Tools for Influenza Vaccine Safety from the National Adult & Influenza Immunization Summit (NAIIS)

Influenza Working Group

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National Adult and Influenza Immunization Summit

National Adult and Influenza Immunization Summit (NAIIS)

- NAIIS mission: Dedicated to addressing and resolving adult and influenza immunization issues and improving the use of vaccines recommended by the Advisory Committee on Immunization Practices

- NAIIS organized by: The CDC, Immunization Action Coalition, and the National Vaccine Program Office

- NAIIS comprises: >700 partners, representing more than 130 public and private organizations

National Adult and Influenza Immunization Summit

The National Adult and Influenza Immunization Summit is organized by the CDC, the Immunization Action Coalition, and the National Vaccine Program Office. It is dedicated to addressing and resolving adult and influenza immunization issues and improving the use of vaccines recommended by the ACIP

The Influenza Working Group at NAIIS

- The Summit's Influenza Working Group was relaunched in 2015 with a mission to work to improve influenza vaccination coverage and promote best practices

- We are a diverse multi-sectoral partnership that strives to improve influenza vaccination coverage rates and adult vaccination best practices through systems-level approaches

- The Working Group operationalizes these goals by:
  - Promoting healthcare personnel vaccination
  - Creating tools that encourage safe vaccine administration
  - Developing resources that encourage more providers to vaccinate

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The Summit's Influenza Working Group was relaunched in 2015 with a mission to improve influenza vaccination coverage and promote best practices. One of the main goals of this group was to create tools that encourage safe vaccine administration

“Best Practice” Tools for Holding Safe Vaccination Clinics in Satellite, Temporary, or Off-site Locations: Checklist and Pledge

1. Background
   - Unique challenges of vaccination clinics held in satellite, temporary, or off-site locations

2. Tools developed to ensure vaccination clinics held in these settings are done safely:
   - The Checklist of Best Practices
   - The Pledge
   - Additional Resources

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During this presentation I will discuss some unique challenges of vaccination clinics held in satellite, temporary or off-site locations. Then I will discuss materials that were developed by the influenza working group to promote safety

Background

- Satellite, temporary, and off-site vaccination clinics play an important role in improving vaccination coverage rates and vaccinating hard-to-reach populations

- 17% of U.S. adults receive their influenza vaccination at their workplace[1]

http://www.cdc.gov/flu/business/index.htm?s_cid=seasonalflu-btn-055" title=

1. Black CL, Yue X, Ball SW, et al. Influenza Vaccination Coverage Among Health Care Personnel — United States, 2017–18 Influenza Season. *MMWR.* 2018; 67(38):1050-4. DOI: http://dx.doi.org/10.15585/mmwr.mm6738a2

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Satellite, temporary, and off-site vaccination clinics can play a very important role in improving vaccination coverage rates and vaccinating hard-to-reach populations by optimizing convenience for recipients.

Of US adults who receive influenza vaccination, 17% are vaccinated at their workplace[1]. And likely to grow in the future as we see increased access to vaccines outside of traditional visits to primary care providers

Challenges of Vaccination Clinics in Temporary Settings

- Vaccination clinics held in these settings have unique challenges:
  - — Training and oversight of HCP
  - — Vaccine transport, storage and handling
  - — Monitoring proper vaccine administration techniques
  - — Managing documentation for large groups

- May lead to unsafe environments, vaccine temperature excursions, and vaccine administration errors

https://phil.cdc.gov/Details.aspx?pid=5401

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However, vaccination clinics held in these non-traditional settings also have unique challenges, including:

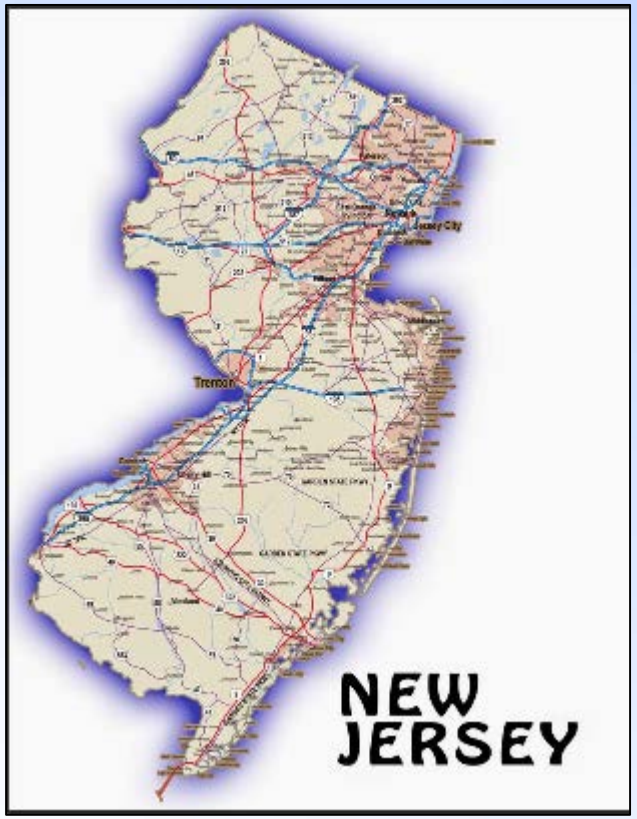
1. Training and oversight of health care personnel – who are often hired and trained as part of "surge staffing" efforts
2. Vaccine transport, storage and handling obstacles for maintaining temperature control and sterility
3. Monitoring, and proper vaccine administration techniques
4. Managing documentation for large groups without usual office-based charts

As a result of these challenges, vaccination clinics held in satellite, temporary, or off-site settings may lead to unsafe environments, vaccine temperature excursions, and vaccine administration errors.

Incident— New Jersey

- Sept 30, 2015:
  - NJDOH was notified of infection control breach at a workplace-sponsored flu vaccination clinic
  - A contracted nurse used same syringe on 67 patients

- NJDOH found other problems with the clinic:
  - Inadequate dosing
  - Inappropriate transport, storage and handling



https://printable-maps.blogspot.com/2009/02/state-map-of-new-jersey.html

These are not merely theoretical concerns! As some of you may remember, during the fall of 2015, adverse events at a non-hospital workplace influenza vaccination clinic illustrated almost everything that can go wrong in an influenza immunization campaign and highlighted all the vulnerabilities of nontraditional sites and surge staffing.

The following events were reported after a workplace-sponsored flu vaccination clinic in New Jersey.

On September 30, 2015, the New Jersey Department of Health (NJDOH) was notified of an infection control breach that occurred at a workplace-sponsored flu vaccination clinic held earlier that day. The nurse administering the vaccines changed the needle between each patient, but used the same syringe on 67 patients. This is a well-recognized hazard for bloodborne pathogen transmission since "flashback" of patients' blood can occur into the barrel of a syringe.

We learned that Company A, a wellness company, had contracted with the implicated nurse to provide flu vaccines at a workplace-sponsored flu vaccination clinic for Company B.

An employee who received an injection in the flu vaccination clinic noticed that the nurse reused a syringe. After the clinic, he notified management of his employer, Company B. Company B notified Company A which then appropriately reported the breach to the NJDOH.

- NJDOH found other problems with the clinic, including:

  Inadequate dosing (since the nurse was drawing up the wrong amount of vaccine), and

  Inappropriate transport, storage, and handling of the vaccine.

Coordinated Response

- Coordinated response by NJDOH and CDC required
  - Extensive testing for bloodborne pathogens
  - Hepatitis B immunization
  - Revaccination for influenza
  - Follow up with NJ Board of Nursing
  - Addressing mainstream media reports and concerns

STATE OF NEW JERSEY
DEPARTMENT OF HEALTH

CDC
Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

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A Coordinated response by NJDOH and CDC was required, including:

Extensive testing for bloodborne pathogens

Hepatitis B immunization

Revaccination for influenza so that employees received the correct dose

Follow up with NJ Board of Nursing, and

Addressing mainstream media reports and concerns

Morbidity and Mortality Weekly Report (*MMWR*)

MMWR

Notes from the Field: Injection Safety and Vaccine Administration Errors at an Employee Influenza Vaccination Clinic — New Jersey, 2015

Weekly
December 18, 2015 / 64(49);1363-4

Laura Taylor, PhD[1]; Rebecca Greeley, MPH[1]; Jill Dinitz-Sklar, MPH[1]; Nicole Mazur, MPH[1]; Jill Swanson, MPH[2]; JoEllen Wolicki, BSN[3]; Joseph Perz, DrPH[4]; Christina Tan, MD[1]; Barbara Montana, MD[1]

On September 30, 2015, the New Jersey Department of Health (NJDOH) was notified by an out-of-state health services company that an experienced nurse had reused syringes for multiple persons earlier that day. This occurred at an employee influenza vaccination clinic on the premises of a New Jersey business that had contracted with the health services company to provide influenza vaccinations to its employees. The employees were to receive vaccine from manufacturer-prefilled, single-dose syringes. However, the nurse contracted by the health services company brought three multiple-dose vials of vaccine that were intended for another event. The nurse reported using two syringes she found among her supplies to administer vaccine to 67 employees of the New Jersey business. She reported wiping the syringes with alcohol and using a new needle for each of the 67 persons. One of the vaccine recipients witnessed and questioned the syringe reuse, and brought it to the attention of managers at the business who, in turn, reported the practice to the health services company contracted to provide the influenza vaccinations.

A report of this incident was published in CDC's Morbidity and Mortality Weekly Report in December 2015.

CBS NEWS NEWS SHOWS VIDEO CBSN MORE

Nurse giving flu shots in New Jersey reused syringes

Share / Tweet / Reddit / Flipboard / Email

Last Updated Oct 7, 2015 10:37 PM EDT

A nurse administering flu shots to dozens of employees of a pharmaceutical company in New Jersey reused syringes, the state Department of Health said Wednesday.

NBC 10 Home News Weather Politics Investigators •••

Nurse Reuses Syringe While Giving Flu Shots Clinic: Officials

By David Chang

Published at 6:24 PM EDT on Oct 5, 2015 | Updated at 12:20 AM EDT on Oct 8, 2015

Sections The Washington Post Democracy Dies in Darkness Sign In

Morning Mix

Nurse reused syringes during flu vaccine clinic, N.J. health authorities say

By Lindsey Bever
October 7, 2015

Most Read World

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Additionally, there was extensive media coverage in New Jersey, NY, and PA, as well as mainstream media nationally. This incident not only brought a lot of media attention, but also awareness to issues surrounding the lack of oversight at influenza vaccination clinics.

Other Reported Incidents

- Montgomery County, TX (2015): $70,000 worth of revaccinations required after vaccines were stored at the wrong temperature
- Wellesley, MA (2010): School staff given insulin in flu vaccine error. Some staffers had to be hospitalized, but all recovered
- Collier County, FL (2009): 77 students given wrong flu shot

- http://www.click2houston.com/news/local/montgomery-county/re-vaccinations-required-after-error-in-montgomery-county
- http://www.boston.com/news/education/k_12/articles/2010/01/19/wellesley_school_staff_given_insulin_in_flu_vaccine_error/
- http://www.nbc-2.com/story/11477899/dozens-of-students-given-wrong-flu-shot

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There have been other documented incidents of issues such as temperature excursions, and even a school where staff were mistakenly injected with insulin meant for students with diabetes

Rationale for Creating the Checklist and Pledge

No "gold standard" at the time of the NJ incident for organizations that run these clinics

National Adult and Influenza Immunization Summit decided to take this issue on and create a "Checklist of Best Practices" for vaccination clinics held in non-traditional settings

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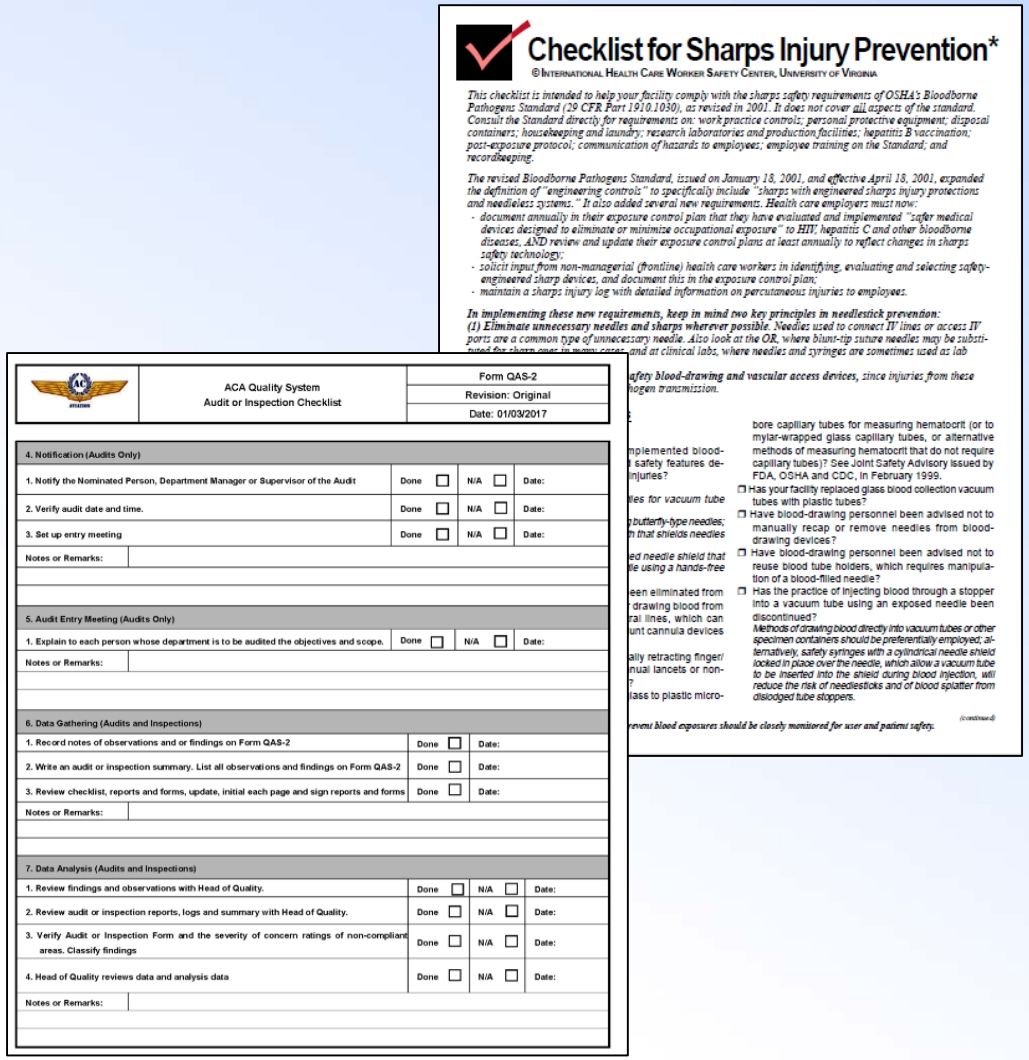
At the time of the NJ incident there was no central resource tool that was the gold standard for safety in nontraditional settings.

As a result, our workgroup decided to create a checklist of best practices for vaccination clinics held in non-traditional settings

Safety Checklists are Validated Risk Reduction Tools in Healthcare and Industry

- Sharps Injury Risk Reduction
- Prevention of “Wrong Site” Surgeries
- Aviation Safety
- Mine Safety and Inspections
- Laboratory Safety
- Environmental Services
- **WHY NOT VACCINATION CLINICS?**



Checklist for Sharps Injury Prevention*

© International Health Care Worker Safety Center, University of Virginia

This checklist is intended to help your facility comply with the sharps safety requirements of OSHA's Bloodborne Pathogens Standard (29 CFR Part 1910.1030), as revised in 2001. It does not cover all aspects of the standard. Consult the Standard directly for requirements on: work practice controls; personal protective equipment; disposal containers; housekeeping and laundry; research laboratories and production facilities; hepatitis B vaccination; post-exposure protocol; communication of hazards to employees; employee training on the Standard; and recordkeeping.

The revised Bloodborne Pathogens Standard, issued on January 18, 2001, and effective April 18, 2001, expanded the definition of "engineering controls" to specifically include "sharps with engineered sharps injury protections and needleless systems." It also added several new requirements. Health care employers must now:

- *document annually in their exposure control plan that they have evaluated and implemented "safer medical devices designed to eliminate or minimize occupational exposure" to HIV, hepatitis C and other bloodborne diseases, AND review and update their exposure control plans at least annually to reflect changes in sharps safety technology;*
- *solicit input from non-managerial (frontline) health care workers in identifying, evaluating and selecting safety-engineered sharp devices, and document this in the exposure control plan;*
- *maintain a sharps injury log with detailed information on percutaneous injuries to employees.*

In implementing these new requirements, keep in mind two key principles in needlestick prevention:
***(1) Eliminate unnecessary needles and sharps wherever possible.** Needles used to connect IV lines or access IV ports are a common type of unnecessary needle. Also look at the OR, where blunt-tip suture needles may be substituted for sharp ones in many cases, and at clinical labs, where needles and syringes are sometimes used as lab*

***afety blood-drawing and vascular access devices,** since injuries from these hogen transmission.*

nplemented blood- safety features de- injuries?

les for vacuum tube

butterfly-type needles; h that shields needles

ed needle shield that le using a hands-free

een eliminated from drawing blood from ral lines, which can unt cannula devices

ally retracting finger/ nual lancets or non- ?

lass to plastic micro-

bore capillary tubes for measuring hematocrit (or to mylar-wrapped glass capillary tubes, or alternative methods of measuring hematocrit that do not require capillary tubes)? See Joint Safety Advisory issued by FDA, OSHA and CDC, in February 1999.

- ❒ Has your facility replaced glass blood collection vacuum tubes with plastic tubes?
- ❒ Have blood-drawing personnel been advised not to manually recap or remove needles from blood-drawing devices?
- ❒ Have blood-drawing personnel been advised not to reuse blood tube holders, which requires manipulation of a blood-filled needle?
- ❒ Has the practice of injecting blood through a stopper into a vacuum tube using an exposed needle been discontinued?

Methods of drawing blood directly into vacuum tubes or other specimen containers should be preferentially employed; alternatively, safety syringes with a cylindrical needle shield locked in place over the needle, which allow a vacuum tube to be inserted into the shield during blood injection, will reduce the risk of needlesticks and of blood splatter from dislodged tube stoppers.

(continued)

revent blood exposures should be closely monitored for user and patient safety.

ACA Quality System
Audit or Inspection Checklist

Form QAS-2
Revision: Original
Date: 01/03/2017

4. Notification (Audits Only)			
1. Notify the Nominated Person, Department Manager or Supervisor of the Audit	Done ☐	N/A ☐	Date:
2. Verify audit date and time.	Done ☐	N/A ☐	Date:
3. Set up entry meeting	Done ☐	N/A ☐	Date:
Notes or Remarks:			
5. Audit Entry Meeting (Audits Only)			
1. Explain to each person whose department is to be audited the objectives and scope.	Done ☐	N/A ☐	Date:
Notes or Remarks:			
6. Data Gathering (Audits and Inspections)			
1. Record notes of observations and or findings on Form QAS-2	Done ☐		Date:
2. Write an audit or inspection summary. List all observations and findings on Form QAS-2	Done ☐		Date:
3. Review checklist, reports and forms, update, initial each page and sign reports and forms	Done ☐		Date:
Notes or Remarks:			
7. Data Analysis (Audits and Inspections)			
1. Review findings and observations with Head of Quality.	Done ☐	N/A ☐	Date:
2. Review audit or inspection reports, logs and summary with Head of Quality.	Done ☐	N/A ☐	Date:
3. Verify Audit or Inspection Form and the severity of concern ratings of non-compliant areas. Classify findings	Done ☐	N/A ☐	Date:
4. Head of Quality reviews data and analysis data	Done ☐	N/A ☐	Date:
Notes or Remarks:			

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After all, safety checklists are validated risk reduction tools in healthcare and other industries. Thus, why not have one for vaccine clinics, particularly in temporary settings to help mitigate mistakes

Creation of Safety Checklist and Other Materials

- To standardize the process of holding clinics in these non-traditional settings, the NAIIS Influenza Working Group developed:
  - A checklist of best practices for vaccination clinics held at satellite, temporary, or off-site locations
  - A pledge for organizations implementing vaccination clinics held in these non-traditional locations affirming they will adhere to best practices.
  - Ten point "poster" (resource guide) summarizing the principles in the checklist
  - FAQ document
- **Our goal was to improve safety but not to decrease access to these non-traditional vaccination clinics**

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Along with the checklist of best practices, we developed a pledge for organizations implementing vaccination clinics held in these non-traditional locations affirming they will adhere to best practices; a poster that summarizes the ten principles of the checklist; and an FAQ document

The Checklist of Best Practices

Purpose and Function of the *Checklist of Best Practices*

- Comprehensive, step-by-step guide for clinic coordinators/supervisors overseeing vaccination clinics

- Checklist is divided into “before”, “during”, and “after” clinic sections and covers:
  - Vaccine Shipment
  - Vaccine Transport
  - Vaccine Storage and Handling
  - Clinic Preparation and Supplies
  - Vaccine Administration
  - Documentation

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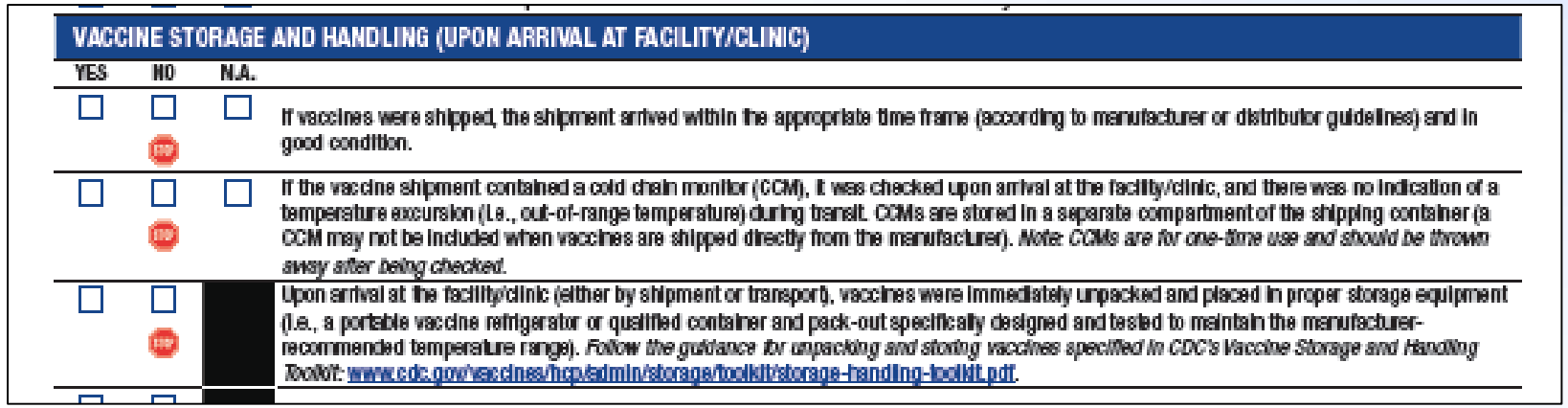
The checklist is a comprehensive step by step guide for supervisors overseeing vaccination clinics in non-traditional settings. The document is divided into before, during, and after the clinic sections.

