or viral pneumonia and how it presents. The most common symptoms of COVID-19 -- and they appear to be growing as we gather more information -- is that

researchers found that 96% of all of the COVID patients had a fever or a cough or shortness of breath. However, more than half of those 65 years and older had all three of those symptoms simultaneously, so that is very noteworthy. So look at someone who has a fever plus a cough plus shortness of breath. In terms of the most common symptom, that was cough, and it was followed by -- closely -- fever. Among adults, the shortness of breath was the most commonly reported symptom for hospitalized patients. The shortness of breath is going to be your trigger to dial 911 and get that resident the acute care that they need. Coronavirus patients also showed other symptoms, including, as I discussed, chills, muscle pain, the headache, the overwhelming tiredness, and digestive problems including nausea, abdominal pain, vomiting, and diarrhea. As a matter of fact, approximately half of all COVID patients reported some type of GI symptom, where diarrhea was certainly more prevalent than vomiting, but, nevertheless, we seldom see vomiting and diarrhea with influenza or the common cold. We know that we want to vaccinate everyone with influenza vaccination and all of the others that they would need throughout the course of the year, and we generally take the months of August, September, and October to not only evaluate influenza but catch our seniors up on their pneumonia vaccinations and make sure that they have their shingles vaccination, but what we want to see here is that, right now, the CDC is saying that, if you have someone who has COVID, routine vaccination should be deferred for people with suspected or confirmed COVID-19, regardless of their symptomology, until they have over or past the criteria for which they could discontinue isolation. Now, isolation is different for different patients who have COVID. For patients with severe COVID illness, the duration of isolation can be up to 20 days after the onset of their symptoms. So, really, we need to consider your infection-control experts, including your infection preventionist, your medical director, and the infectious-disease consultant physicians that you may be bringing in to support you during this time. For those who never have any symptoms of COVID-19 or they're not immune-suppressed or otherwise healthy, the isolation and all of the other precautions can be discontinued 10 days after the date of their first positive test. So, as this is new information and, again, likely to change, as many other things have changed over the course of the past several months, this is something that stands for today, and it is something that your infection preventionist should help you monitor and make sure that policies and procedures are updated as we receive new information and new guidance. We all know the critical importance of influenza vaccination, but most important and what we really need to remember is that influenza vaccinations decrease symptoms and shorten the duration of the disease. What we really want to do this fall is reduce the burden of respiratory illnesses amongst our vulnerable population that are at severe risk for severe illness, and that also includes all of our staff. Healthcare providers should take every opportunity, then, during the influenza-vaccination season, to make sure that we are immunizing everyone who's eligible to receive the vaccination, and that would be looking at all essential workers, such as healthcare personnel, including all nursing-home and long-term-care-facility personnel, including those who work in the kitchen, in housekeeping, in engineering, and every other administration in the building. Everybody -- everybody -- on the nursing-home staff needs to receive their vaccination. And then we also, of course, need to talk about immunizing all of our residents. But remember that we need to assure that persons with increased risk of illness due to COVID receive their immunization as soon as possible to make sure that we can build up their immunity to the flu as soon as we possibly can. Remember the CDC also says you should start to administer influenza vaccinations as soon as they become available, and of course this year we're expecting to see