Importance of the "Stop Sign" Symbol

- Critical steps for patient safety and vaccine effectiveness are identified with a stop sign icon STOP

- If any of these stop sign items are checked as "NO," users are directed to STOP the clinic and follow their organization's protocols and/or contact the state or local health department before proceeding



VACCINE STORAGE AND HANDLING (UPON ARRIVAL AT FACILITY/CLINIC)			
YES	NO	N.A.	
☐	☐ STOP	☐	If vaccines were shipped, the shipment arrived within the appropriate time frame (according to manufacturer or distributor guidelines) and in good condition.
☐	☐ STOP	☐	If the vaccine shipment contained a cold chain monitor (CCM), it was checked upon arrival at the facility/clinic, and there was no indication of a temperature excursion (i.e., out-of-range temperature) during transit. CCMs are stored in a separate compartment of the shipping container (a CCM may not be included when vaccines are shipped directly from the manufacturer). *Note: CCMs are for one-time use and should be thrown away after being checked.*
☐	☐ STOP	[redacted]	Upon arrival at the facility/clinic (either by shipment or transport), vaccines were immediately unpacked and placed in proper storage equipment (i.e., a portable vaccine refrigerator or qualified container and pack-out specifically designed and tested to maintain the manufacturer-recommended temperature range). *Follow the guidance for unpacking and storing vaccines specified in CDC's Vaccine Storage and Handling Toolkit:* www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.

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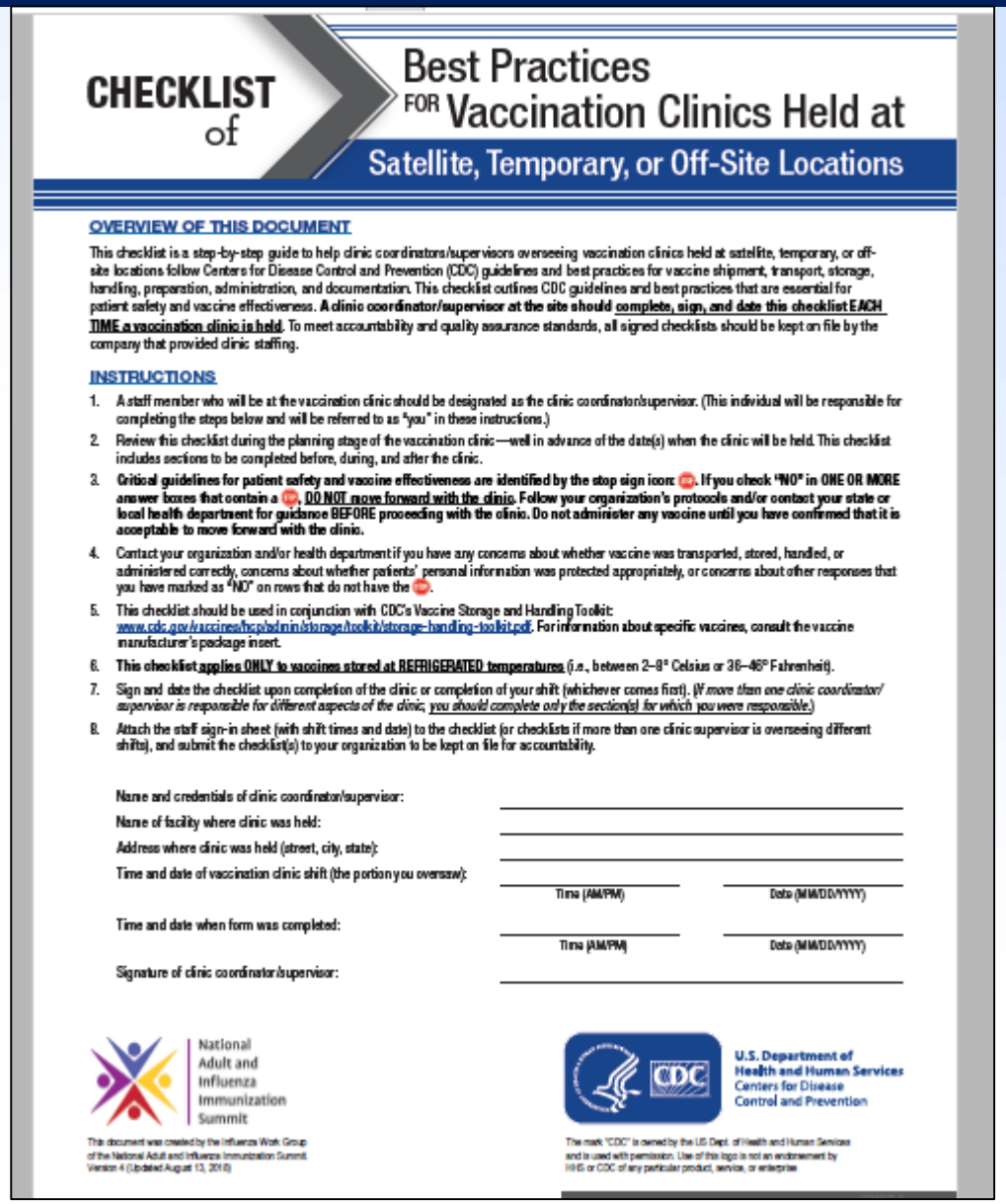
Throughout the document critical steps for patient safety and vaccine effectiveness are identified with a stop sign icon

If a clinic coordinator checks “no” on any of the items indicated with a stop sign, they are directed to follow their organization’s protocols and/or contact the state or local health department prior to proceeding

Title Page of Checklist



CHECKLIST of

Best Practices FOR Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations

OVERVIEW OF THIS DOCUMENT

This checklist is a step-by-step guide to help clinic coordinators/supervisors overseeing vaccination clinics held at satellite, temporary, or off-site locations follow Centers for Disease Control and Prevention (CDC) guidelines and best practices for vaccine shipment, transport, storage, handling, preparation, administration, and documentation. This checklist outlines CDC guidelines and best practices that are essential for patient safety and vaccine effectiveness. **A clinic coordinator/supervisor at the site should complete, sign, and date this checklist EACH TIME a vaccination clinic is held.** To meet accountability and quality assurance standards, all signed checklists should be kept on file by the company that provided clinic staffing.

INSTRUCTIONS

1. A staff member who will be at the vaccination clinic should be designated as the clinic coordinator/supervisor. (This individual will be responsible for completing the steps below and will be referred to as "you" in these instructions.)
2. Review this checklist during the planning stage of the vaccination clinic—well in advance of the date(s) when the clinic will be held. This checklist includes sections to be completed before, during, and after the clinic.
3. **Critical guidelines for patient safety and vaccine effectiveness are identified by the stop sign icon: STOP. If you check "NO" in ONE OR MORE answer boxes that contain a STOP, DO NOT move forward with the clinic. Follow your organization's protocols and/or contact your state or local health department for guidance BEFORE proceeding with the clinic. Do not administer any vaccine until you have confirmed that it is acceptable to move forward with the clinic.**
4. Contact your organization and/or health department if you have any concerns about whether vaccine was transported, stored, handled, or administered correctly, concerns about whether patients' personal information was protected appropriately, or concerns about other responses that you have marked as "NO" on rows that do not have the STOP.
5. This checklist should be used in conjunction with CDC's Vaccine Storage and Handling Toolkit: www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf. For information about specific vaccines, consult the vaccine manufacturer's package insert.
6. **This checklist applies ONLY to vaccines stored at REFRIGERATED temperatures** (i.e., between 2–8° Celsius or 36–46° Fahrenheit).
7. Sign and date the checklist upon completion of the clinic or completion of your shift (whichever comes first). (*If more than one clinic coordinator/supervisor is responsible for different aspects of the clinic, you should complete only the section(s) for which you were responsible.*)
8. Attach the staff sign-in sheet (with shift times and date) to the checklist (or checklists if more than one clinic supervisor is overseeing different shifts), and submit the checklist(s) to your organization to be kept on file for accountability.

Name and credentials of clinic coordinator/supervisor: _____

Name of facility where clinic was held: _____

Address where clinic was held (street, city, state): _____

Time and date of vaccination clinic shift (the portion you oversaw): _____ Time (AM/PM) _____ Date (MM/DD/YYYY)

Time and date when form was completed: _____ Time (AM/PM) _____ Date (MM/DD/YYYY)

Signature of clinic coordinator/supervisor: _____

National Adult and Influenza Immunization Summit

This document was created by the Influenza Work Group of the National Adult and Influenza Immunization Summit. Version 4 (Updated August 13, 2018)

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

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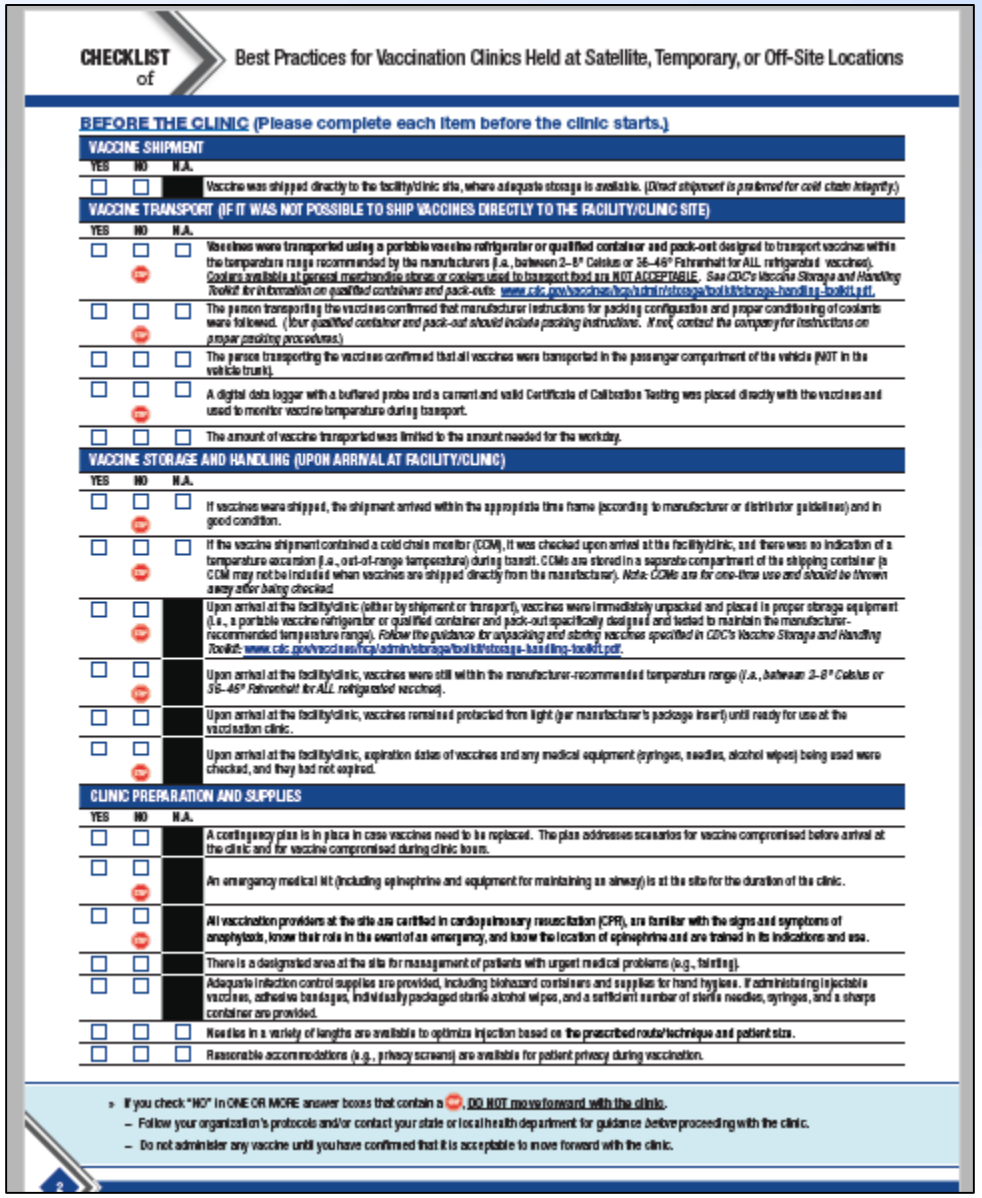
The title page of the checklist has instructions for how to use the checklist; and the ability to document the clinic coordinator, facility location, time of the clinic, and signature of the clinic supervisor

You will notice the CDC logo is on the checklist, and this is because the checklist has passed the CDC clearance process.

“BEFORE the Clinic” Section of the Checklist



CHECKLIST of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations

BEFORE THE CLINIC (Please complete each item before the clinic starts.)

VACCINE SHIPMENT

YES	NO	N.A.	
☐	☐	■	Vaccine was shipped directly to the facility/clinic site, where adequate storage is available. (*Direct shipment is preferred for cold chain integrity.*)

VACCINE TRANSPORT (IF IT WAS NOT POSSIBLE TO SHIP VACCINES DIRECTLY TO THE FACILITY/CLINIC SITE)

YES	NO	N.A.	
☐	☐	☐	Vaccines were transported using a portable vaccine refrigerator or qualified container and pack-out designed to transport vaccines within the temperature range recommended by the manufacturers (i.e., between 2–8° Celsius or 36–46° Fahrenheit for ALL refrigerated vaccines). Coolers available at general merchandise stores or coolers used to transport food are NOT ACCEPTABLE. *See CDC's Vaccine Storage and Handling Toolkit for information on qualified containers and pack-outs:* www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.
☐	☐	☐	The person transporting the vaccines confirmed that manufacturer instructions for packing configuration and proper conditioning of coolants were followed. (*Your qualified container and pack-out should include packing instructions. If not, contact the company for instructions on proper packing procedures.*)
☐	☐	☐	The person transporting the vaccines confirmed that all vaccines were transported in the passenger compartment of the vehicle (NOT in the vehicle trunk).
☐	☐	☐	A digital data logger with a buffered probe and a current and valid Certificate of Calibration Testing was placed directly with the vaccines and used to monitor vaccine temperature during transport.
☐	☐	☐	The amount of vaccine transported was limited to the amount needed for the workday.

VACCINE STORAGE AND HANDLING (UPON ARRIVAL AT FACILITY/CLINIC)

YES	NO	N.A.	
☐	☐	☐	If vaccines were shipped, the shipment arrived within the appropriate time frame (according to manufacturer or distributor guidelines) and in good condition.
☐	☐	☐	If the vaccine shipment contained a cold chain monitor (CCM), it was checked upon arrival at the facility/clinic, and there was no indication of a temperature excursion (i.e., out-of-range temperature) during transit. CCMs are stored in a separate compartment of the shipping container (a CCM may not be included when vaccines are shipped directly from the manufacturer). *Note: CCMs are for one-time use and should be thrown away after being checked.*
☐	☐	■	Upon arrival at the facility/clinic (either by shipment or transport), vaccines were immediately unpacked and placed in proper storage equipment (i.e., a portable vaccine refrigerator or qualified container and pack-out specifically designed and tested to maintain the manufacturer-recommended temperature range). *Follow the guidance for unpacking and storing vaccines specified in CDC's Vaccine Storage and Handling Toolkit:* www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.
☐	☐	■	Upon arrival at the facility/clinic, vaccines were still within the manufacturer-recommended temperature range (*i.e., between 2–8° Celsius or 36–46° Fahrenheit for ALL refrigerated vaccines*).
☐	☐	■	Upon arrival at the facility/clinic, vaccines remained protected from light (per manufacturer's package insert) until ready for use at the vaccination clinic.
☐	☐	■	Upon arrival at the facility/clinic, expiration dates of vaccines and any medical equipment (syringes, needles, alcohol wipes) being used were checked, and they had not expired.

CLINIC PREPARATION AND SUPPLIES

YES	NO	N.A.	
☐	☐	■	A contingency plan is in place in case vaccines need to be replaced. The plan addresses scenarios for vaccine compromised before arrival at the clinic and for vaccine compromised during clinic hours.
☐	☐	■	An emergency medical kit (including epinephrine and equipment for maintaining an airway) is at the site for the duration of the clinic.
☐	☐	■	All vaccination providers at the site are certified in cardiopulmonary resuscitation (CPR), are familiar with the signs and symptoms of anaphylaxis, know their role in the event of an emergency, and know the location of epinephrine and are trained in its indications and use.
☐	☐	■	There is a designated area at the site for management of patients with urgent medical problems (e.g., fainting).
☐	☐	■	Adequate infection control supplies are provided, including biohazard containers and supplies for hand hygiene. If administering injectable vaccines, adhesive bandages, individually packaged sterile alcohol wipes, and a sufficient number of sterile needles, syringes, and a sharps container are provided.
☐	☐	☐	Needles in a variety of lengths are available to optimize injection based on the prescribed route/technique and patient size.
☐	☐	☐	Reasonable accommodations (e.g., privacy screens) are available for patient privacy during vaccination.

- If you check "NO" in ONE OR MORE answer boxes that contain a STOP, DO NOT move forward with the clinic.
  - Follow your organization's protocols and/or contact your state or local health department for guidance before proceeding with the clinic.
  - Do not administer any vaccine until you have confirmed that it is acceptable to move forward with the clinic.

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The before section of the checklist goes through vaccine shipment, transport, storage, handling, and clinic preparation

You'll notice that there are stop signs on many of the rows in this section since maintaining the proper temperature of the vaccine, having an emergency medical kit, and having providers on site who are certified in CPR and able to address medical emergencies is of utmost importance

“BEFORE the Clinic” Section of the Checklist

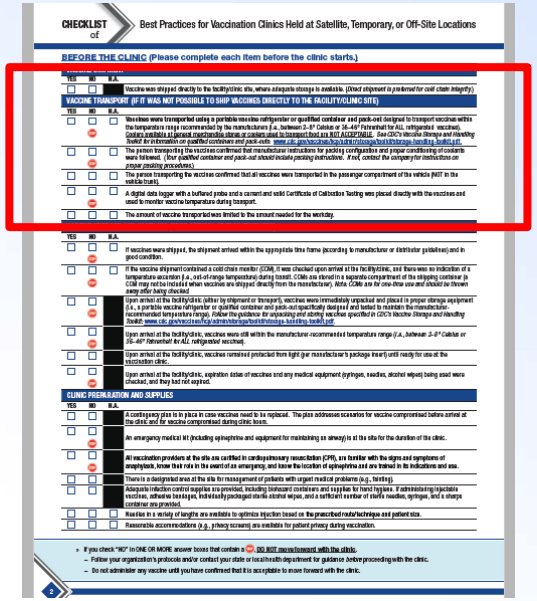
BEFORE THE CLINIC (Please complete each item before the clinic starts.)

VACCINE SHIPMENT

YES	NO	N.A.	
☐	☐	■	Vaccine was shipped directly to the facility/clinic site, where adequate storage is available. (*Direct shipment is preferred for cold chain integrity.*)

VACCINE TRANSPORT (IF IT WAS NOT POSSIBLE TO SHIP VACCINES DIRECTLY TO THE FACILITY/CLINIC SITE)

YES	NO	N.A.	
☐	☐ STOP	☐	**Vaccines were transported using a portable vaccine refrigerator or qualified container and pack-out** designed to transport vaccines within the temperature range recommended by the manufacturers (i.e., between 2–8° Celsius or 36–46° Fahrenheit for ALL refrigerated vaccines). Coolers available at general merchandise stores or coolers used to transport food are NOT ACCEPTABLE. *See CDC’s Vaccine Storage and Handling Toolkit for information on qualified containers and pack-outs*: www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.
☐	☐ STOP	☐	The person transporting the vaccines confirmed that manufacturer instructions for packing configuration and proper conditioning of coolants were followed. (*Your qualified container and pack-out should include packing instructions. If not, contact the company for instructions on proper packing procedures.*)
☐	☐	☐	The person transporting the vaccines confirmed that all vaccines were transported in the passenger compartment of the vehicle (NOT in the vehicle trunk).
☐	☐ STOP	☐	A digital data logger with a buffered probe and a current and valid Certificate of Calibration Testing was placed directly with the vaccines and used to monitor vaccine temperature during transport.
☐	☐	☐	The amount of vaccine transported was limited to the amount needed for the workday.



National Adult and Influenza Immunization

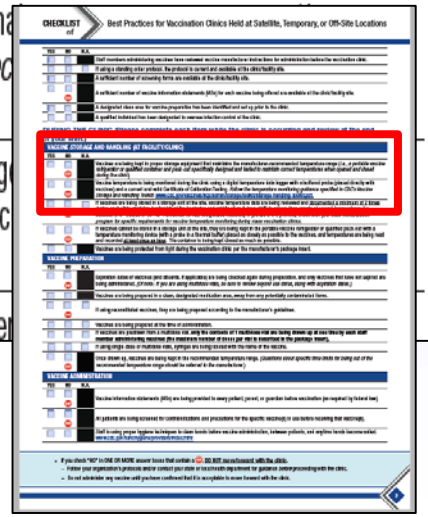
This is a closer look at one of the before the clinic sections.

“DURING the Clinic” Section of the Checklist

DURING THE CLINIC (Please complete each item while the clinic is occurring and review at the end of your shift.)

VACCINE STORAGE AND HANDLING (AT FACILITY/CLINIC)

YES	NO	N.A.	
☐	☐ STOP		Vaccines are being kept in proper storage equipment that maintains the manufacturer-recommended temperature range (*i.e., a portable vaccine refrigerator or qualified container and pack-out specifically designed and tested to maintain correct temperatures when opened and closed during the clinic*).
☐	☐ STOP		Vaccine temperature is being monitored during the clinic using a digital temperature data logger with a buffered probe (placed directly with vaccines) and a current and valid Certificate of Calibration Testing. *Follow the temperature monitoring guidance specified in CDC’s Vaccine Storage and Handling Toolkit.* www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.
☐	☐ STOP	☐	If vaccines are being stored in a storage unit at the site, vaccine temperature data are being reviewed and documented a minimum of 2 times during each clinic workday (preferably at the beginning and middle of an 8-hour shift) to ensure they rema *between 2–8° Celsius or 36–46° Fahrenheit for ALL refrigerated vaccines). If you are a VFC provider, chec program for specific requirements for vaccine temperature monitoring during mass vaccination clinics.*
☐	☐ STOP	☐	If vaccines cannot be stored in a storage unit at the site, they are being kept in the portable vaccine refrig temperature monitoring device (with a probe in a thermal buffer) placed as closely as possible to the vacc and recorded at least once an hour. The container is being kept closed as much as possible.
☐	☐		Vaccines are being protected from light during the vaccination clinic per the manufacturer’s package inse



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The second section of the checklist is the “During the Clinic” section. This section is to be completed while the clinic is occurring and reviewed at the end of the shift.

This is a closer look at the first subsection in the “During the Clinic” section, which covers vaccine storage and handling at the facility or clinic.

“DURING the Clinic” Section of the Checklist

VACCINE PREPARATION

YES	NO	N.A.	
☐	☐ STOP		Expiration dates of vaccines (and diluents, if applicable) are being checked again during preparation, and only vaccines that have not expired are being administered. *(Of note: If you are using multidose vials, be sure to review beyond use dates, along with expiration dates.)*
☐	☐		Vaccines are being prepared in a clean, designated medication area, away from any potentially contaminated items.
☐	☐ STOP	☐	If using reconstituted vaccines, they are being prepared according to the manufacturer’s guidelines.
☐	☐	☐	Vaccines are being prepared at the time of administration.
☐	☐	☐	If vaccines are predrawn from a multidose vial, **only the contents of 1 multidose vial are being drawn up at one time by each staff member administering vaccines (the maximum number of doses per vial is described in the package insert).**
☐	☐	☐	If using single-dose or multidose vials, syringes are being labeled with the name of the vaccine.
☐	☐ STOP		Once drawn up, vaccines are being kept in the recommended temperature range. (*Questions about … recommended temperature range should be referred to the manufacturer.*)

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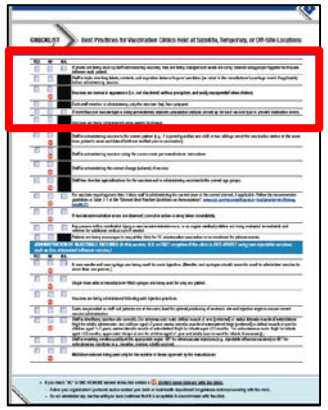
The second subsection for during the clinic is on vaccine preparation. Stop signs are included to verify that expiration dates of vaccines are being checked and are not expired, and again to check that vaccines are being kept in the recommended temperature range once they've been drawn up.

“DURING the Clinic” Section of the Checklist



VACCINE ADMINISTRATION			
YES	NO	N.A.	
☐	☐ STOP		Vaccine information statements (VISs) are being provided to every patient, parent, or guardian before vaccination (as required by federal law).
☐	☐ STOP		All patients are being screened for contraindications and precautions for the specific vaccine(s) in use before receiving that vaccine(s).
☐	☐		Staff is using proper hygiene techniques to clean hands before vaccine administration, between patients, and anytime hands become soiled. www.cdc.gov/handhygiene/providers/index.html
☐	☐	☐	If gloves are being worn by staff administering vaccines, they are being changed and hands are being cleaned using proper hygiene techniques between each patient.
☐	☐		Staff is triple-checking labels, contents, and expiration dates or beyond use dates (as noted in the manufacturer’s package insert, if applicable) before administering vaccine.
☐	☐ STOP		Vaccines are normal in appearance (i.e., not discolored, without precipitate, and easily resuspended when shaken).
☐	☐		Each staff member is administering only the vaccines they have prepared.
☐	☐	☐	If more than one vaccine type is being administered, separate preparation stations are set up for each vaccine type to prevent medication errors.
☐	☐ STOP		Vaccines are being administered using aseptic technique.
☐	☐ STOP		Staff is administering vaccine to the correct patient (e.g., if a parent/guardian and child or two siblings are at the vaccination station at the same time, patient’s name and date of birth are verified prior to vaccination).
☐	☐ STOP		Staff is administering vaccines using the correct route per manufacturer instructions.
☐	☐ STOP		Staff is administering the correct dosage (volume) of vaccine.
☐	☐ STOP		Staff has checked age indications for the vaccines and is administering vaccines to the correct age groups.
☐	☐ STOP	☐	For vaccines requiring more than 1 dose, staff is administering the current dose at the correct interval, if applicable. *Follow the recommended guidelines in Table 3-1 of the “General Best Practice Guidelines on Immunization”*: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html#t-01.
☐	☐ STOP	☐	If vaccine administration errors are observed, corrective action is being taken immediately.
☐	☐	☐	Any persons with a needlestick injury, a vaccine administration error, or an urgent medical problem are being evaluated immediately and referred for additional medical care if needed.
☐	☐		Patients are being encouraged to stay at the clinic for 15 minutes after vaccination to be monitored for adverse events.

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The third subsection to be completed “During the Clinic” is for Vaccine Administration. There are a number of stop signs in this subsection for the clinic coordinator to make sure that staff is administering vaccines using the correct route, and dose, to the correct patient.

"DURING the Clinic" Section of the Checklist

ADMINISTRATION OF INJECTABLE VACCINES *(In this section, N.A. is ONLY an option if the clinic is EXCLUSIVELY using non-injectable vaccines, such as live, attenuated influenza vaccine.)*			
YES	NO	N.A.	
☐	☐ STOP	☐	**A new needle and new syringe are being used for each injection. (Needles and syringes should never be used to administer vaccine to more than one person.)**
☐	☐ STOP	☐	Single-dose vials or manufacturer-filled syringes are being used for only one patient.
☐	☐ STOP	☐	Vaccines are being administered following safe injection practices.
☐	☐	☐	Seats are provided so staff and patients are at the same level for optimal positioning of anatomic site and injection angle to ensure correct vaccine administration.
☐	☐ STOP	☐	Staff is identifying injection site correctly. (For intramuscular route: deltoid muscle of arm [preferred] or vastus lateralis muscle of anterolateral thigh for adults, adolescents, and children aged ≥3 years; vastus lateralis muscle of anterolateral thigh [preferred] or deltoid muscle of arm for children aged 1–2 years; vastus lateralis muscle of anterolateral thigh for infants aged ≤12 months. For subcutaneous route: thigh for infants aged <12 months; upper outer triceps of arm for children aged ≥1 year and adults [can be used for infants if necessary].)
☐	☐	☐	Staff is inserting needles quickly at the appropriate angle: 90° for intramuscular injections (e.g., injectable influenza [illegible] subcutaneous injections (e.g., measles, mumps, rubella vaccine).
☐	☐ STOP	☐	Multidose vials are being used only for the number of doses approved by the manufacturer.

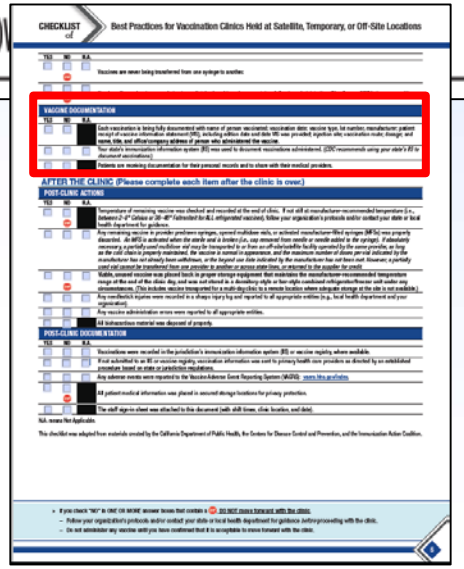
National Adult and Influenza Immunization

There is also a subsection on administration of injectable vaccines.

“DURING the Clinic” Section of the Checklist

VACCINE DOCUMENTATION

YES	NO	N.A.	
☐	☐		Each vaccination is being fully documented with name of person vaccinated; vaccination date; vaccine type, lot number, manufacturer; patient receipt of vaccine information statement (VIS), including edition date and date VIS was provided; injection site; vaccination route; dosage; and name, title, and office/company address of person who administered the vaccine.
☐	☐	☐	Your state's immunization information system (IIS) was used to document vaccinations administered. (*CDC recommends using your state's IIS to document vaccinations.*)
☐	☐		Patients are receiving documentation for their personal records and to share with their medical prov


CHECKLIST of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations

VACCINE DOCUMENTATION

AFTER THE CLINIC (Please complete each item after the clinic is over.)

POST-CLINIC ACTIONS

POST-CLINIC DOCUMENTATION

National Adult and Influenza Immunization Summit

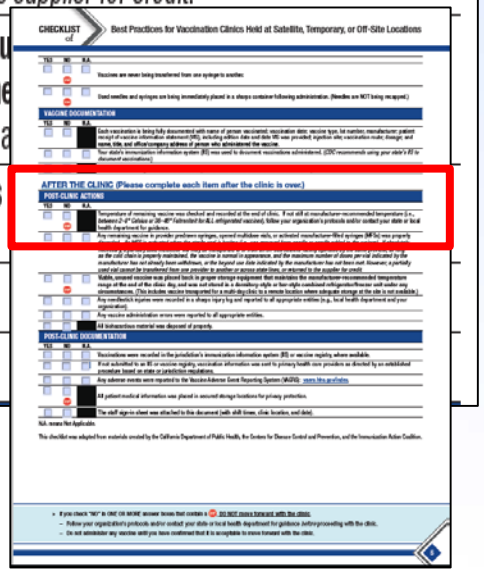
Vaccine documentation is the last section to be completed during the clinic.

“AFTER the Clinic” Section

AFTER THE CLINIC (Please complete each item after the clinic is over.)

POST-CLINIC ACTIONS

YES	NO	N.A.	
☐	☐ STOP		Temperature of remaining vaccine was checked and recorded at the end of clinic. If not still at manufacturer-recommended temperature (i.e., *between 2–8° Celsius or 36–46° Fahrenheit for ALL refrigerated vaccines*), follow your organization’s protocols and/or contact your state or local health department for guidance.
☐	☐	☐	Any remaining vaccine in provider predrawn syringes, opened multidose vials, or activated manufacturer-filled syringes (MFSs) was properly discarded. *An MFS is activated when the sterile seal is broken (i.e., cap removed from needle or needle added to the syringe). If absolutely necessary, a partially used multidose vial may be transported to or from an off-site/satellite facility operated by the same provider, as long as the cold chain is properly maintained, the vaccine is normal in appearance, and the maximum number of doses per vial indicated by the manufacturer has not already been withdrawn, or the beyond use date indicated by the manufacturer has not been met. However, a partially used vial cannot be transferred from one provider to another or across state lines, or returned to the supplier for credit.*
☐	☐ STOP	☐	**Viable, unused vaccine was placed back in proper storage equipment that maintains the manu range at the end of the clinic day, and was not stored in a dormitory-style or bar-style combine circumstances.** (This includes vaccine transported for a multi-day clinic to a remote location where a
☐	☐	☐	Any needlestick injuries were recorded in a sharps injury log and reported to all appropriate entities organization).
☐	☐	☐	Any vaccine administration errors were reported to all appropriate entities.
☐	☐		All biohazardous material was disposed of properly.



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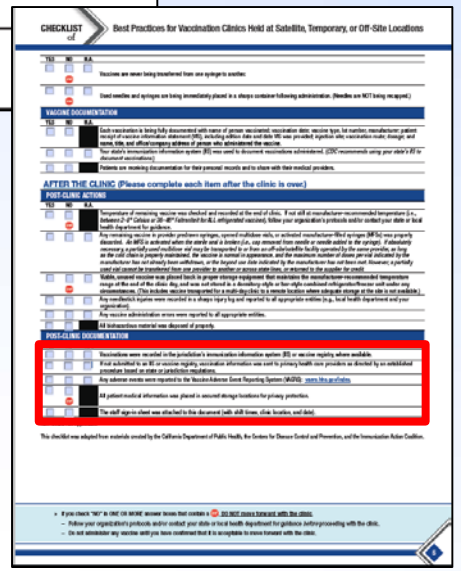
The Final Section of the checklist pertains to “after the clinic”.

“AFTER the Clinic” Section

POST-CLINIC DOCUMENTATION			
YES	NO	N.A.	
☐	☐	☐	Vaccinations were recorded in the jurisdiction’s immunization information system (IIS) or vaccine registry, where available.
☐	☐	☐	If not submitted to an IIS or vaccine registry, vaccination information was sent to primary health care providers as directed by an established procedure based on state or jurisdiction regulations.
☐	☐	☐	Any adverse events were reported to the Vaccine Adverse Event Reporting System (VAERS): vaers.hhs.gov/index.
☐	☐ STOP		All patient medical information was placed in secured storage locations for privacy protection.
☐	☐		The staff sign-in sheet was attached to this document (with shift times, clinic location, and date).



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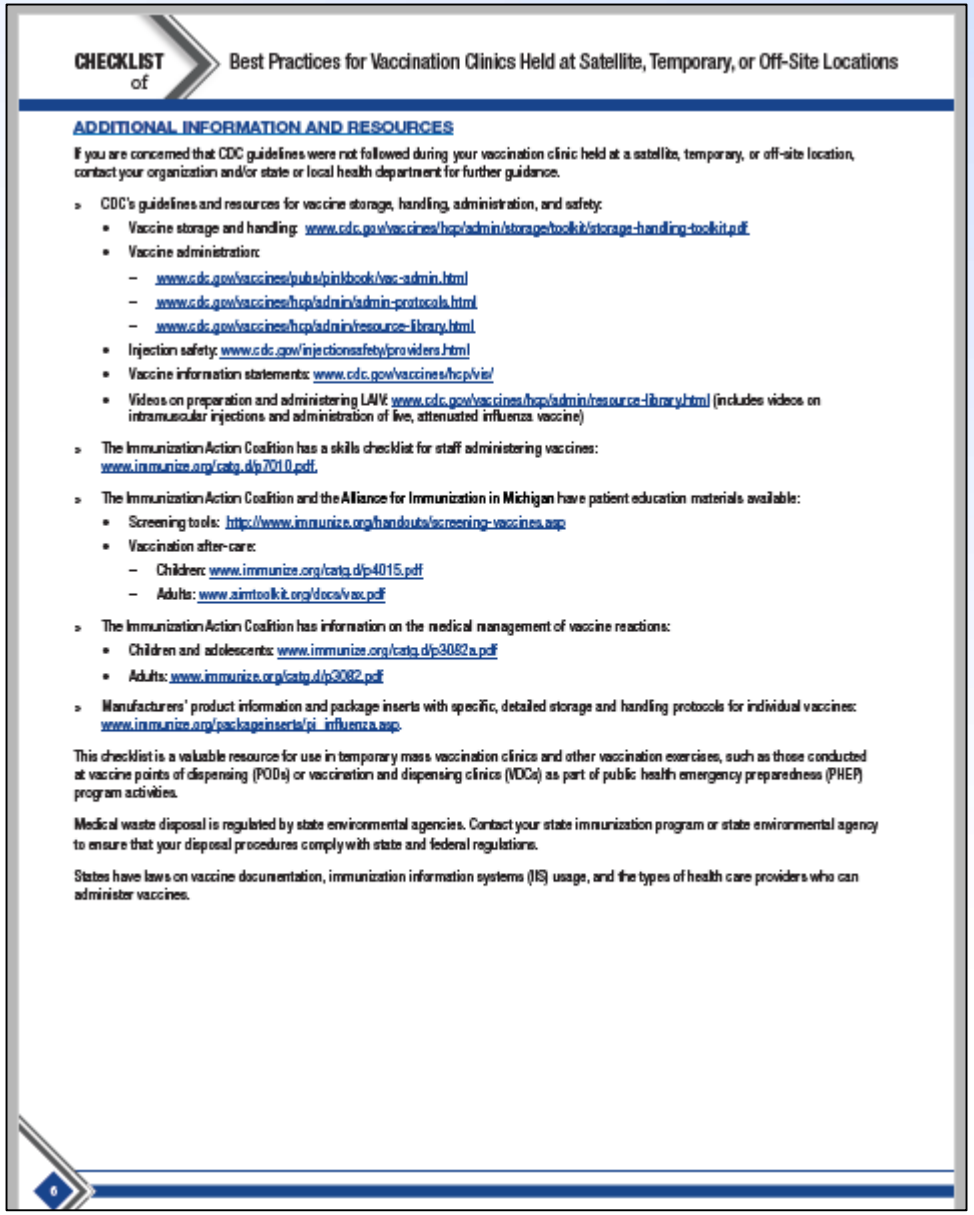
The final subsection relates to post-clinic documentation, with a stop sign on placing patient medical information in secured storage locations.

Checklist Resources



CHECKLIST of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations

ADDITIONAL INFORMATION AND RESOURCES

If you are concerned that CDC guidelines were not followed during your vaccination clinic held at a satellite, temporary, or off-site location, contact your organization and/or state or local health department for further guidance.

- CDC's guidelines and resources for vaccine storage, handling, administration, and safety:
  - Vaccine storage and handling: www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf
  - Vaccine administration:
    - www.cdc.gov/vaccines/pubs/pinkbook/vac-admin.html
    - www.cdc.gov/vaccines/hcp/admin/admin-protocols.html
    - www.cdc.gov/vaccines/hcp/admin/resource-library.html
  - Injection safety: www.cdc.gov/injectionsafety/providers.html
  - Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/
  - Videos on preparation and administering LAIV: www.cdc.gov/vaccines/hcp/admin/resource-library.html (includes videos on intramuscular injections and administration of live, attenuated influenza vaccine)
- The Immunization Action Coalition has a skills checklist for staff administering vaccines: www.immunize.org/catg.d/p7010.pdf.
- The Immunization Action Coalition and the **Alliance for Immunization in Michigan** have patient education materials available:
  - Screening tools: http://www.immunize.org/handouts/screening-vaccines.asp
  - Vaccination after-care:
    - Children: www.immunize.org/catg.d/p4015.pdf
    - Adults: www.aimtoolkit.org/docs/vac.pdf
- The Immunization Action Coalition has information on the medical management of vaccine reactions:
  - Children and adolescents: www.immunize.org/catg.d/p3082a.pdf
  - Adults: www.immunize.org/catg.d/p3082.pdf
- Manufacturers' product information and package inserts with specific, detailed storage and handling protocols for individual vaccines: www.immunize.org/packageinserts/pi_influenza.asp.

This checklist is a valuable resource for use in temporary mass vaccination clinics and other vaccination exercises, such as those conducted at vaccine points of dispensing (PODs) or vaccination and dispensing clinics (VDCs) as part of public health emergency preparedness (PHEP) program activities.

Medical waste disposal is regulated by state environmental agencies. Contact your state immunization program or state environmental agency to ensure that your disposal procedures comply with state and federal regulations.

States have laws on vaccine documentation, immunization information systems (IIS) usage, and the types of health care providers who can administer vaccines.

6

National Adult and Influenza Immunization Summit

On the final page of the checklist, we've included additional information and resources.

Putting the Checklist to Use

- If your vaccination clinics are done in-house by your Occupational Health staff, they can use the checklist for events held in non-traditional sites

- If you hire out your vaccination clinics to an agency, prior to signing a contract with them, you can ask that they follow the checklist and sign the pledge

National Adult and Influenza Immunization Summit

We recognize that the checklist is a useful resource, but only if it is actually being used. So whenever talking about the checklist we always encourage our audience to review and use the checklist where appropriate

The Pledge

The Pledge

- Organizations pledge to adhere to CDC guidelines and best practices when implementing vaccination clinics
  - Including adhering to the Checklist

- Reviewed and signed annually by an organization executive

- Completed pledges should be sent to NAIIS Clinic Pledge Coordinator:
  - vaxclinicpledge@izsummitpartners.org

National Adult and Influenza Immunization Summit

We created a supplemental resource to the checklist that is a pledge. The pledge can be signed by organizations that adhere to CDC guidelines and best practices when implementing vaccination clinics, this includes adhering to the checklist at every vaccination clinic.

The pledge should be reviewed and signed annually by an organization executive.

Benefits of Signing the Pledge

Organizations Pledging Support to Adhere to CDC Guidelines and Best Practices When Implementing Vaccination Clinics at Satellite, Temporary, or Off-site Locations

Each organization listed below has formally pledged to follow Centers for Disease Control and Prevention (CDC) guidelines and best practices for vaccine shipment, transport, storage, handling, preparation, administration, and documentation when implementing vaccination clinics at satellite, temporary, or off-site locations. These guidelines and best practices are essential for patient safety and vaccine effectiveness.

Organizations That Have Taken The Pledge

2018–2019 influenza season*

- CDC Occupational Health Clinic
- OccuMed Health & Wellness, LLC
- Passport Health

2017–2018 influenza season

- Corporate Wellness, Inc.
- Passport Health
- Promerica Health

National Adult and Influenza Immunization Summit

Pledging organizations are recognized on the Summit's "Organizations Pledging Support Page", as shown here. This is also an honor that can be included in an organization's promotional materials, and as a way to show that an organization follows the gold standard, as far as safety guidelines.