plenty of the high dose that's generally used for seniors because of its effect and what they have proven to be fewer symptoms but a longer duration of efficacy for seniors. We also have to consider that COVID was prevalent in certain racial, ethnic, and minority groups, but that sometimes clashes with the culture of some groups to actually become vaccinated. So we'll talk about getting them to move forward and advancing their previous thoughts about vaccination in just a few moments. You also have to remember that others that are at risk that we may be caring for are infants and young children, especially those children that you may be caring for with neurologic conditions, all of the pregnant women that care for our residents or who are working for us, adults over 65 and older, and persons with any underlying medical condition.] As you can see, COVID ravished them, those with diabetes and heart disease. So these are the critical elements of getting that vaccination and one of those points that you need to drive home this fall to make sure that we have everyone who is willing to get their flu vaccine for which it's not contraindicated. When we take a look at long-term care facilities, according to the information that's still available, we are the industry or the arena within the industry where immunization of influenza vaccination still lags. What we're seeing right now is there's an average among healthcare workers, that 81.1% of all of us get our flu vaccine, and it's been progressing well for the past four or five influenza seasons, but the vaccination coverage was higher in the acute-care area than it was in long-term-care settings. Unfortunately, the last numbers that we've seen are only about 68% to 70% of long-term-care workers accept an influenza vaccination. That's not good enough for a time of year when we're seeing both influenza and COVID. So when they took a look at some of the older data and been tracking it, we looked at the World Health Organization's Healthy People 2020 target, and it was supposed to be 90% of all healthcare workers, and you can see that long-term-care facilities still lag behind -- not necessarily in our residents since we now regulations and F-tags around immunization, but certainly amongst our staff. So, one of the things about vaccinations and the information that you need to move forward is you're networking with your public-health partners and building coordination and a coalition with them. I will tell you that there's too many of us in long-term care who don't call the public-health department, who don't the county health department. If you were to call up and say, "Hello, this is Jim," I would not expect someone at your county health department to say, "Jim who?" We really need to make sure they know who we are, where we are, and how we serve. When you start to build this type of networking among these security agencies in your area or FEMA or Department of Defense that has public-health workers or other utility agencies, private organizations, foundations, other healthcare providers in your community and your referral sources, you will begin to know the names of people who know who to know. If you run out of vaccine, do you know where to get some from the state or the county? If you're not able to vaccinate all of your staff, can you send them to where they can get county-free vaccinations. If you can provide a vaccination to one of your nurses but that nurse has three children and a husband, do you know where the four of them can get their flu vaccination? So, again, beginning to network, picking up the telephone, joining those in your professional association and other folks that are on the call with us today. It's very important in understanding who the contacts could be during these times of uncertainty where we need full planning. So, let's take a look at the barriers of vaccinations. And a lot of times, we just take for granted -- we know that there's public confusion about vaccines, but we also have to remember that we in long-term care have so many barriers to get through, the first one being the consent. "Oh, do you have a consent form? Is it okay if we use the consent form from last

year? Has the flu vaccine been upgraded with what's included in the vaccine, and do I have to change the consent form?" And then you have this overwhelming problem of trying to get consent forms from responsible parties and families that you don't see anymore, that aren't coming to your building. So does that mean sending out letters followed up by a telephone call or an e-mail or a text messaging? But you know that it's got to be something different this coming season because our families and loved ones are not coming in to visit our residents. You also need to take a look at yourself as an organization. How did you do last year with vaccinations? What are your targets this year? And what is your attitude and culture yourself of your own people to promote vaccinations and deliver a strong message? Then there is always the cost. That should have been done early on in your fiscal year as your budget for vaccinations in your building. And know how, of course, to get reimbursed for them -- not just for the vaccination, but for the administration of the vaccination. And you have really got to promote the heck out of vaccination season. If you want to do a good job, you need to sell it. You need to get out there with assuring that your placards are up, that you're communicating strongly, that you convincingly get out a message that lets people know why vaccinations are good for them, why they're good for our residents, why they're good for our community, why they're good for our state. And of course there's a lot of either misinformation or lack of knowledge about vaccines and how they work. So when you take a look at the misperceptions -- I have to tell you that, a couple of years ago, when I was an emergency medical corps volunteer in my county, I was asked to work at an annual wellness fair -- which we don't have an opportunity to do this year -- and discuss with seniors about flu vaccine and where they could get them from the county and how they work. And one of the loveliest ladies came up and said to me, "Don't you know that vaccines cause Alzheimer's disease? I'm surprised that you, as a pharmacist, don't know that already." So I was taken aback. I simply smiled, turned my back, and said, "Thank God for herd immunity," because we still have a lot of nonbelievers out there and those that we really need to convince of some very deep beliefs or traditions regarding getting vaccinated. So we still have some believers who think that, if we give them the vaccine, they're gonna get the disease. Well, the vaccines that are given today, the germs are dead or they're of so little titration that they actually cannot make you sick or there's just enough to give you the immunity that you need. There are other people who think that vaccines are unnatural. We have people who swear that they take vitamins and they eat well so they're not immune-compromised, so they don't need to have a flu vaccine. And we have others that just object to having a foreign body in them and they're afraid that, if they get flu vaccinations while they're pregnant, that their children will have autism or their children will become autistic in the presence of vaccinations. And I'm sure you've read the same stories that I have, that there are pockets within communities and cultures that just don't believe in vaccinations, and so we have to work from the inside of our facilities outward to make sure that everyone who comes into our building believes in vaccinations or at least understands them and, if it's possible to have a vaccination, that they're willing to do so. So, what will it take to demystify vaccines? Well, I think, as I said before, we need to make sure that people understand that, while the vaccines contain the same bacteria or the same germ that causes the disease, they're either weakened to the point where they don't make you sick -- and some vaccines only have pieces of the germ itself or just some parts of the DNA in it to cause immunity without making people sick. One of the things that I can tell you is that pharmacists are trained on vaccines, how they're made, what they cause, what they can do, and what a miracle medicine they really are, and those are the