The Pledge

National Adult and Influenza Immunization Summit

Pledge for Organizations Implementing Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations
2018–2019 Influenza Season

Our organization pledges to adhere to the guidelines and best practices of the Centers for Disease Control and Prevention (CDC) when implementing vaccination clinics that are held at satellite, temporary, or off-site locations. The pledge will be **reviewed and signed annually by an employee in an executive-level position** within our organization.

Completed pledges should be sent to the National Adult and Influenza Immunization Summit (NAIIS) Clinic Pledge Coordinator. Pledging organizations are recognized on the NAIIS Organizations Pledging Support page.

As an organization, we pledge to:

A. Follow best practices *at each vaccination clinic* held in a satellite, temporary, or off-site location, by implementing the Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations.

B. Adhere to all manufacturer storage and handling guidelines during vaccine shipment or transport and administration, including using a portable refrigerator or qualified container and pack-out if transporting vaccine and performing recommended temperature monitoring.

C. Adhere to CDC vaccine administration and immunization schedule guidelines.

D. Establish a plan to replace mishandled, expired, or damaged vaccine and have a documented plan to complete the clinic.

E. Accommodate language or literacy barriers and special needs of patients/guardians to help make them feel comfortable and informed about the vaccination process.

F. Provide all patients with Vaccine Information Statements (VISs) prior to immunization, as required by federal law.

G. Designate a clean area for vaccine preparation and designate a qualified individual to oversee infection control.

H. Ensure the presence of an emergency medical kit with epinephrine at the site and a designated trained health care provider, certified in CPR, who can administer treatment for allergic reactions and address urgent medical problems.

I. Ensure all vaccinators are legally allowed to administer vaccines, per local jurisdiction laws and/or policies.

J. Communicate immunization and emergency medical protocols to all staff administering vaccines.

K. Encourage all employees to be up to date on their vaccinations, including annual influenza vaccine.

L. Ensure staff who prepare and administer vaccines have been trained and have demonstrated competency in the following areas:

1. Adhering to CDC guidelines for vaccine shipment or transport, storage and handling, preparation, administration, and documentation.
2. Adhering to standard precautions, which include proper hand hygiene and safe injection practices when preparing and administering vaccines, and knowing the location of and how to administer epinephrine and clinical situations in which its use would be indicated.
3. Reporting any needlestick injury and maintaining a sharps injury log.
4. Reporting adverse immunization events to the Vaccine Adverse Event Reporting System (VAERS).
5. Returning all patient medical information to an appropriate storage location.
6. Disposing of all biohazardous materials properly.
7. Documenting all vaccinations per local jurisdiction laws and, whenever possible, entering vaccination records into a state immunization information system (vaccination registry).

Printed Name and Title of Organization Executive: _____

Signature of Organization Executive: _____

Name of Organization: _____

Email address of an organizational contact: _____

Date: _____

This form is valid through the 2018–2019 influenza season. To continue to be recognized as a pledging organization, a new form will need to be signed prior to October 1, 2019 for the 2019–2020 influenza season. NOTE: Although we use the influenza season as the timeframe to help organizations keep track of when to renew their pledge, the pledge applies to **ANY TYPE of VACCINE** (not just influenza) given at satellite, temporary, or off-site clinics.

Version 4 (updated 8/13/2018)

National Adult and Influenza Immunization Summit

This slide shows the full pledge,

The first section of the pledge gives directions on the purpose of the pledge, who should sign it, and where to send the completed pledge form.

The next section of the pledge covers topics including:

-following best practices at each vaccination clinic by using the checklist.

-Adhering to all manufacturer storage and handling guidelines, and

-Having a plan to replace expired or damaged vaccine.

Here are an additional 5 requirements as noted in rows G- K, including ensuring that all vaccinators are legally allowed to administer vaccines.

On the bottom of the pledge, it states that all staff who administer vaccines should be trained and have demonstrated competency.

Then there is a place for the organization executive to sign and date.

Additional Tools

I also wanted to discuss a couple additional tools that we've created.

“Frequently Asked Questions” Document

Frequently Asked Questions

about the National Adult and Influenza Immunization Summit “Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations” and Pledge for Implementing the Checklist

- *The questions in this document relate to the checklist and pledge found here:*

CHECKLIST: www.izsummitpartners.org/off-site-vaccination-clinic-checklist
PLEDGE: www.izsummitpartners.org/pledge-for-organizations-conducting-off-site-vaccination-clinics

Questions about the purpose of the checklist and pledge

1 What is the purpose of the checklist? It seems long and complicated.

Recently, reports have been published of major errors occurring at vaccination clinics held at satellite, temporary, or off-site locations related to the safe transport, storage, and administration of vaccines. These reports are likely the tip of the iceberg. To prevent future errors at clinics in these settings, we developed this checklist as a step-by-step guide to help clinic coordinators/supervisors overseeing vaccination clinics held at satellite, temporary, or off- site locations follow Centers for Disease Control and Prevention (CDC) guidelines and best practices for vaccine shipment, transport, storage, handling, preparation, administration, and documentation. This checklist outlines CDC guidelines and best practices that are essential for patient safety and vaccine effectiveness.

National Adult and Influenza Immunization Summit

In response to numerous questions we've received since publishing the checklist and pledge, we've developed a "Frequently Asked Questions" page, the first question is shown here.

Questions on the FAQ include:

All of our staff have many years of experience and we do hundreds of vaccination clinics a year. Do we still need to use the checklist? The answer is yes, and more detail is provided on the FAQ document.

We have many new staff all over the country. The checklist seems too cumbersome to use in our situation. Do we need to use it? Again, the answer is yes, with a detailed response on the document.

Are we allowed to use coolers purchased at big box stores/retail stores for transporting vaccine? The answer here is no, with the rationale that this is not an acceptable practice and that vaccine should be transported in qualified containers and pack-outs.

1- Page Summary Resource

Ten Principles for Holding Safe Vaccination Clinics at Satellite, Temporary, or Off-Site Locations

During All Stages (Pre-Clinic, During the Clinic, and Post-Clinic)

1. **Keep vaccines at the correct temperature at all times** using proper procedures for vaccine transport, handling and storage. Document temperature monitoring at appropriate intervals during all stages. For further guidance: www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf

Pre-Clinic

2. **Have vaccine shipped directly to the site.** If direct shipment is not possible, **transport vaccine using correct storage and handling guidelines.**
3. **Train staff to perform CPR and treat medical emergencies,** including anaphylaxis. Ensure supplies are on site, including an emergency medical kit and infection control supplies, as well as **enough Vaccine Information Statements (VISs).**

During the Clinic

4. **Always check for medical contraindications and allergies** before vaccinating anyone. **Provide VISs for all patients or guardians.**
5. **Follow manufacturers' instructions and Advisory Committee on Immunization Practices guidelines for correct age and intervals** (for vaccines that require more than one dose).
6. **Follow manufacturers' instructions for injection dose, site, and route.**
7. **Only use vaccines that are not damaged, not expired, at the correct temperature, and prepared using aseptic technique.**
8. **Follow safe handling of needles and syringes,** including using a new needle and syringe for every injection. Dispose of all sharps in a sharps container.
9. **Document** every vaccination and give patients a copy.

Post-Clinic

10. Keep patient information **secure and private.** Record vaccinations in the Immunization Information System (IIS), if available.

For further guidance, refer to the full checklist:
www.izsummitpartners.org/off-site-vaccination-clinic-checklist

National Adult and Influenza Immunization Summit

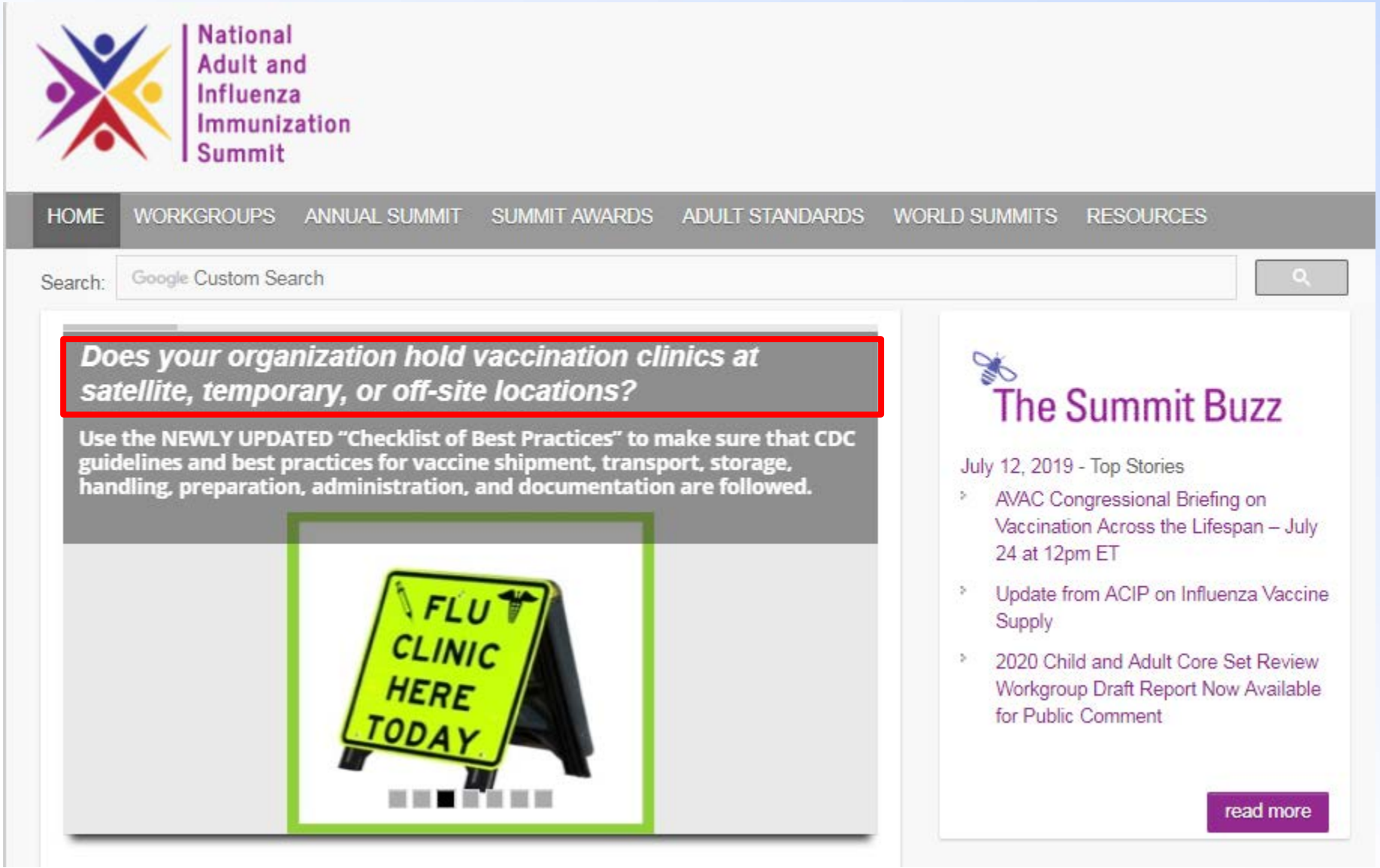
This document is NOT intended to replace use of the checklist.

Version 3 (Updated January 25, 2019)

National Adult and Influenza Immunization Summit

Also, in response to feedback we received, we created a 1 –page summary resource titled “Ten Principles for Holding Safe Vaccination Clinics at Satellite, Temporary, or Off-site Locations”, as shown here. This resource is not intended to replace the checklist. Rather, it is a summary document of the main points on the checklist in 10 concise bullet points.

Where to Find These Documents: From NAIIS Home Page



National Adult and Influenza Immunization Summit

Next, I would like to make sure you know where you can find these resources. The checklist and other resources can be found by going to the homepage for the National Adult and Influenza Immunization Summit. The picture outlined in red here, rotates images, but when this Flu Clinic Sign is on the screen and you click on it, it will take you directly to the checklist. You can also access the resources through the influenza working group's landing page

Where to Find These Documents

- **Landing page for all 4 documents: https://www.izsummitpartners.org/naiis-workgroups/influenza-workgroup/off-site-clinic-resources/**
  - Checklist:
    - https://www.izsummitpartners.org/content/uploads/2019/02/off-site-vaccination-clinic-checklist.pdf
  - Pledge:
    - https://www.izsummitpartners.org/content/uploads/2019/02/pledge-for-organizations-providing-vaccination-clinics.pdf
  - FAQs:
    - https://www.izsummitpartners.org/content/uploads/2019/02/faqs-for-checklist-and-pledge.pdf
  - 1-Page Resource
    - https://www.izsummitpartners.org/content/uploads/2017/04/Ten-principles-for-safe-vac-clinics-1-pg-sum.pdf

National Adult and Influenza Immunization Summit

For your reference, I've also included the direct links to all the resources I've discussed on this slide.

Checklist Project-- Challenges and Needs: Increase Knowledge and Use of These Tools

- Please help us spread the word!
  - — Implement the Checklist and Pledge
  - — Distribute the documents and websites widely
  - — Educate your peers on the Checklist rationale and importance
  - — Feed the FAQs: Send questions to: checklist@izsummitpartners.org

National Adult and Influenza Immunization Summit

We continue to try to distribute these documents widely. We encourage the use of the resources and ask for assistance raising awareness.

We continue to review and update these documents, as appropriate, and welcome feedback, which can be sent, along with questions, to the email address provided on this slide

Contact Information for NAIIS Influenza Working Group Leads:

Contact Information for NAIIS Influenza Working Group Leads:

- Amy Parker Fiebelkorn, CDC
  dez8@cdc.gov

- Amy Behrman, American College of Occupational and Environmental Medicine (ACOEM)
  behrman@pennmedicine.upenn.edu

- Kelly McKenna, The American Academy of Hospice and Palliative Care kmckenna@aahpm.org

Thank you to our many working group members!

Thank you to the many subject matter experts that contributed to these resources!

National Adult and Influenza Immunization Summit

I will conclude by thanking our workgroup members, and the many subject matter experts that informed these materials. Additionally you can see the contact information for the Working Group leads on this slide

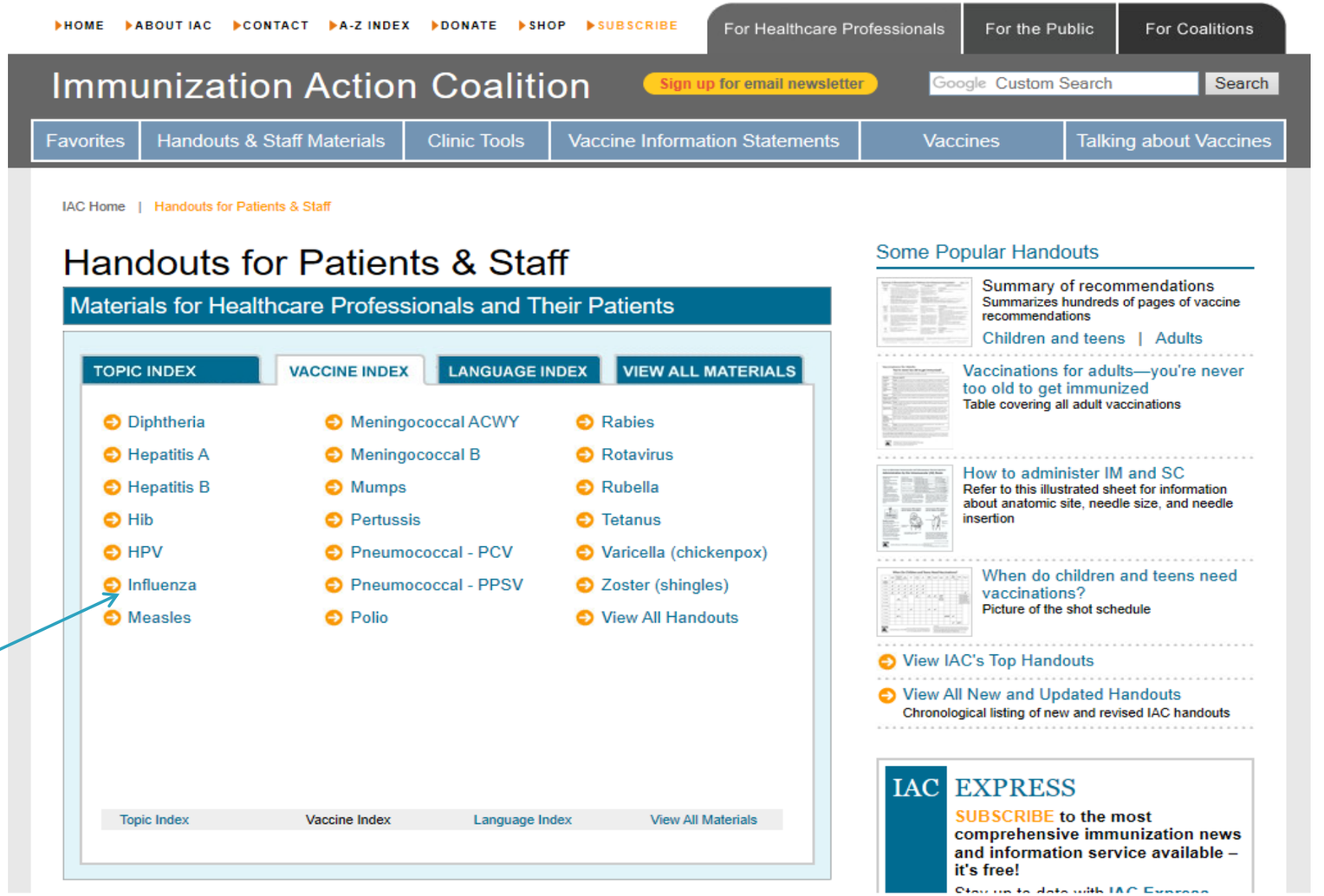
Tools and materials to help in

Improving Influenza Vaccination Efforts

Presentation to the National Vaccine Advisory Committee

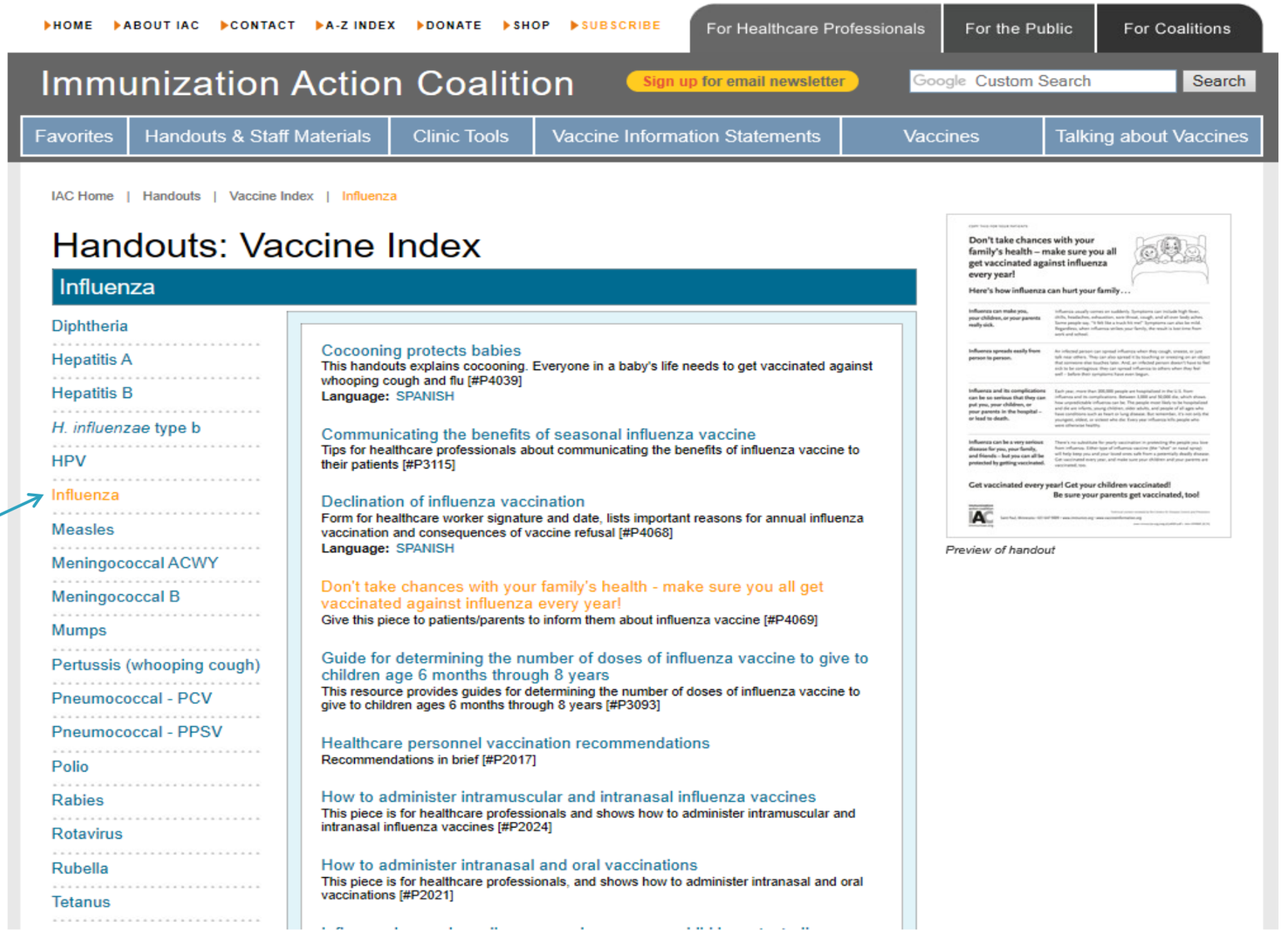
September 18, 2019

www.immunize.org



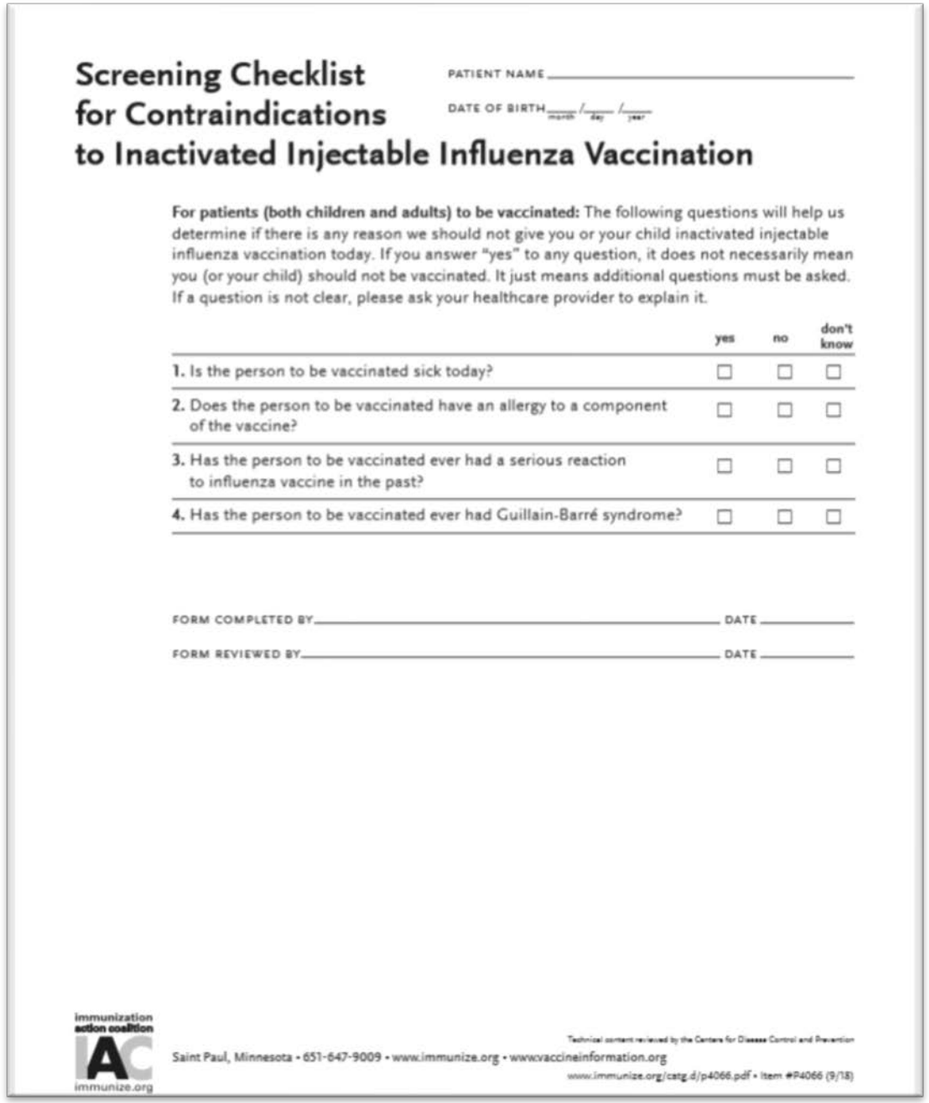
www.immunize.org/handouts

Influenza Educational Materials



Preview of handout

www.immunize.org/influenza-vaccines.asp



Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ___/___/___ (month/day/year)

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

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www.immunize.org/catg.d/p4066.pdf • Item #P4066 (9/18)

Information for Healthcare Professionals about the Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination (IIV or RIV)

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the sources listed at the bottom of this page.