folks that you need on your webcast. Get your consultant pharmacist involved to provide a webcast for maybe family night or for your residents. As we move into an area of telehealth and telemedicine, none of this is impossible. I can tell you that every consultant pharmacist has a laptop and a cellphone and knows how to use Zoom or something similar to that to set you up with a family night that can be viewed perhaps even on the televisions in your own community, where you can spread out people across the entire building. So we need to understand that vaccines are the most powerful medicine not because they treat or cure diseases, but vaccines prevent them. One of the things that we really need to think about is what we're going to do with meeting these types of challenges and who we're going to vaccinate while we still have a pandemic with COVID going on. The common consensus today of CDC is -- and it may change -- is that when vaccinations come out, we would always do occupational health groups, so it's personnel that are deployed abroad so we get our farthest-reaching citizens their vaccinations -- public health personnel who provide the guidance and the information and the data collection, critical healthcare personnel, pharmacists and pharmacy technicians who now provide the overwhelming number of injections in the community and across the country, our emergency-medical-services staff, law enforcement, and fire services that we depend upon, and that we also vaccinate those who make the vaccines and those who distribute the vaccine and the antiviral drugs. Then we finally get down to patients./ Now we start to take a look at the high-risk adults in our own communities, adults who are over 65, pregnant women, infants and toddlers, and all children, whether they're healthy or they're high-risk, should be vaccinated. So what I mean to say here, as we've planned this out in our mind for influenza, when the COVID vaccination comes, you may see a pattern that is described to us and how it will be distributed. And we cannot get ahead of ourselves by thinking that the first people in line to get a vaccine will be those who are residents of long-term care. So that means what? That means we need to vaccinate with influenza vaccinations and we need to continue to have the strongest infection-control programs that we possibly can. When it comes to convincing residents, there's a couple things that we can do. First of all, our residents generally love their attending physicians, and a word from them, even if it's through a telephone, is very helpful in convincing our residents that they should be vaccinated or helping our families who are resistant. That physician should be calling the responsible party themselves to try and convince them that Mom or Dad or Aunt or Uncle should be having their flu vaccine. Take the voice of a senior in your building. Most seniors today can remember 1954, when President Eisenhower mandated that every child in the country would get their polio vaccine. These are the children who stood in line at public schools to get polio vaccine on a sugar cube. The seniors today are those that have seen polio and other diseases wiped out in our country because of vaccinations. So if you need a testimonial to the rest of your staff or the rest of your residents, ask a senior citizen who's a believer to spread the word and let them know what it was like when they would go out in the yard and see a puddle and their mother would call it "polio water." Clergy can get involved. Your consultant pharmacist can certainly help to spread the good word, and we have to remind patients that the vaccine won't give you influenza and that we have to overcome this idea that, just because you're healthy, you're immune to influenza. And, finally, there's going to be those that want absolute concrete medical evidence that vaccines work. Well, the only thing you need to do is open up the package insert and look at the clinical studies, and while not everybody understands it, certainly your pharmacist can explain that data to demonstrate why it has been efficacious and approved for market. In addition to that, we really need to get out to