1. Is the person to be vaccinated sick today?

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. People with a moderate or severe illness usually should not be vaccinated until their symptoms have improved. Minor illnesses with or without fever do not contraindicate use of influenza vaccine. Do not withhold vaccination if a person is taking antibiotics.

2. Does the person to be vaccinated have an allergy to a component of the vaccine?

All vaccines, including influenza vaccines, contain various components that might cause allergic and anaphylactic reactions. Not all such reactions are related to egg proteins. However, the possibility of a reaction to influenza vaccines in egg-allergic people might be of concern to both the person and vaccine providers.

An egg-free recombinant influenza vaccine (RIV) is available for people age 18 years and older. ACIP does not state a preference for the use of RIV for egg-allergic people although some providers may choose to administer RIV to their severely egg-allergic patients.

Reviews of studies of IIV and LAIV indicate that severe allergic reactions to egg-based influenza vaccines in persons with egg allergy are unlikely. ACIP recommends that persons with a history of egg allergy who have experienced only hives after exposure to egg should receive influenza vaccine. Any recommended and age-appropriate influenza vaccine (IIV, RIV, or LAIV) may be used. Providers should consider observing all patients for 15 minutes after vaccination to decrease the risk for injury should they experience syncope.

Persons who report having had reactions to egg involving symptoms other than hives, such as angioedema, respiratory distress, lightheadedness, or recurrent vomiting; or who required epinephrine or another emergency medical intervention, may also receive any recommended and age-appropriate influenza vaccine (IIV, RIV or LAIV). The vaccine should be administered in a medical setting (e.g., a health department or physician office). Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.

Inactivated influenza vaccines provided in multi-dose vials contains thimerosal as a preservative. Most people who had sensitivity to thimerosal when it was used in contact lens solution do not have reactions to thimerosal when it is used in vaccines. Check the package insert at www.immunize.org/packageinserts for a list of the vaccine components (i.e., excipients and culture media) used in the production of the vaccine, or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.

For the 2018–2019 influenza season, no vaccine or packaging contains latex.

3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?

Patients reporting a serious reaction to a previous dose of inactivated influenza vaccine should be asked to describe their symptoms. Immediate – presumably allergic – reactions are usually a contraindication to further vaccination against influenza.

Fever, malaise, myalgia, and other systemic symptoms most often affect people who are first-time vaccinees. These mild-to-moderate local reactions are not a contraindication to future vaccination. Also, red eyes or mild upper facial swelling following vaccination with inactivated injectable influenza vaccine is most likely a coincidental event and not related to the vaccine. These people can receive injectable vaccine without further evaluation.

4. Has the person to be vaccinated ever had Guillain-Barré syndrome?

It is prudent to avoid vaccinating people who are not at high risk for severe influenza complications (see source 3) and who are known to have developed Guillain-Barré syndrome (GBS) within 6 weeks after receiving a previous influenza vaccination. As an alternative, clinicians might consider using influenza antiviral chemoprophylaxis for these people. Although data are limited, the established benefits of influenza vaccination for the majority of people who have a history of GBS, and who are at high risk for severe complications from influenza, justify yearly vaccination.

SOURCES

1. CDC. *Epidemiology & Prevention of Vaccine-Preventable Diseases*. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. at www.cdc.gov/vaccines/pubs/pinkbook/index.html.
2. CDC. *Best practices guidance of the Advisory Committee on Immunization Practices Committee (ACIP)* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
3. CDC. *Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, . . .* Access links to current ACIP recommendations at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

www.immunize.org/catg.d/p4066.pdf

Screening Checklist for Contraindications to Live Attenuated Intranasal Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____/____/____ (month / day / year)

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the influenza vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐	☐	☐
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐	☐	☐
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	☐	☐	☐
7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that affect the immune system, such as prednisone, other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or anticancer drugs; or have they had radiation treatments?	☐	☐	☐
8. Is the person to be vaccinated receiving influenza antiviral medications?	☐	☐	☐
9. Is the person to be vaccinated a child or teen age 2 through 17 years and receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
11. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

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www.immunize.org/catg.d/p4067.pdf • Item #P4067 (9/18)

Information for Healthcare Professionals about the Screening Checklist for Contraindications to Live Attenuated Intranasal Influenza Vaccination

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the sources listed at the bottom of this page.

1. Is the person to be vaccinated sick today?
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. People with an acute febrile illness usually should not be vaccinated until their symptoms have improved. Minor illnesses with or without fever do not contraindicate use of influenza vaccine. Do not withhold vaccination if a person is taking antibiotics.

2. Does the person to be vaccinated have an allergy to a component of the influenza vaccine?
A history of an anaphylactic reaction such as wheezing, difficulty breathing, circulatory collapse or shock, or who required epinephrine or another emergency medical intervention after a previous dose of intranasal live attenuated influenza vaccine (LAIV; tradename FluMist) usually means no further doses of LAIV should be given. ACIP recommends that people with a history of egg allergy who have experienced only hives after exposure to egg may receive any recommended and age-appropriate influenza vaccine that is otherwise appropriate for their health status without specific precautions (except a 15 minute observation period for syncope). People who report having had an anaphylactic reaction to egg may also receive any age-appropriate influenza vaccine. The vaccine should be administered in a medical setting (e.g., a health department or physician office). Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.For a complete list of vaccine components (i.e., excipients and culture media) used in the production of the vaccine, check the package insert (at www.immunize.org/packageinserts) or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf.

3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?
Patients reporting a serious reaction to a previous dose of LAIV should be asked to describe their symptoms. Immediate – presumably allergic – reactions are usually a contraindication to further vaccination with LAIV.

4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?
LAIV is not licensed or recommended for use in people younger than age 2 years or older than age 49 years.

5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?
The safety of LAIV in people with any of these health conditions has not been established. These conditions, including asthma in people age 5 years and older, should be considered precautions for the use of LAIV.

6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you that the child had wheezing or asthma?
LAIV is not recommended for a child this age if their parent or guardian answers yes to this question or if the child has a history of asthma or recurrent wheezing. Instead, the child should be given the inactivated injectable influenza vaccine (IIV).

7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that affect the immune system, such as prednisone, other steroids, or drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, anticancer drugs; or have they had radiation treatments?
People with weakened immune systems should not be given LAIV. Instead, they should be given the inactivated injectable influenza vaccine (IIV).

8. Is the person to be vaccinated receiving influenza antiviral medications?
Receipt of certain influenza antivirals (e.g., amantadine, rimantadine, zanamivir, oseltamivir, peramivir) could reduce LAIV vaccine effectiveness; therefore, providers should defer vaccination with LAIV in people who took these antivirals within the previous 48 hours and to advise avoiding use of these antivirals for 14 days after vaccination, if feasible. Influenza antivirals may be used in people vaccinated with IIV.

9. Is the person to be vaccinated a child or teen age 2 through 17 years who is receiving aspirin therapy or aspirin-containing therapy?
Because of the theoretical risk of Reye's syndrome, children age 2 through 17 years on aspirin therapy should not be given LAIV. Instead they should be vaccinated with the inactivated injectable influenza vaccine (IIV).

10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?
Pregnant women or women planning to become pregnant within a month should not be given LAIV. All pregnant women should, however, be vaccinated with the inactivated injectable influenza vaccine. Pregnancy testing is not necessary before administering LAIV.

11. Has the person to be vaccinated ever had Guillain-Barré syndrome?
It is prudent to avoid vaccinating people who are not at high risk for severe influenza complications and who are known to have developed Guillain-Barré syndrome (GBS) within 6 weeks after receiving a previous influenza vaccination. As an alternative, clinicians might consider using influenza antiviral chemoprophylaxis for these people. Although data are limited, the established benefits of influenza vaccination for the majority of people who have a history of GBS, and who are at high risk for severe complications from influenza, justify yearly vaccination.

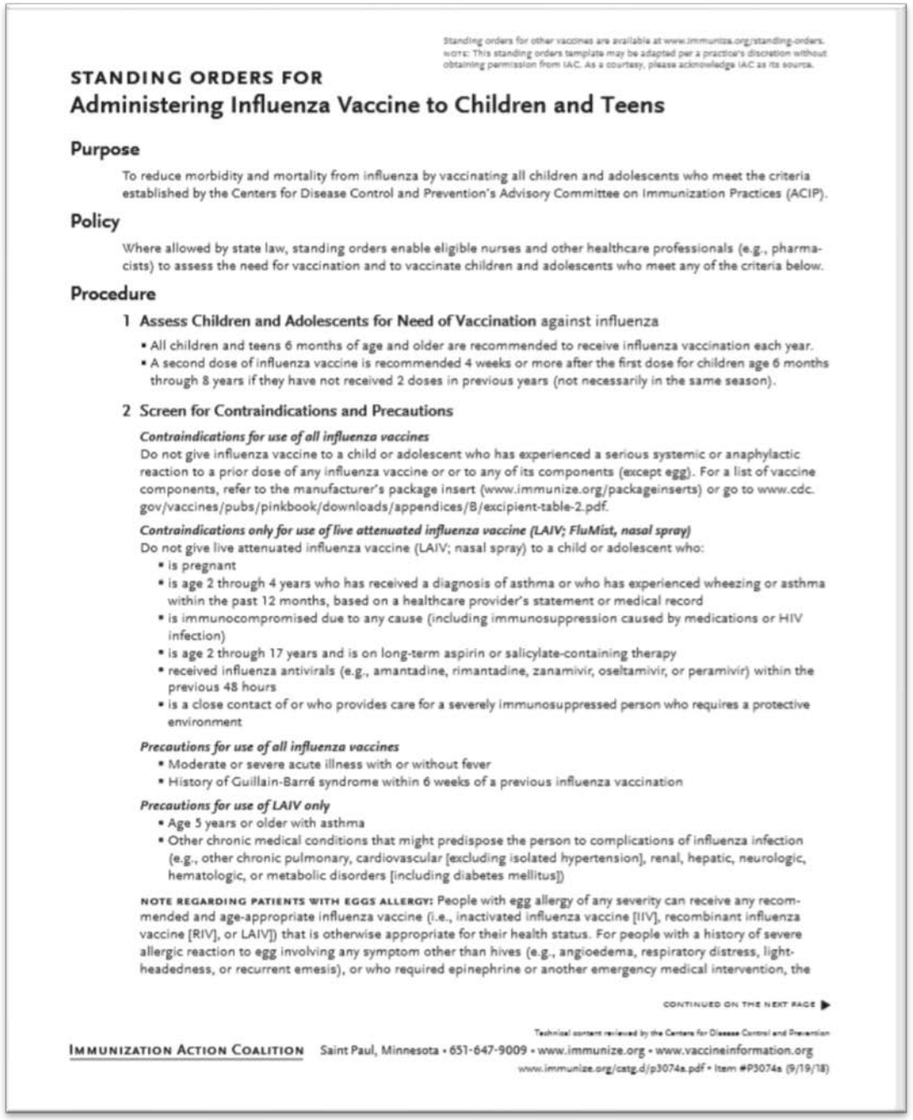
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?
Inactivated injectable influenza vaccine is preferred for people who anticipate close contact with a severely immunosuppressed person during periods in which the immunosuppressed person requires care in protective isolation (e.g., in a specialized patient-care area with a positive airflow relative to the corridor, high-efficiency particulate air filtration, and frequent air changes). Either the inactivated injectable influenza vaccine or LAIV may be used in people who have close contact with people having lesser degrees of immunosuppression.

13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?
People who were previously given an injectable live virus vaccine (e.g., MMR, MMRV, varicella, zoster [Zostavax], yellow fever) should wait at least 28 days before receiving LAIV (30 days for yellow fever). LAIV can be given on the same days as other live vaccines. There is no reason to defer giving LAIV if people were vaccinated with an inactivated vaccine or if they have recently received blood or other antibody-containing blood products (e.g., IG).

SOURCES

1. CDC. *Epidemiology & Prevention of Vaccine-Preventable Diseases*. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. at www.cdc.gov/vaccines/pubs/pinkbook/index.html
2. CDC. *Best Practices Guidance of the Advisory Committee on Immunization Practices (ACIP)* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
3. CDC. *Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, . . .* Access links to current ACIP recommendations at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

www.immunize.org/catg.d/p4066.pdf



Standing orders for other vaccines are available at www.immunize.org/standing-orders.
NOTE: This standing orders template may be adapted per a practice's discretion without obtaining permission from IAC. As a courtesy, please acknowledge IAC as its source.

STANDING ORDERS FOR
Administering Influenza Vaccine to Children and Teens

Purpose

To reduce morbidity and mortality from influenza by vaccinating all children and adolescents who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP).

Policy

Where allowed by state law, standing orders enable eligible nurses and other healthcare professionals (e.g., pharmacists) to assess the need for vaccination and to vaccinate children and adolescents who meet any of the criteria below.

Procedure

1 **Assess Children and Adolescents for Need of Vaccination** against influenza

- All children and teens 6 months of age and older are recommended to receive influenza vaccination each year.
- A second dose of influenza vaccine is recommended 4 weeks or more after the first dose for children age 6 months through 8 years if they have not received 2 doses in previous years (not necessarily in the same season).

2 **Screen for Contraindications and Precautions**

Contraindications for use of all influenza vaccines
Do not give influenza vaccine to a child or adolescent who has experienced a serious systemic or anaphylactic reaction to a prior dose of any influenza vaccine or or to any of its components (except egg). For a list of vaccine components, refer to the manufacturer's package insert (www.immunize.org/packageinserts) or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.

Contraindications only for use of live attenuated influenza vaccine (LAIV; FluMist, nasal spray)
Do not give live attenuated influenza vaccine (LAIV; nasal spray) to a child or adolescent who:

- is pregnant
- is age 2 through 4 years who has received a diagnosis of asthma or who has experienced wheezing or asthma within the past 12 months, based on a healthcare provider's statement or medical record
- is immunocompromised due to any cause (including immunosuppression caused by medications or HIV infection)
- is age 2 through 17 years and is on long-term aspirin or salicylate-containing therapy
- received influenza antivirals (e.g., amantadine, rimantadine, zanamivir, oseltamivir, or peramivir) within the previous 48 hours
- is a close contact of or who provides care for a severely immunosuppressed person who requires a protective environment

Precautions for use of all influenza vaccines

- Moderate or severe acute illness with or without fever
- History of Guillain-Barré syndrome within 6 weeks of a previous influenza vaccination

Precautions for use of LAIV only

- Age 5 years or older with asthma
- Other chronic medical conditions that might predispose the person to complications of influenza infection (e.g., other chronic pulmonary, cardiovascular [excluding isolated hypertension], renal, hepatic, neurologic, hematologic, or metabolic disorders [including diabetes mellitus])

NOTE REGARDING PATIENTS WITH EGGS ALLERGY: People with egg allergy of any severity can receive any recommended and age-appropriate influenza vaccine (i.e., inactivated influenza vaccine [IIV], recombinant influenza vaccine [RIV], or LAIV]) that is otherwise appropriate for their health status. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress, lightheadedness, or recurrent emesis), or who required epinephrine or another emergency medical intervention, the

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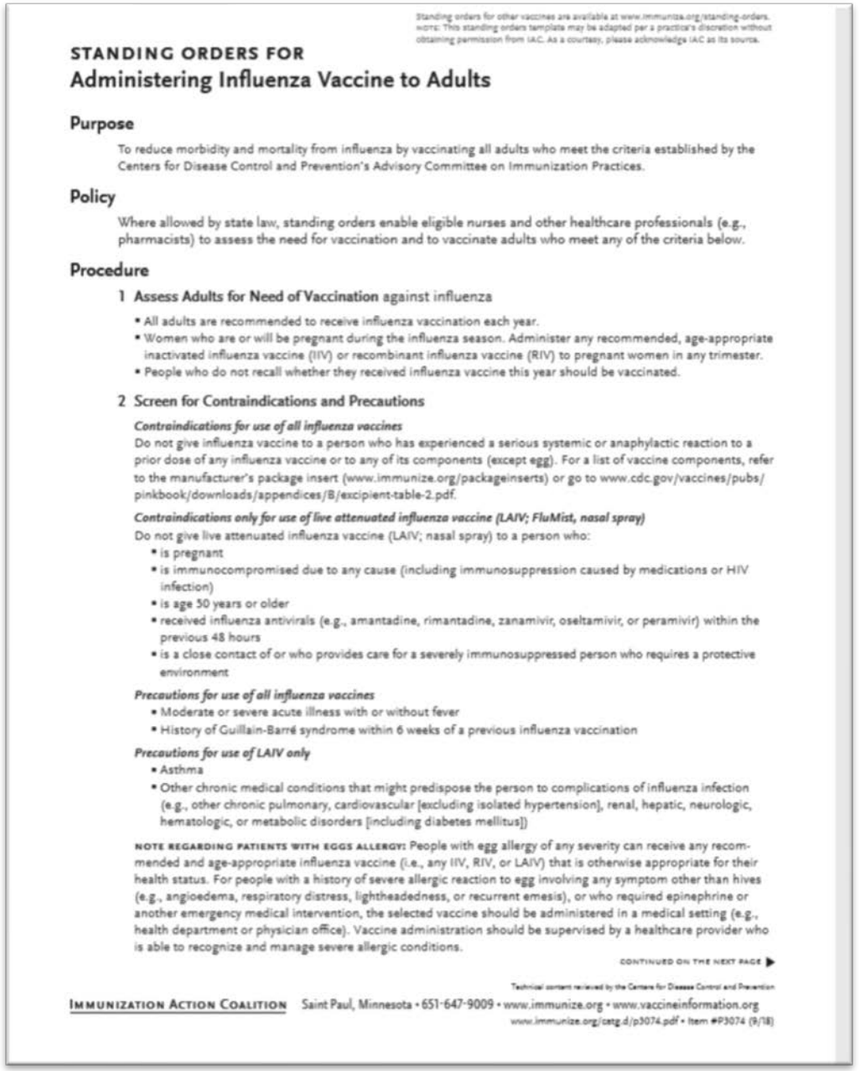
www.immunize.org/catg.d/p3074a.pdf • Item #P3074a (9/19/18)

www.immunize.org/catg.d/p3074a.pdf



Standing orders for other vaccines are available at www.immunize.org/standing-orders.
NOTE: This standing orders template may be adapted per a practice's discretion without obtaining permission from IAC. As a courtesy, please acknowledge IAC as its source.

STANDING ORDERS FOR
Administering Influenza Vaccine to Adults

Purpose

To reduce morbidity and mortality from influenza by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy

Where allowed by state law, standing orders enable eligible nurses and other healthcare professionals (e.g., pharmacists) to assess the need for vaccination and to vaccinate adults who meet any of the criteria below.

Procedure

1 **Assess Adults for Need of Vaccination** against influenza

- All adults are recommended to receive influenza vaccination each year.
- Women who are or will be pregnant during the influenza season. Administer any recommended, age-appropriate inactivated influenza vaccine (IIV) or recombinant influenza vaccine (RIV) to pregnant women in any trimester.
- People who do not recall whether they received influenza vaccine this year should be vaccinated.