those foundations and other organizations, such as the Alzheimer's organization or the Society for Autism, and get them to help us to spread the message that vaccinations don't cause either of those diseases or any other. Please use the CDC promotional placards. There's no reason for you to spend your time creating placards, PowerPoint sessions, and signs for the doorway. They are readily available to download not only in black and white -- you can have them in color, and you can have them in a myriad of different languages, depending on where you're located, who works in your building, and who lives in your facility. One of the things that we can be using -- and you've heard me refer to it -- is telehealth or telemedicine. The good news was, just two days ago, we learned that there is going to be new resources, especially for those in long-term care who are located in rural areas where it's very difficult, at times, to get a doctor to come in, let alone come in during COVID pandemic and flu season. So we're going to have to maximize that, and, as I said, resources and budget may mean that we need to have a few more portable laptops that we can have the resident actually come to a room or the laptop go to the resident so they can communicate with their physician. And we see it used more commonly now in assisted-living communities, where the insurance company is providing access to the doctor to do telemedicine with their residents, along with managed-care companies, and we're seeing a lot of specialist consultations, especially urinary-tract infections and cardiac physicians using telehealth, especially with the type of devices now where you can use telephony to transmit EKGs. So if we're not there yet, if our residents aren't there yet, we're gonna be there sooner rather than later, and what we've seen is an explosion of telemedicine in long-term care, and there are great CDC and CMS tool kits out there specifically for long-term care and nursing homes that takes a look at Medicare visits, how they're done, they're paid for with parity, how to perform a virtual check-in after admission, and how to do e-visits, or electronic visits, with our residents, and many of our physicians are not coming into the building. But you also want to leverage that time to communicate the need for the flu vaccine and encourage those orders and encourage the doctor-patient relationship to improve your targeted numbers for vaccination. So, again, referring what we can do with telehealth, remember, there's now over 135 allowable services through telemedicine. These certainly are allowed for post-acute-care facilities, and all of the insurance companies are paying for these, and a lot of the co-pays, especially for the assisted-living residents, has been waived. So it's a low cost, and while I'm sure that everybody believes that they would prefer to have the hands-on care that's delivered by their primary-care physician, during these times, we can certainly, through the use of the assessment tools in the building and the communication tools that are electronic, use them to provide the best care we can in these incidences. We certainly don't want the physician running into your building with every incidence of influenza, but it may come that telemedicine will be the alternative. In addition to that, when we talk about the infection-control and prevention program and what you're gonna beef up this coming fall, administrators need to know that your infection preventionist might not be able to keep up with the data collection. You're going to have to revisit your budget and move some things around, assure that staff is on board, staff is readily available, and that your infection-control program is really reviewed, because I'm sure you well-know that, when the surveyors came in to do your infection-control program the past several months and take a look at it, the first that thing that they asked for was a copy of your manual. So when we keep focused on the regulatory reviews and pending surveys, re-surveys, and how do we leverage regulation to promote health and wellness in the facilities, I can tell you that nothing makes things happen better than a

regulation for long-term care. So be prepared for a regulatory review again. You may be a new DON, a new administrator, a new infection preventionist, a new education coordinator, a new MDS coordinator. Your infection-control procedures is usually about a 400-page book. They should all be written. Make sure that your annual review is done by the entire quality-assurance committee and that you signed the fact that it's been reviewed and you enter the fact that it's been reviewed into your QA minutes. Remember to review your transmission-based precautions. Assure that you not only have the right PPE supplies but that everybody is using them properly. The most common citation recently out there for F-Tag 880 was when surveyors saw our staff leave the room with their gloves still on. So of course we don't need a rock to fall on our heads to reinforce that, but that's what your infection preventionist does on a daily basis, and we need to help him or her because they cannot do it alone. Again, review hand hygiene. Go down to your laundry room often. I don't know if you go down there much, but the idea of putting clean laundry on a dirty laundry cart is something that every surveyor watches for. I can tell you that, as a consultant pharmacist myself, when I was assigned to a new building, I always drove around the building before I went in to see what it looked like on the outside, and one of the things I did was make sure that I stopped back where the laundry was so that I could smell the exhaust coming out of there. Tell you, a lot of times, it told me what kind of building I was gonna be walking into. Remember, surveillance is labor-intensive. Inspection preventionists today look like Bob Cratchit, with their heads down into a computer recording numbers, working with calculators and trying to get infections per resident, per resident-patient days in their building. Also, antibiotic stewardship is going to open up, so back to your Loeb and McGreer Criteria. Make sure it's being used because we saw just as many unnecessary drug regulations and F-tags hit as we did antibiotic stewardship -- maybe the stewardship a little less. But if you don't use antibiotic stewardship, you will certainly have unnecessary drugs, unnecessary cost, unnecessary care that could be diverted more readily to your infection-control program and your immunization program. Lastly, what I wanted to talk about is let your infection-prevention or QA/PI team lead the way. They're the directors, but they're also the most skilled people that you have working with you. Allow them to take the data that your infection preventionist is collecting and analyze it and get it back to him or her. Identify the gaps that are needed to make it a better system. Identify what was the vaccination rate last year and what the gap is to your target today, and let the QA/PI team determine how you're going to get there, while the infection preventionist goes about the daily duties of monitoring staff, influencing policies-and-procedures compliance, and calculating lots and lots of different numbers to make reports. But what your QA/PI committee can always do is prevent your data from just being another piece of paper. The QA/PI committee is really responsible for turning that data into information and taking that information and making actionable plans. So, one of the things you might want to think about, as we saw with the recent regulation changes and easing up of them, that performance-improvement projects were not going to be as stringent in terms of reporting them to CMS or the state as we had once thought. But they still are designed beautifully to help us with particular projects. So, as you go ahead and you say, "Well, how can a PIP help me with COVID?" well, COVID or infection control is a scope of care. What a PIP will help you do is define the aspect of care that you need the most help with. So, for example, the scope of care is infection control, but the aspect of care that you need would be in droplet precautions or airborne precautions or the proper disposal of PPE, for example, or the proper doffing of PPE. Your PIP really gets down into what they call "the weeds" to help you make your program more successful, and it makes your

QA/PI program far more meaningful than convening around a table once a month, looking at numbers, and moving away scratching your head on what we're going to do next. So, again, how will we support them? Well, take a look at the overall infection-prevention program. Make sure that it is everything that you expect it to be in the facility. The committee can also do that annual review, take a look at surveillance and those who have gone from perhaps colonized to active infections. Take a look at your antibiotic-stewardship programs and the number of unnecessary antibiotics that are being used. Review the immunization of residents last year compared to this year. Everybody walk down to the laundry and other areas -- biohazard rooms, into the bathrooms and the tub rooms to make sure that your facility is everything that we hope it will be. Look at residents who are on transmission-based precautions and isolation. You know that they're always the first ones that are going to be looked at when the surveyors come into the front door. And they can also help you with other aspects of care-specific observations as they move around the building. An infection-control committee is only successful when the entire QA/PI committee gets up from the table and away from the data and supports the infection preventionist. So, while I hope that we have given you today a few tidbits, I think that, in summary, what we're saying here is that we expect the flu season, whether it's mild or whether it's robust, to be nothing like we've ever seen before. There are certainly ways that you can begin to prepare this month and the next to get influenza vaccinations done, tune up your practices, review your policies, do education, reach out to your residents, reach out to your vendor, reach out to your network to make sure you have all of the resources you need because we just don't know exactly how much or what resources we will need. If there is a second wave of COVID in the middle of influenza season, it may be very difficult for all of us. So, as I said in the beginning to Liza, I'm not sure that we'll be any less concerned, but I think that we have provided and I hope provided some path for you to walk down to have an infection-control, prevention, and immunization program that leads you to wellness and to the best possible care you can deliver to your residents and those that we all love caring for. And with that, we can open it up to questions. I thank you for your time. There are so many of you on the call. We appreciate your interest in this topic and hope you found it valuable.