2 **Screen for Contraindications and Precautions**

Contraindications for use of all influenza vaccines
Do not give influenza vaccine to a person who has experienced a serious systemic or anaphylactic reaction to a prior dose of any influenza vaccine or to any of its components (except egg). For a list of vaccine components, refer to the manufacturer's package insert (www.immunize.org/packageinserts) or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.

Contraindications only for use of live attenuated influenza vaccine (LAIV; FluMist, nasal spray)
Do not give live attenuated influenza vaccine (LAIV; nasal spray) to a person who:

- is pregnant
- is immunocompromised due to any cause (including immunosuppression caused by medications or HIV infection)
- is age 50 years or older
- received influenza antivirals (e.g., amantadine, rimantadine, zanamivir, oseltamivir, or peramivir) within the previous 48 hours
- is a close contact of or who provides care for a severely immunosuppressed person who requires a protective environment

Precautions for use of all influenza vaccines

- Moderate or severe acute illness with or without fever
- History of Guillain-Barré syndrome within 6 weeks of a previous influenza vaccination

Precautions for use of LAIV only

- Asthma
- Other chronic medical conditions that might predispose the person to complications of influenza infection (e.g., other chronic pulmonary, cardiovascular [excluding isolated hypertension], renal, hepatic, neurologic, hematologic, or metabolic disorders [including diabetes mellitus])

NOTE REGARDING PATIENTS WITH EGGS ALLERGY: People with egg allergy of any severity can receive any recommended and age-appropriate influenza vaccine (i.e., any IIV, RIV, or LAIV) that is otherwise appropriate for their health status. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress, lightheadedness, or recurrent emesis), or who required epinephrine or another emergency medical intervention, the selected vaccine should be administered in a medical setting (e.g., health department or physician office). Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.

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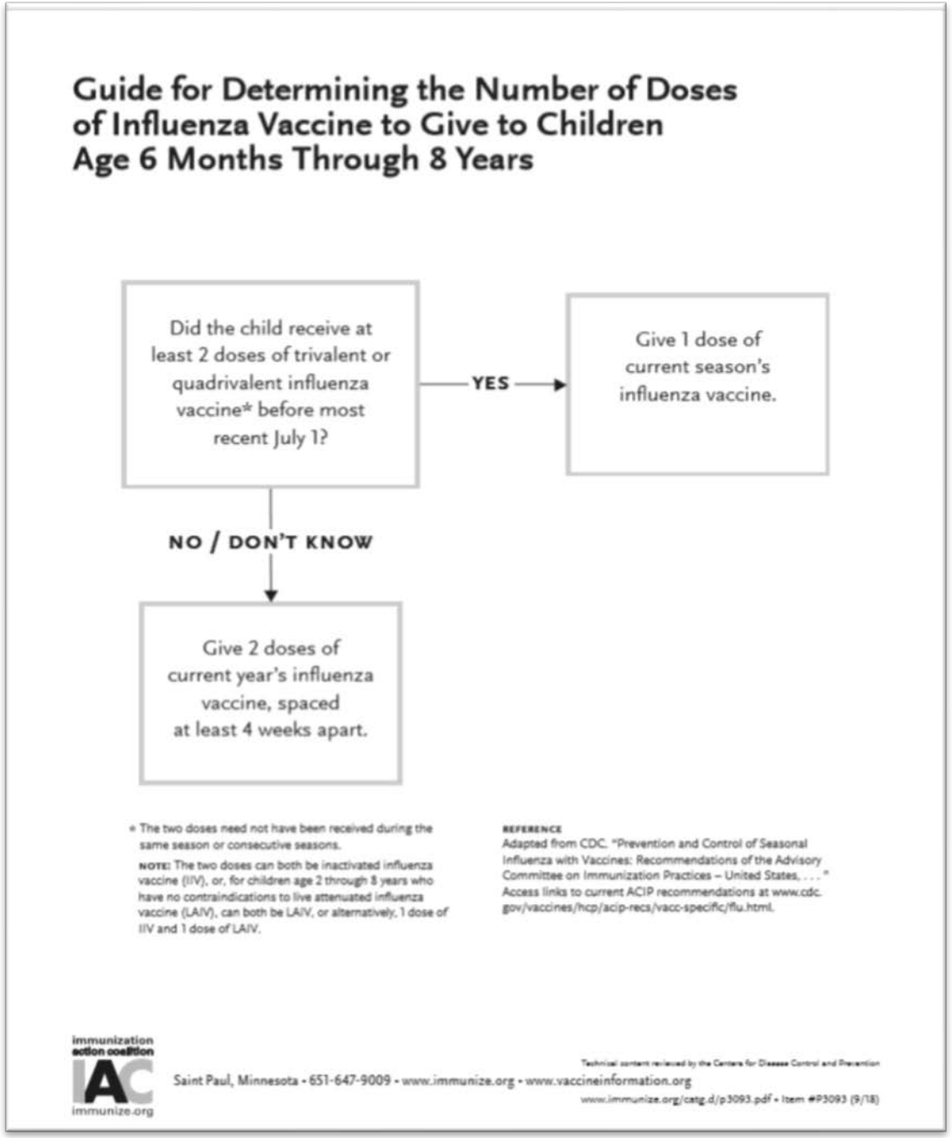
www.immunize.org/catg.d/p3074.pdf • Item #P3074 (9/18)

www.immunize.org/catg.d/p3074.pdf



Guide for Determining the Number of Doses of Influenza Vaccine to Give to Children Age 6 Months Through 8 Years

Did the child receive at least 2 doses of trivalent or quadrivalent influenza vaccine* before most recent July 1?

YES → Give 1 dose of current season's influenza vaccine.

NO / DON'T KNOW → Give 2 doses of current year's influenza vaccine, spaced at least 4 weeks apart.

* The two doses need not have been received during the same season or consecutive seasons.

NOTE: The two doses can both be inactivated influenza vaccine (IIV), or, for children age 2 through 8 years who have no contraindications to live attenuated influenza vaccine (LAIV), can both be LAIV, or alternatively, 1 dose of IIV and 1 dose of LAIV.

REFERENCE

Adapted from CDC. "Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, . . . " Access links to current ACIP recommendations at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html.

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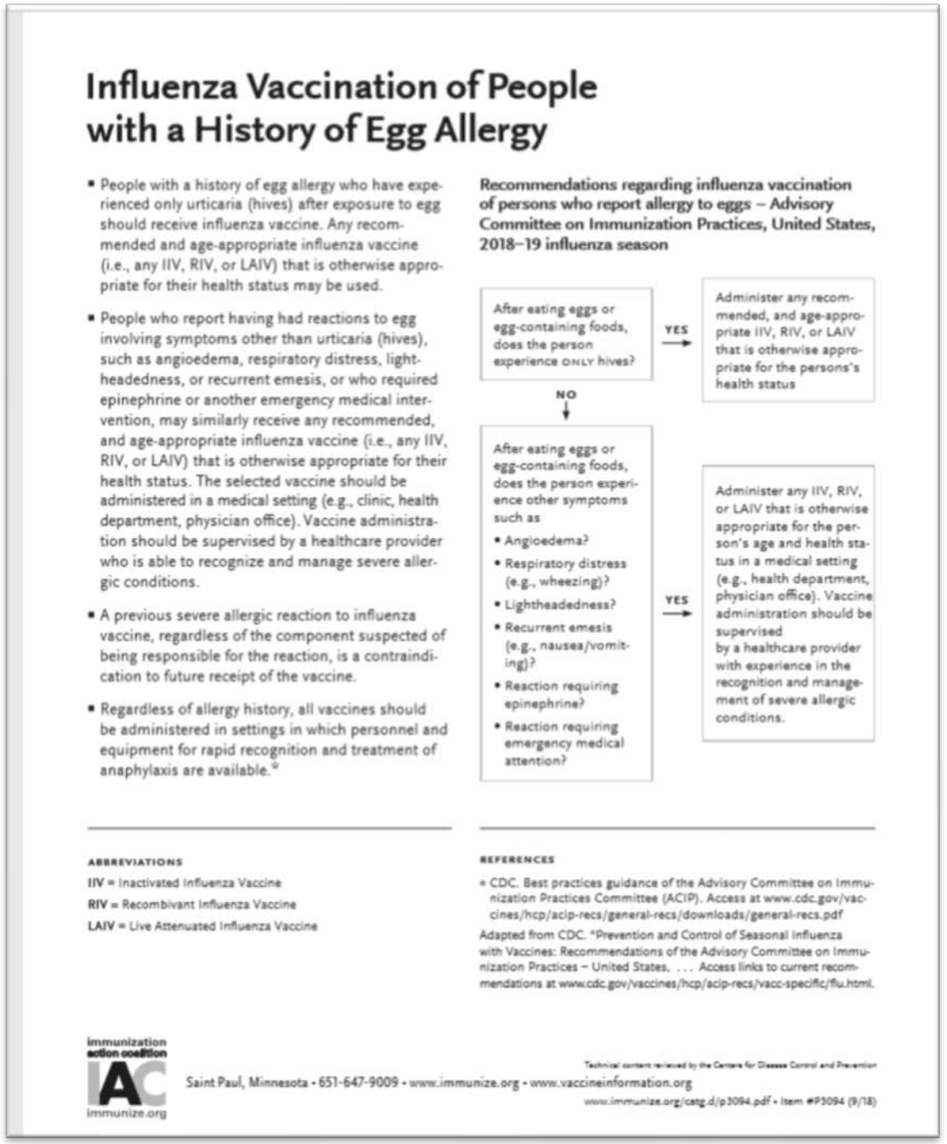
www.immunize.org/catg.d/p3093.pdf



Influenza Vaccination of People with a History of Egg Allergy

- People with a history of egg allergy who have experienced only urticaria (hives) after exposure to egg should receive influenza vaccine. Any recommended and age-appropriate influenza vaccine (i.e., any IIV, RIV, or LAIV) that is otherwise appropriate for their health status may be used.
- People who report having had reactions to egg involving symptoms other than urticaria (hives), such as angioedema, respiratory distress, lightheadedness, or recurrent emesis, or who required epinephrine or another emergency medical intervention, may similarly receive any recommended, and age-appropriate influenza vaccine (i.e., any IIV, RIV, or LAIV) that is otherwise appropriate for their health status. The selected vaccine should be administered in a medical setting (e.g., clinic, health department, physician office). Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.
- A previous severe allergic reaction to influenza vaccine, regardless of the component suspected of being responsible for the reaction, is a contraindication to future receipt of the vaccine.
- Regardless of allergy history, all vaccines should be administered in settings in which personnel and equipment for rapid recognition and treatment of anaphylaxis are available.*

Recommendations regarding influenza vaccination of persons who report allergy to eggs – Advisory Committee on Immunization Practices, United States, 2018–19 influenza season

After eating eggs or egg-containing foods, does the person experience ONLY hives?

YES → Administer any recommended, and age-appropriate IIV, RIV, or LAIV that is otherwise appropriate for the persons's health status

NO ↓

After eating eggs or egg-containing foods, does the person experience other symptoms such as

- Angioedema?
- Respiratory distress (e.g., wheezing)?
- Lightheadedness?
- Recurrent emesis (e.g., nausea/vomiting)?
- Reaction requiring epinephrine?
- Reaction requiring emergency medical attention?

YES → Administer any IIV, RIV, or LAIV that is otherwise appropriate for the person's age and health status in a medical setting (e.g., health department, physician office). Vaccine administration should be supervised by a healthcare provider with experience in the recognition and management of severe allergic conditions.

ABBREVIATIONS

IIV = Inactivated Influenza Vaccine
RIV = Recombivant Influenza Vaccine
LAIV = Live Attenuated Influenza Vaccine

REFERENCES

* CDC. Best practices guidance of the Advisory Committee on Immunization Practices Committee (ACIP). Access at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf

Adapted from CDC. "Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, . . . Access links to current recommendations at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html.

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www.immunize.org/catg.d/p3094.pdf • Item #P3094 (9/18)

www.immunize.org/catg.d/p3094.pdf

How to Administer Intramuscular and Intranasal Influenza Vaccines

Intramuscular injection (IM)

Inactivated Influenza Vaccines (IIV), including recombinant hemagglutinin influenza vaccine (RIV), cell culture-based vaccine (ccIIV), and adjuvanted influenza vaccine (aIIV)

1 Use a needle long enough to reach deep into the muscle. Infants age 6 through 11 mos: 1"; 1 through 10 yrs: 1–1¼", and children and adults 11 years and older: 1–1½".

2 With your left hand*, bunch up the muscle.

3 With your right hand*, insert the needle at a 90° angle to the skin with a quick thrust.

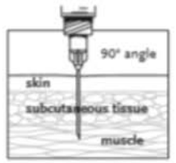
4 Push down on the plunger and inject the entire contents of the syringe. There is no need to aspirate.

5 Remove the needle and simultaneously apply pressure to the injection site with a dry cotton ball or gauze. Hold in place for several seconds.

6 If there is any bleeding, cover the injection site with a bandage.

7 Put the used syringe in a sharps container.

*Use the opposite hand if you are left-handed.



Intranasal administration (NAS)

Live Attenuated Influenza Vaccine (LAIV)

1 FluMist (LAIV) is for intranasal administration only. Do not inject FluMist.

2 Remove rubber tip protector. Do not remove dose-divider clip at the other end of the sprayer.

3 With the patient in an upright position, place the tip just inside the nostril to ensure LAIV is delivered into the nose. The patient should breathe normally.

4 With a single motion, depress plunger as rapidly as possible until the dose-divider clip prevents you from going further.

5 Pinch and remove the dose-divider clip from the plunger.

6 Place the tip just inside the other nostril, and with a single motion, depress plunger as rapidly as possible to deliver the remaining vaccine.

7 Dispose of the applicator in a sharps container.

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www.immunize.org/catg.d/p2024.pdf • Item #P2024 (10/18)

Declination of Influenza Vaccination

My employer or affiliated health facility, _____, has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
  - all patients in this healthcare facility
  - my coworkers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: _____

_____

_____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Department: _____

Reference: CDC. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

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Medical Management of Vaccine Reactions in Children and Teens in a Community Setting

The table below describes steps to take if an adverse reaction occurs following vaccination.

Administering any medication, including vaccines, has the potential to cause an adverse reaction. To minimize the likelihood of an adverse event, screen patients for vaccine contraindications and precautions prior to vaccination (see "Screening Checklist for Contraindications to Vaccines for Children and Teens" at www.immunize.org/catg.d/p4060.pdf). When adverse reactions do occur, they can vary from minor (e.g., soreness, itching) to the rare and serious (e.g., anaphylaxis). Be prepared.

Vaccine providers should know how to recognize allergic reactions, including anaphylaxis. Have a plan in place and supplies available to provide appropriate medical care should such an event occur.

REACTION	SIGNS AND SYMPTOMS	MANAGEMENT
Localized	Soreness, redness, itching, or swelling at the injection site	Apply a cold compress to the injection site. Consider giving an analgesic (pain reliever) or antipruritic (anti-itch) medication.
	Slight bleeding	Apply pressure and an adhesive compress over the injection site.
	Continuous bleeding	Place thick layer of gauze pads over site and maintain direct and firm pressure; raise the bleeding injection site (e.g., arm) above the level of the patient's heart.
Psychological fright and syncope (fainting)	Fright before injection is given	Have patient sit or lie down for the vaccination.
	Paleness, sweating, coldness of the hands and feet, nausea, light-headedness, dizziness, weakness, or visual disturbances	Have patient lie flat. Loosen any tight clothing and maintain open airway. Apply cool, damp cloth to patient's face and neck. Keep them under close observation until full recovery.
	Fall, without loss of consciousness	Examine the patient to determine if injury is present before attempting to move the patient. Place patient flat on back with feet elevated.
	Loss of consciousness	Check to determine if injury is present before attempting to move the patient. Place patient flat on back with feet elevated. Call 911 if patient does not recover immediately.
Anaphylaxis	**Skin and mucosal symptoms** such as generalized hives, itching, or flushing; swelling of lips, face, throat, or eyes. **Respiratory symptoms** such as nasal congestion, change in voice, sensation of throat closing, stridor, shortness of breath, wheeze, or cough. **Gastrointestinal symptoms** such as nausea, vomiting, diarrhea, cramping abdominal pain. **Cardiovascular symptoms** such as collapse, dizziness, tachycardia, hypotension.	See the emergency medical protocol on the next page for detailed steps to follow in treating anaphylaxis.

CONTINUED ON NEXT PAGE ▶

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Emergency medical protocol for management of anaphylactic reactions in children and teens in a community setting

1 If itching and swelling are confined to the injection site where the vaccination was given, observe patient closely for the development of generalized symptoms.

2 If symptoms are generalized, activate the emergency medical system (EMS; e.g., call 911) and notify the patient's physician. This should be done by a second person, while the primary healthcare professional assesses the airway, breathing, circulation, and level of consciousness of the patient. Vital signs should be monitored continuously.

3 **DRUG DOSING INFORMATION: The first-line and most important therapy in anaphylaxis is epinephrine. There are NO absolute contraindications to epinephrine in the setting of anaphylaxis.**

a **First-line treatment: EPINEPHRINE is the first-line treatment for anaphylaxis, and there is no known equivalent substitute.** Use **epinephrine** in a 1.0 mg/mL aqueous solution (1:1000 dilution). See page 3 to determine correct dose to be used based on child's weight. If using an autoinjector or pre-filled syringe, administer a dose of 0.1 mg, 0.15 mg, or 0.3 mg IM (as appropriate for the patient's weight) into the anterolateral thigh. If using another epinephrine format, the recommended dose is 0.01 mg/kg per dose, up to a maximum single dose of 0.5 mg. Administer IM, preferably in the anterolateral thigh. Epinephrine dose may be repeated every 5–15 minutes (or sooner as needed) while waiting for EMS to arrive.

b **Optional treatment: H_1 ANTIHISTAMINES** relieve itching and urticaria (hives). These medications DO NOT relieve upper or lower airway obstruction, hypotension, or shock. Consider giving **diphenhydramine** (e.g., Benadryl®) or **hydroxyzine** (e.g., Atarax, Vistaril) for relief of itching or hives.

- Administer **diphenhydramine** orally, standard dose of 1–2 mg/kg every 4–6 hours. Maximum single dose is 40 mg for children age <12 years; for children age ≥12 years, 100 mg. See dosing chart on page 3.*
- Administer **hydroxyzine** orally; the standard dose is 0.5–1 mg/kg/dose, up to 50–100 mg maximum per day in children and adolescents. See dosing chart on page 3.

4 Monitor the patient closely until EMS arrives. Perform cardiopulmonary resuscitation (CPR), if necessary, and maintain airway. Keep patient in recumbent position (flat on back) unless he or she is having breathing difficulty. If breathing is difficult, patient's head may be elevated, provided blood pressure is adequate to prevent loss of consciousness. If blood pressure is low, elevate legs. Monitor blood pressure and pulse every 5 minutes.

5 Record the patient's reaction (e.g., hives, anaphylaxis) to the vaccine, all vital signs, medications administered to the patient, including the time, dosage, response, and the name of the medical personnel who administered the medication, and other relevant clinical information.

6 Notify the patient's primary care physician.

7 Report the incident to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov.

CONTINUED ON NEXT PAGE ▶

e, approximate dosages based on weight and age are provided in the following charts. you are administering the correct dose for your patient.

nent: Epinephrine

	Age group	Range of weight (lb)	Range of weight (kg)*	Epinephrine Dose: 1.0 mg/mL aqueous solution (1:1000 dilution); intramuscular. Minimum dose: 0.05 mL	Epinephrine Dose: Epinephrine autoinjector or prefilled syringe (0.1 mg, 0.15 mg, 0.3 mg)
Infants and children	1–6 months	9–19 lb	4–8.5 kg	0.05 mL (or mg)	off label
	7–36 months	20–32 lb†	9–14.5 kg†	0.1 mL (or mg)	0.1 mg†
	37–59 months	33–39 lb	15–17.5 kg	0.15 mL (or mg)	0.15 mg/dose
	5–7 years	40–56 lb	18–25.5 kg	0.2–0.25 mL (or mg)	0.15 mg/dose
	8–10 years	57–76 lb	26–34.5 kg	0.25–0.3 mL (or mg)	0.15 mg or 0.3 mg/dose
Teens	11–12 years	77–99 lb	35–45 kg	0.35–0.4 mL (or mg)	0.3 mg/dose
	13 years & older	100+ lb	46+ kg	0.5 mL (or mg) – max. dose	0.3 mg/dose

un, then dosing by weight is preferred. If weight available, dosing by age is appropriate.

* Rounded weight at the 50th percentile for each age range
† 0.1 mg autoinjector is licensed for use in 7.5 to 14 kg infants and children

nent: Diphenhydramine

	Age group	Range of weight (lb)	Range of weight (kg)*	Diphenhydramine dose calculations based on 1 mg/kg†: Liquid: 12.5 mg/5 mL Tablets: 25 mg or 50 mg
Infants and children	7–36 months	20–32 lb	9–14.5 kg	10–15 mg/dose†
	37–59 months	33–39 lb	15–17.5 kg	15–20 mg/dose†
	5–7 years	40–56 lb	18–25.5 kg	20–25 mg/dose†
	8–12 years	57–99 lb	26–45 kg	25–50 mg/dose†
Teens	13 years & older	100+ lb	46+ kg	50 mg/dose (up to 50 mg or 100 mg single dose)†

un, then dosing by weight is preferred. If weight available, dosing by age is appropriate.

* Rounded weight at the 50th percentile for each age range
† AAP. *Red Book*: 2018–2021, 31st ed. (p. 66). Diphenhydramine maximum single dose for children younger than age 12 years is 40 mg, for children age 12 years and older, 100 mg.

nent: Hydroxyzine

	Age group	Range of weight (lb)	Range of weight (kg)*	Hydroxyzine dose calculations based on 0.5 mg/kg: Liquid: 10 mg/5 mL Tablets: 10 mg or 25 mg
Infants and children	7–36 months	20–32 lb	9–14.5 kg	5–7.5 mg/dose
	37–59 months	33–39 lb	15–17.5 kg	7.5–10 mg/dose
	5–7 years	40–56 lb	18–25.5 kg	10–12.5 mg/dose
	8–10 years	57–76 lb	26–34.5 kg	12.5–15 mg/dose
Teens	11–12 years	77–99 lb	35–45 kg	15–25 mg/dose
	13 years & older	100+ lb	46+ kg	25 mg/dose (50–100 mg, maximum per day)

un, then dosing by weight is preferred. If weight available, dosing by age is appropriate.

* Rounded weight at the 50th percentile for each age range

cedure shall remain in effect for all patients of the

Medical Director

NAME OF PRACTICE OR CLINIC

PRINT NAME

until rescinded or until

DATE

SIGNATURE DATE

www.immuni[illegible]org/catg.d/p3082.pdf

COPY THIS FOR YOUR PATIENTS

Don't take chances with your family's health – make sure you all get vaccinated against influenza every year!

Here's how influenza can hurt your family . . .

Influenza can make you, your children, or your parents really sick.

Influenza usually comes on suddenly. Symptoms can include high fever, chills, headaches, exhaustion, sore throat, cough, and all-over body aches. Some people say, "It felt like a truck hit me!" Symptoms can also be mild. Regardless, when influenza strikes your family, the result is lost time from work and school.

Influenza spreads easily from person to person.

An infected person can spread influenza when they cough, sneeze, or just talk near others. They can also spread it by touching or sneezing on an object that someone else touches later. An infected person doesn't have to feel sick to be contagious: they can spread influenza to others when they feel well – before their symptoms have even begun.

Influenza and its complications can be so serious that they can put you, your children, or your parents in the hospital – or lead to death.

Each year, more than 200,000 people are hospitalized in the U.S. from influenza and its complications. Between 3,000 and 50,000 die, which shows how unpredictable influenza can be. The people most likely to be hospitalized and die are infants, young children, older adults, and people of all ages who have conditions such as heart or lung disease. But remember, it's not only the youngest, oldest, or sickest who die: Every year influenza kills people who were otherwise healthy.

Influenza can be a very serious disease for you, your family, and friends – but you can all be protected by getting vaccinated.

There's no substitute for yearly vaccination in protecting the people you love from influenza. Vaccination will help keep you and your loved ones safe from a potentially deadly disease. Get vaccinated every year, and make sure your children and your parents are vaccinated, too.

Get vaccinated every year! Get your children vaccinated!
Be sure your parents get vaccinated, too!

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COPY THIS FOR YOUR PATIENTS

Seek emergency medical care if you or a family member shows the signs below – a life could be at risk!

It's a fact – every year, people of all ages in the U.S. die from influenza and its complications.

Emergency warning signs for children or teens with influenza

Any child or teen who shows the following emergency warning signs needs urgent medical attention – take them to an emergency room or call 9-1-1.

- Fast breathing or trouble breathing
- Bluish skin color
- Not waking up or not interacting
- Being so irritable that the child does not want to be held
- Not drinking enough fluids
- Not urinating or no tears when crying
- Severe or persistent vomiting
- Influenza-like symptoms improve but then return with fever and worse cough

Emergency warning signs for adults with influenza

Any adult who shows the following emergency warning signs needs urgent medical attention – take them to an emergency room or call 9-1-1.

- Difficulty breathing or shortness of breath
- Pain or pressure in the chest or abdomen
- Confusion
- Severe or persistent vomiting
- Sudden dizziness
- Influenza-like symptoms improve but then return with fever and worse cough

Keep this handy! Post it on your refrigerator or another place where it will be easy to find!

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www.immunize.org/catg.d/p4073.pdf

Influenza Vaccine Products for the 2019–2020 Influenza Season DRAFT: 8-23-2019

Manufacturer	Trade Name (vaccine abbreviation)[1]	How Supplied	Mercury Content (mcg Hg/0.5mL)	Age Range	CVX Code	Vaccine Product Billing Code[2] CPT
GlaxoSmithKline	Fluarix (IIV4)	0.5 mL (single-dose syringe)	0	6 months & older[3]	150	90686
	FluLaval (IIV4)	0.5 mL (single-dose syringe)	0	6 months & older[3]	150	90686
		5.0 mL (multi-dose vial)	<25	6 months & older[3]	158	90688
AstraZeneca	FluMist (LAIV4)	0.2 mL (single-use nasal spray)	0	2 through 49 years	149	90672
Sanofi Pasteur	Flublok (RIV4)	0.5 mL (single-dose syringe)	0	18 years & older	185	90682
	Fluzone (IIV4)	0.25 mL (single-dose syringe)	0	6 through 35 months[3]	161	90685
		0.5 mL (single-dose syringe)	0	6 months & older	150	90686
		0.5 mL (single-dose vial)	0	6 months & older	150	90686
		5.0 mL (multi-dose vial)	25	6 through 35 months[3]	158	90687
		5.0 mL (multi-dose vial)	25	3 years & older	158	90688
	Fluzone High-Dose (IIV3-HD)	0.5 mL (single-dose syringe)	0	65 years & older	135	90662
Seqirus	Afluria (IIV4)	0.25 mL (single-dose syringe)	0	6 through 35 months[3]	161	90685
		0.5 mL (single-dose syringe)	0	6 months & older[3]	150	90686
		5.0 mL (multi-dose vial)	24.5	6 through 35 months[3]	158	90687
		5.0 mL (multi-dose vial)	24.5	3 years & older[4]	158	90688
	Fluad (aIIV3)	0.5 mL (single-dose syringe)	0	65 years & older	168	90653
	Flucelvax (ccIIV4)	0.5 mL (single-dose syringe)	0	4 years & older	171	90674
		5.0 mL (multi-dose vial)	25	4 years & older	186	90756

NOTES

1. IIV3/IIV4 = egg-based trivalent/quadrivalent inactivated influenza vaccine (injectable); where necessary to refer to cell culture-based vaccine, the prefix "cc" is used (e.g., ccIIV4); RIV4 = quadrivalent recombinant hemagglutinin influenza vaccine (injectable); aIIV3 = adjuvanted trivalent inactivated influenza vaccine.
2. An administration code should always be reported in addition to the vaccine product code. Note: Third party payers may have specific policies and guidelines that might require providing additional information on their claim forms.
3. Dosing for infants and children age 6 through 35 months:
   - Afluria 0.25 mL
   - Fluarix 0.5 mL
   - FluLaval 0.5 mL
   - Fluzone 0.25 mL or 0.5 mL
4. Afluria is approved by the Food and Drug Administration for intramuscular administration with the PharmaJet Stratis Needle-Free Injection System for persons age 18 through 64 years.

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www.immunize.org/catg.d/p4072.pdf

CDC Answers Your Questions About Influenza

www.immunize.org/askexperts/

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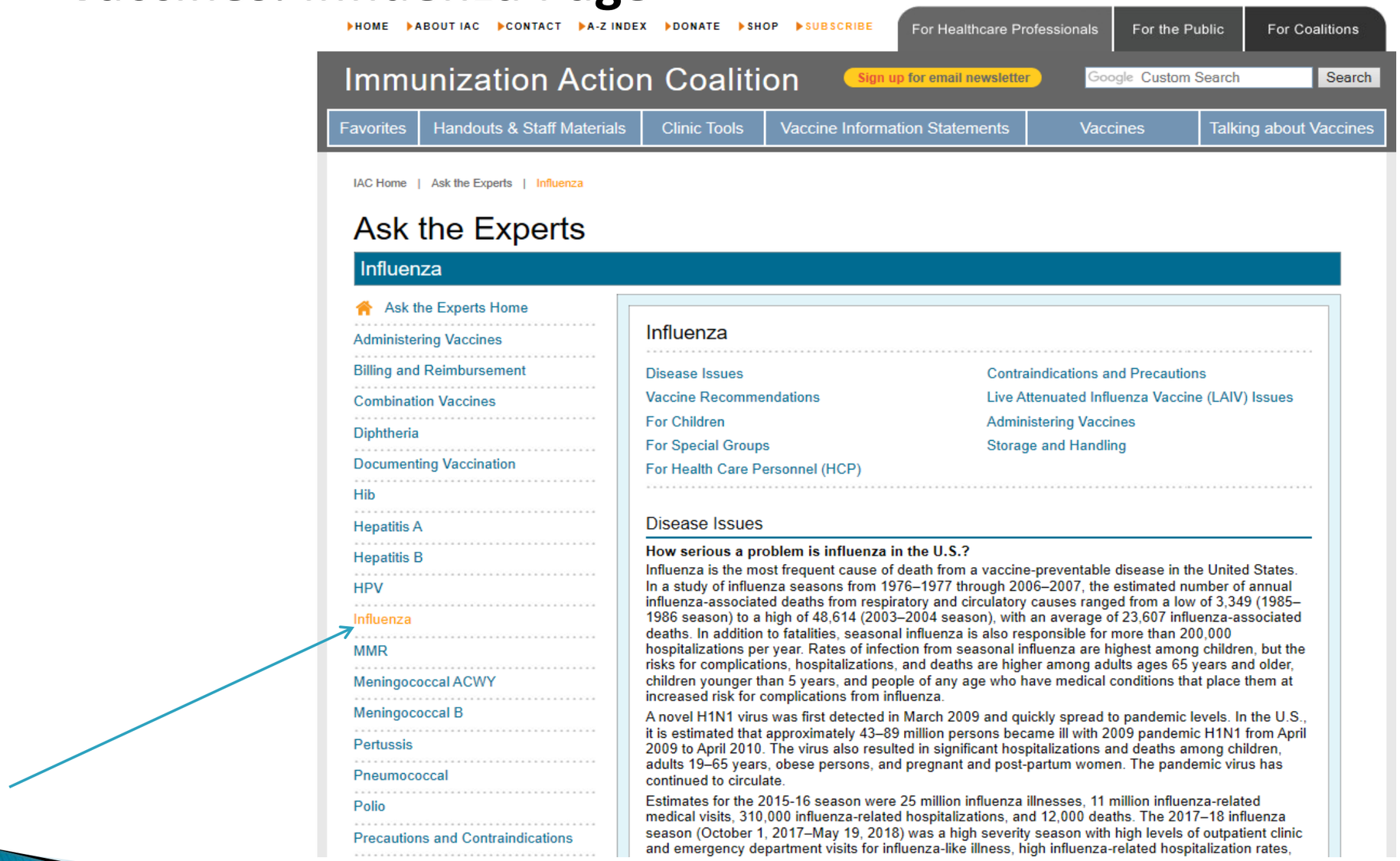
Vaccines: Influenza Page



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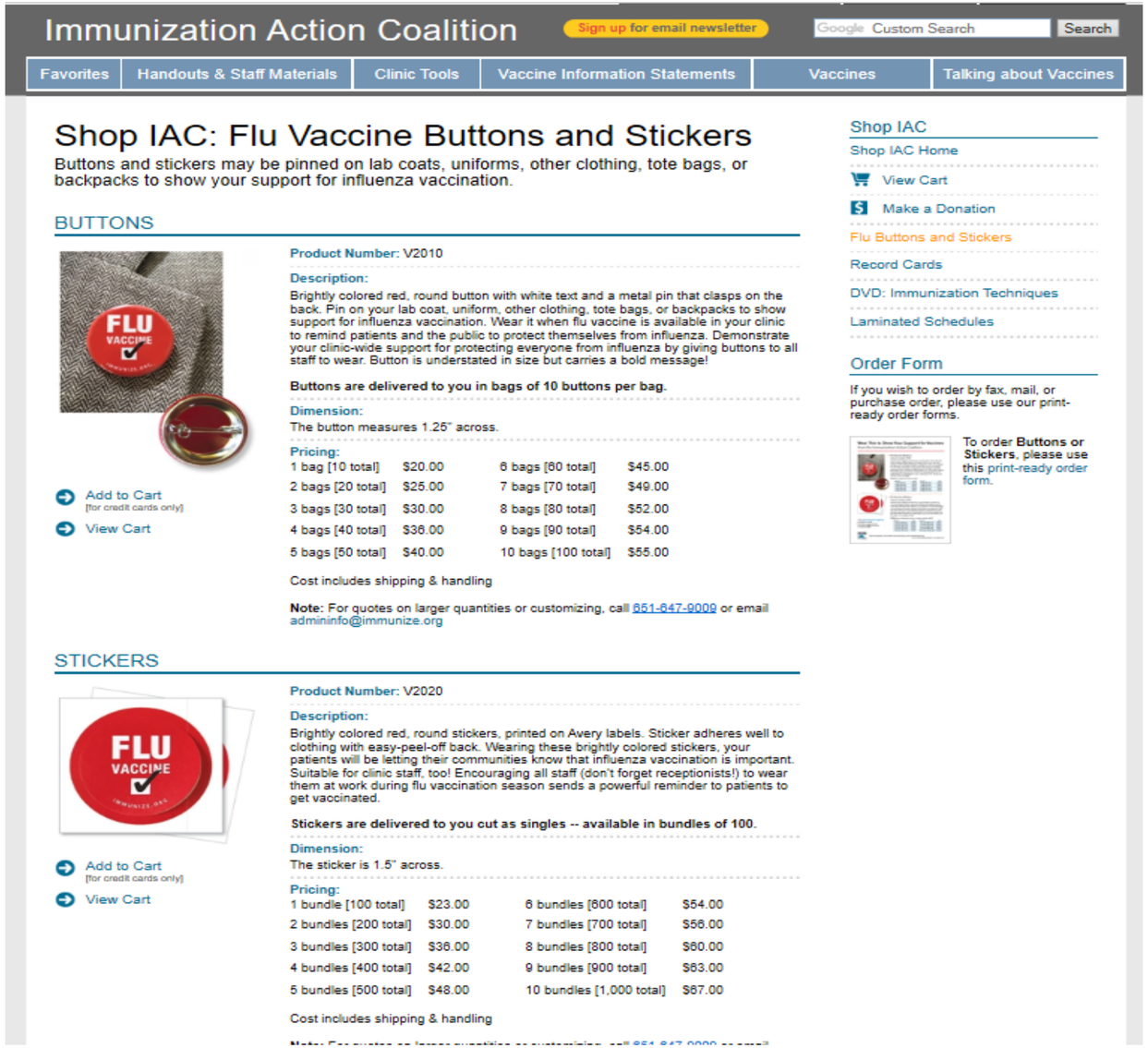
Flu Vaccine Buttons and Stickers



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Shop IAC: Flu Vaccine Buttons and Stickers

Buttons and stickers may be pinned on lab coats, uniforms, other clothing, tote bags, or backpacks to show your support for influenza vaccination.

BUTTONS

Add to Cart
[for credit cards only]

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Product Number: V2010

Description:
Brightly colored red, round button with white text and a metal pin that clasps on the back. Pin on your lab coat, uniform, other clothing, tote bags, or backpacks to show support for influenza vaccination. Wear it when flu vaccine is available in your clinic to remind patients and the public to protect themselves from influenza. Demonstrate your clinic-wide support for protecting everyone from influenza by giving buttons to all staff to wear. Button is understated in size but carries a bold message!

Buttons are delivered to you in bags of 10 buttons per bag.

Dimension:
The button measures 1.25" across.

Pricing:

1 bag [10 total]	$20.00	6 bags [60 total]	$45.00
2 bags [20 total]	$25.00	7 bags [70 total]	$49.00
3 bags [30 total]	$30.00	8 bags [80 total]	$52.00
4 bags [40 total]	$36.00	9 bags [90 total]	$54.00
5 bags [50 total]	$40.00	10 bags [100 total]	$55.00

Cost includes shipping & handling

Note: For quotes on larger quantities or customizing, call 651-647-9009 or email admininfo@immunize.org

STICKERS

Add to Cart
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Product Number: V2020

Description:
Brightly colored red, round stickers, printed on Avery labels. Sticker adheres well to clothing with easy-peel-off back. Wearing these brightly colored stickers, your patients will be letting their communities know that influenza vaccination is important. Suitable for clinic staff, too! Encouraging all staff (don't forget receptionists!) to wear them at work during flu vaccination season sends a powerful reminder to patients to get vaccinated.

Stickers are delivered to you cut as singles -- available in bundles of 100.

Dimension:
The sticker is 1.5" across.

Pricing:

1 bundle [100 total]	$23.00	6 bundles [600 total]	$54.00
2 bundles [200 total]	$30.00	7 bundles [700 total]	$56.00
3 bundles [300 total]	$36.00	8 bundles [800 total]	$60.00
4 bundles [400 total]	$42.00	9 bundles [900 total]	$63.00
5 bundles [500 total]	$48.00	10 bundles [1,000 total]	$67.00

Cost includes shipping & handling

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Flu Buttons and Stickers

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DVD: Immunization Techniques

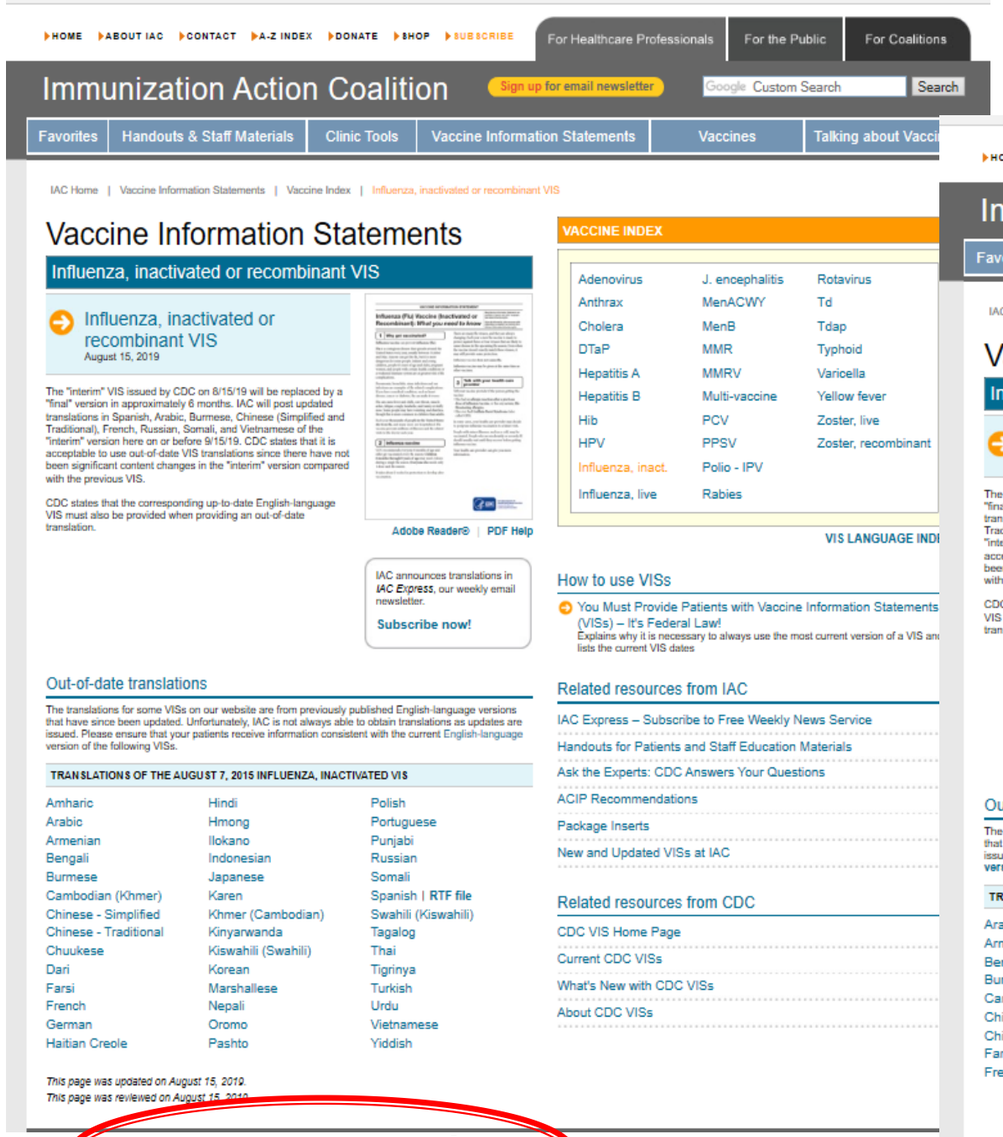
Laminated Schedules

Order Form

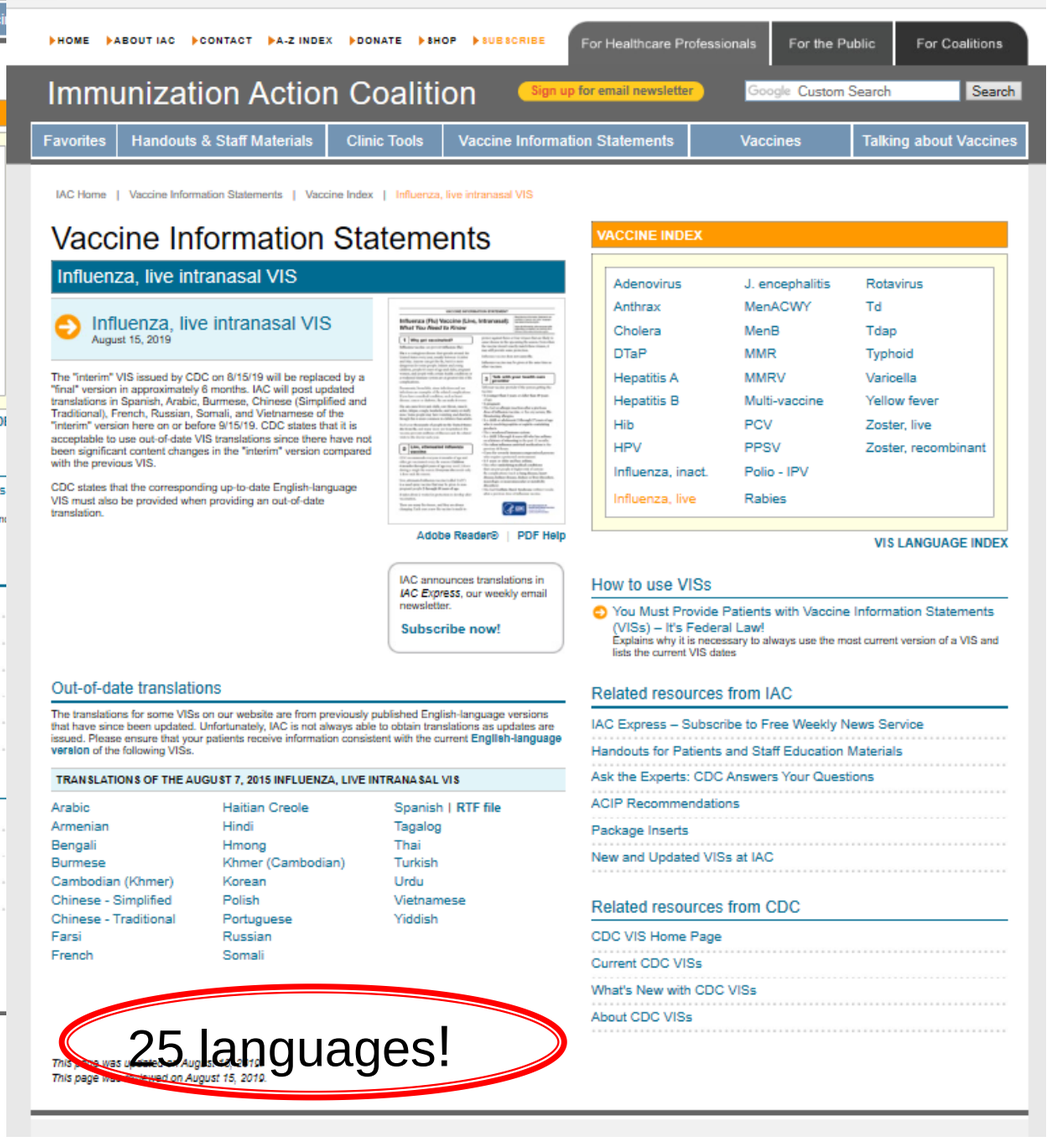
If you wish to order by fax, mail, or purchase order, please use our print-ready order forms.