Well, I know I have, Nancy. Thank you so much. That was just awesome -- so much information. Let's get to some questions. We're going to go over by just a few minutes to see if we can get to as many questions as possible. Nancy, let's start out -- "Can you have the flu and COVID at the same time?"

Yes, absolutely. You can have dual infections, just the same way as you can have a viral and a bacterial infection or a secondary bacterial infection to influenza. We may or may not see that. I think it's a really good idea to reach out to your referring hospital, talk to the infectious-disease departments, and see what other infections have been presented to them from patients who had COVID so that you understand what those coexisting infections may be.

Okay. Here's a different type of question. "Is there an agency or hotline that nervous direct-care workers can call to get their questions answered?"

Believe it or not, you can pose any of your questions to the CDC online. So there are mailboxes. CMS also has an open line, and I always recommend that, if you're not on their distribution list, to have the e-mails pushed to you, that you do that. I don't want you to seek and find the most recent

information, so if you log on to both CMS, Medicare, and long-term care facilities, or you log on to the CDC, look for that area that says "contact us," and you can pose questions to them, as they're the authorities. And of course other of your organizations -- the American Health Care Association, the American Medical Directors Association, and so forth -- will be able to give you those answers. I know that there are a lot of education and a lot of webcasts out there, and there's a lot of information coming at you that varies from one opinion to the other. I have tried to be as precise with current guidelines and references as I can be, but other than a psychiatrist, use those contacts that are listed on those websites to help you through the worst of times or those that you feel really nervous about or unsure. As I said before, pick up the phone and call the county, talk to them, and see what they know about the disease and influenza in your neighborhood and what they can help you with throughout the rest of the year.

That's great. There are several questions about when a flu vaccine should be administered. Some people say it's usually given in mid-October. Should it be earlier this year? Someone from California said they were advised to wait until even November because the flu season doesn't start until January. What do you say?

Refer to the CDC on a routine basis. Go to flu.gov, and look for the information. Again, also look at ASIP and MMWR to help you with the latest guidance on when to administer influenza. A lot of the -- as we know -- of our seniors will be using the high-dose formulations of influenza vaccinations. That usually helps them ride out the entire flu season. As it stands today and when I looked at it, the guidance was still there to administer as soon as you get it. Traditionally, there are many people who feel as though they want to wait till September or October, and I think that those days are past. I know that, we as a company, at one time, did it on Mischief Day in our pharmacies to try and administer influenza vaccine to our staff and make it kind of more fun than not, but now that appears to be a little late. Those days of thinking that flu was in the fall weren't thinking about airplanes and travel, and they still thought that influenza moved from California east, to the shore. That's not happening anymore. So, again, check with the CDC. Check with your state board of health and look for the latest recommendation on when to start immunizing. I do believe that the flu is arriving in your buildings if it's not already there.

Okay.

So get your vaccines.

Okay. Questions about people, particularly employees, who don't want -- who have maybe misperceptions about the vaccine. One person asked, "How do you convince nurses to take it when they read on the label it may contain carcinogens?" So there's that aspect, and then someone says, "Can you address the issue of allergies to vaccines?"

Yes. Obviously, the allergies -- you can become allergic to anything at anytime. However, one of the things that people are most allergic to are eggs. And there egg-free thimerosal or mercury-free vaccinations, bacteriostatic agents that they use to preserve them are quite different than they used to be in the past. Today's vaccines aren't even like they were 10 years ago. They're so much safer. You can read the ingredients. You can consult with your physician. But if you've never been allergic,

certainly the benefit outweighs the risk. I just can't imagine anyone in the building that wants to bring home influenza from a resident to their own family. And the American Medical Directors Association has recommended that facilities have policies that it's mandatory. That's not necessarily easy to execute, but you'll have to follow state guidelines because some of them do require it.

What about that question about carcinogens? How do you handle that one?

Well, you're not exposed to the carc-- If there is anything carcinogenic in there, you're not exposed to it repeatedly. It could be a very small amount of fluid in a single intramuscular vaccination. There certainly is not enough even for OSHA to say that vaccinations are hazardous drugs. So, again, read the label. Anyone is certainly able to call either the FDA or the manufacturer of the vaccination. When you call the manufacturer, ask for medical services or medical information, and discuss with them your fear about being allergic or having a carcinogen into you via a vaccine.

Mm-hmm. Let's just get to a couple more questions. So, going back to the possibility of having flu and COVID, if a symptomatic resident tests positive for flu or COVID, is it recommended to test for the other infection, as well, or should the test concomitantly -- or I guess concurrently?

It's a really good question. What you want to do is that, if you think that the flu is running around or is prevalent in your area and you have access to rapid flu testing, you do that or vice versa, but using one or the other will rule out, generally, one or the other. For those that you feel as though the symptoms are more than influenza, you might want to consider the COVID test first. Again, I tried to point out the differences in the symptomology so that you can take your best-educated assessment of that resident and determine what you want to test for first.

Okay, and then just the last question -- "Can you catch COVID twice?"

We do not know. That is still under investigation. Most of the time, when someone says that they've caught it twice, they weren't tested positively in the beginning or we didn't know the test for COVID. But we don't know what the recurring prevalence will be, and we don't know if a second phase of COVID will infect the same people twice. The thing is we are just not sure yet of the titer that's needed for the antibodies, and that is what the clinical trials are proving. It's not just that they are in Phase 3 trials. Sure, they're giving people the vaccination to see what the adverse reactions are, but they will test them later by challenging some of those patients by exposing them to COVID and see if they actually are immune to it, are able to fight it have, or have fewer symptoms. We're still waiting for that information. That's why I said have the CDC send you information on a daily basis so that you can keep up on it, and remember your infection preventionist has a lot to do. He or she can't just sit there and read e-mails all day long.

Mm. Right. I think you gave a website before. Would you mind giving that again for information?

It is flu.gov. Or just go to cdc/covid or to CMS and the long-term-care sites, Medicare and the long-term care facilities, and you're going to see on most of those screens, up in the right-hand corner, they'll say "contact

us," and you can send them an e-mail, and I have to tell you that my experience is that they are responsive. They have people just manning those types of questions, especially for a long-term-care facilities. So if you're going to do that, please identify yourself as someone who is a healthcare personnel, worker, administrator, owner/operator of a long-term-care facility so that they can make sure that they can prioritize their answer to you and get it back to you as soon as possible.

Okay. Terrific. Well, obviously, we could keep going, but we've already gone over now. So we hope everyone has enjoyed this really informative educational webinar. It will be available very shortly at mcknights.com/081320webinar. A transcript for this webinar will be available to everyone 24 hours after this podcast. Please visit the registration page for this event to find a link to this transcript. Also, I want to correct something that I said at the beginning of the presentation about continuing-education credits. If you listen to this broadcast in its entirety, you will receive a certificate right away. So we'd like to give a very special thank-you to Nancy Losben and Omnicare. You can learn more at www.omnicare.com. We want to thank you, our listeners, for your wonderful questions. This is Liza Berger for McKnight's, wishing you and your residents and staff good health and an easy flu season.