To order **Buttons or Stickers**, please use this print-ready order form.

www.immunize.org/shop/buttons-stickers.asp

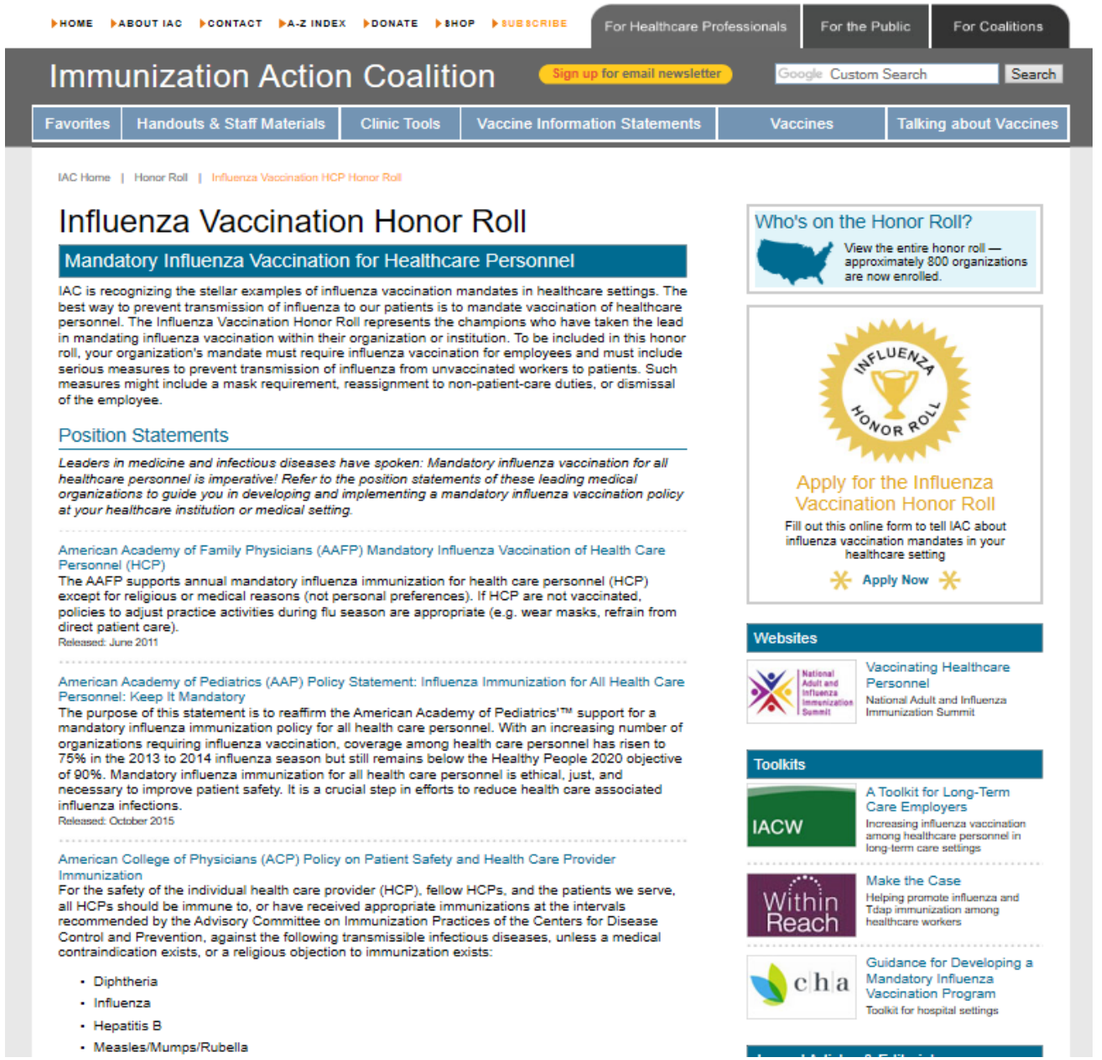


42 languages!



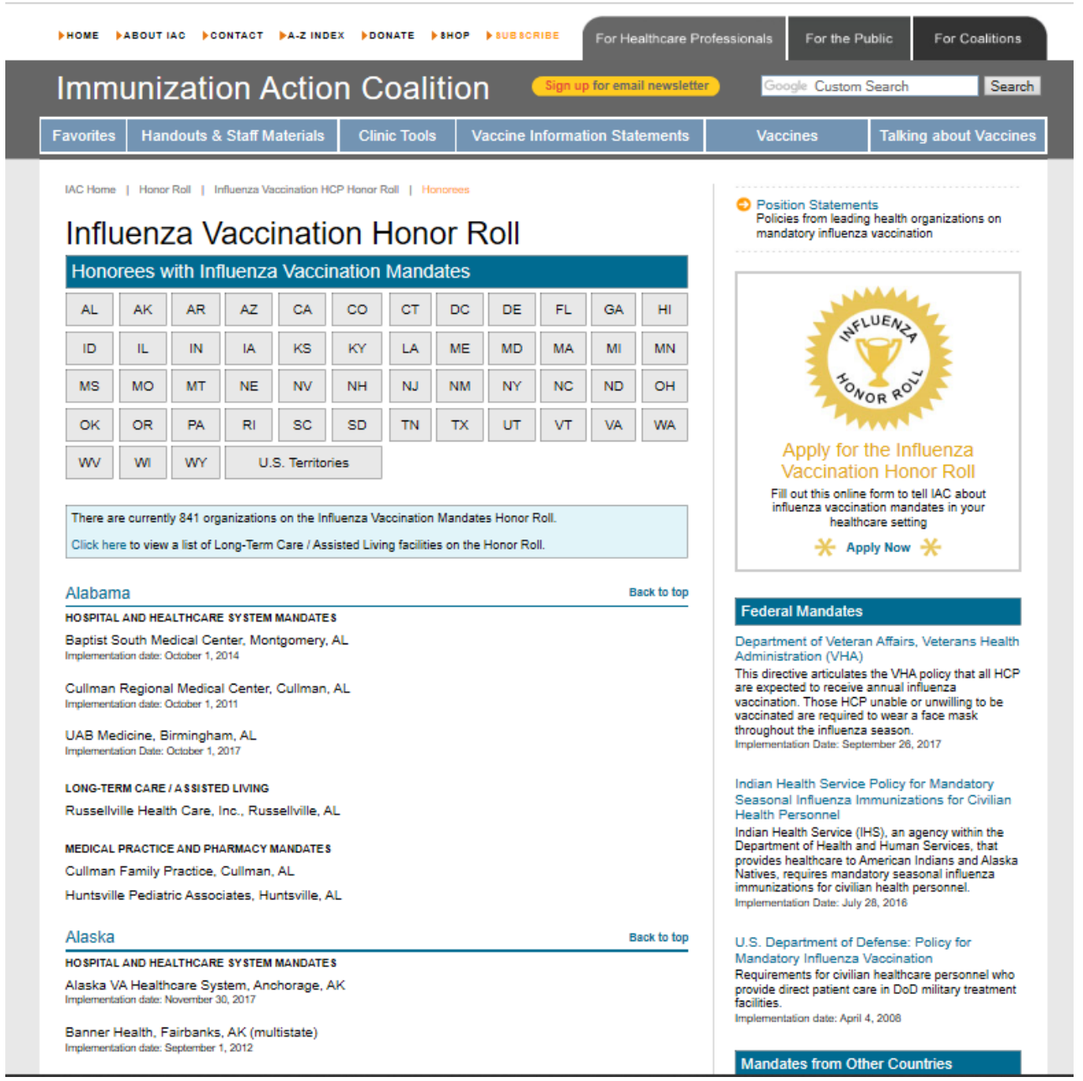
25 languages!

Honor Roll for Mandatory Flu Vaccination of Healthcare Personnel



www.immunize.org/honor-roll/influenza-mandates/

Honor Roll for Mandatory Flu Vaccination of Healthcare Personnel



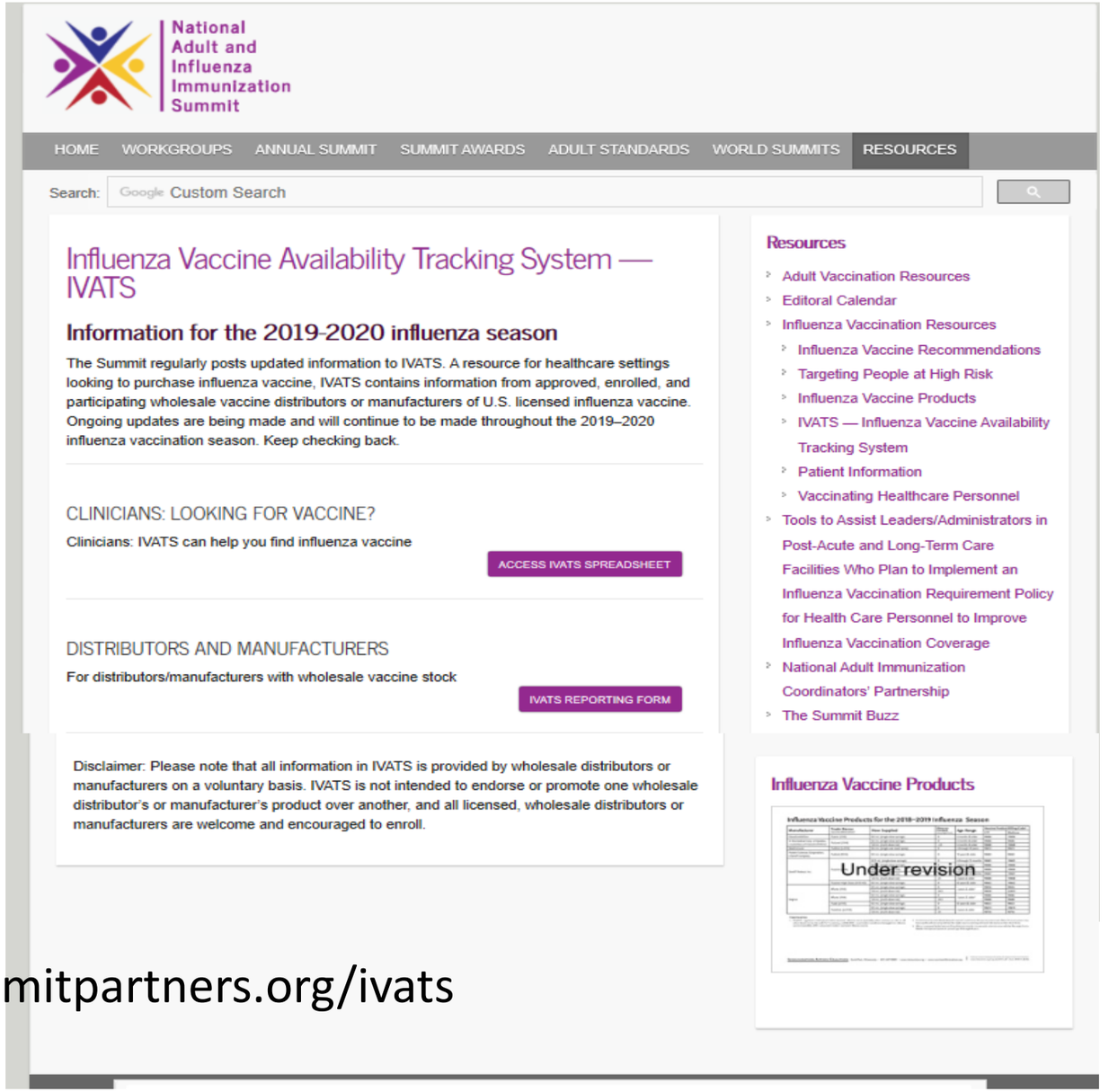
www.immunize.org/honor-roll/influenza-mandates/honorees.asp

Unprotected People Stories: Influenza

Real-life accounts of people who have suffered or died from vaccine-preventable diseases

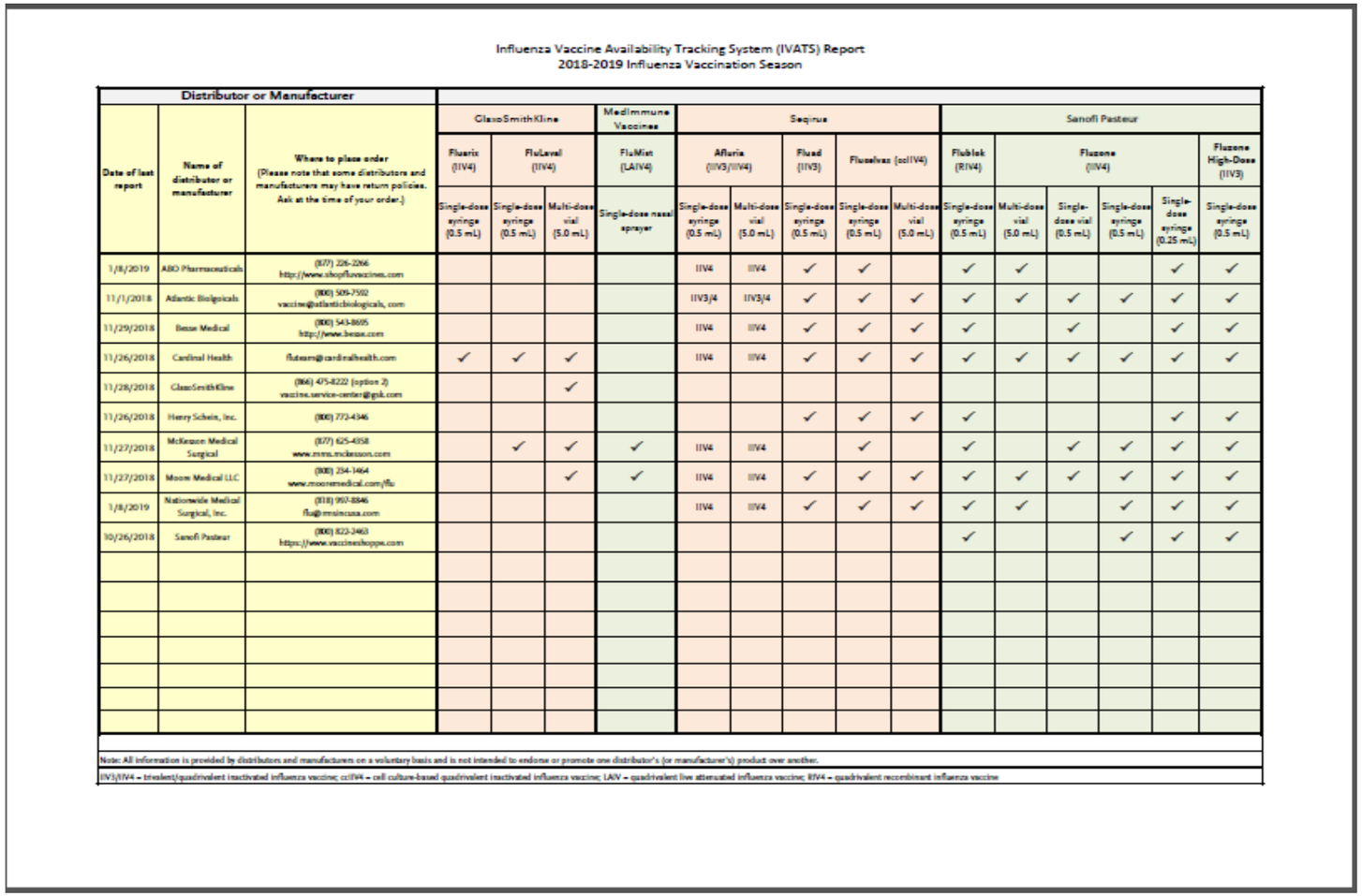
*Click on "HTML" to view the report. Click on "PDF" to view a fully-formatted, print-ready version. **Adobe Reader** must be installed on your computer.*

FORMAT	AGE	TITLE	SUMMARY	PUBLISHED
HTML PDF	15 years	"Influenza Ends Martin McGowan's Life"	Report #103: Families Fighting Flu (FFF) was established in the memory of the children who die each year from the complications of influenza. Diane McGowan, Martin's mother and FFF board member, recounts the devastating loss of their teenager.	10/19/09
HTML PDF	4 years	"The Story of Amanda Kanowitz"	Report #98: Families Fighting Flu (FFF) was established in the memory of the children who die each year from the complications of influenza. The parents of Amanda Kanowitz recount the devastating loss of their young daughter.	4/10/09
HTML PDF	3 1/2 years	"The Story of Emily Lastinger"	Report #97: Families Fighting Flu (FFF) was established in the memory of the children who die each year from the complications of influenza. The parents of Emily Lastinger recount the devastating loss of their young daughter.	4/10/09
HTML PDF	3 1/2 years	"The Story of Katie Bellovich"	Report #96: Families Fighting Flu (FFF) was established in the memory of the children who die each year from the complications of influenza. The parents of Katie Bellovich recount the devastating loss of their young daughter.	3/21/09
HTML PDF	Young men and women	"Pandemic Influenza 1918"	Report #93: Professor N. R. Grist (Glasgow) shares a copy of a poignant letter written by a U.S. Army physician who witnessed first-hand the overwhelming loss of life during the influenza pandemic of 1918.	2/27/07
HTML PDF	23 months	"Influenza killed my beautiful 23-month-old daughter"	Report #67: In December 2003, Colorado experienced its worst influenza epidemic in years. Among the influenza-related fatalities that month was Elizabeth Terese Cover, who died from complications of influenza weeks before her second birthday.	1/26/07
HTML PDF	14 mos. to teenage	"MMWR reports influenza as the cause of severe illness and death among 14 young people in Michigan"	Report #57: An MMWR article describes four influenza-related deaths and ten instances of severe influenza illness among children and young adults under age 21 in early 2003.	9/5/03



www.izsummitpartners.org/ivats

Clinicians looking for vaccine?



Influenza Vaccine Availability Tracking System (IVATS) Report
2018-2019 Influenza Vaccination Season

Distributor or Manufacturer			GlaxoSmithKline			MedImmune Vaccines	Seqirus					Sanofi Pasteur					
Date of last report	Name of distributor or manufacturer	Where to place order (Please note that some distributors and manufacturers may have return policies. Ask at the time of your order.)	Fluarix (IIV4)	FluLaval (IIV4)		FluMist (LAIV4)	Afluria (IIV3/IIV4)		Flud (IIV3)	Fluselvax (ccIIV4)		Flublok (RIV4)	Fluzone (IIV4)				Fluzone High-Dose (IIV3)
			Single-dose syringe (0.5 mL)	Single-dose syringe (0.5 mL)	Multi-dose vial (5.0 mL)	Single-dose nasal sprayer	Single-dose syringe (0.5 mL)	Multi-dose vial (5.0 mL)	Single-dose syringe (0.5 mL)	Single-dose syringe (0.5 mL)	Multi-dose vial (5.0 mL)	Single-dose syringe (0.5 mL)	Multi-dose vial (5.0 mL)	Single-dose vial (0.5 mL)	Single-dose syringe (0.5 mL)	Single-dose syringe (0.25 mL)	Single-dose syringe (0.5 mL)
1/8/2019	ABO Pharmaceuticals	(877) 226-2266 http://www.shopfluvaccines.com					IIV4	IIV4	✓	✓		✓	✓			✓	✓
11/1/2018	Atlantic Biologicals	(800) 509-7502 vaccine@atlanticbiologicals, com					IIV3/4	IIV3/4	✓	✓	✓	✓	✓	✓	✓	✓	✓
11/29/2018	Besse Medical	(800) 543-8695 http://www.besse.com					IIV4	IIV4	✓	✓	✓	✓		✓		✓	✓
11/26/2018	Cardinal Health	fluteam@cardinalhealth.com	✓	✓	✓		IIV4	IIV4	✓	✓	✓	✓	✓	✓	✓	✓	✓
11/28/2018	GlaxoSmithKline	(866) 475-8222 (option 2) vaccine.service-center@gsk.com			✓												
11/26/2018	Henry Schein, Inc.	(800) 772-4346							✓	✓	✓	✓				✓	✓
11/27/2018	McKesson Medical Surgical	(877) 625-4358 www.mms.mckesson.com		✓	✓	✓	IIV4	IIV4		✓		✓		✓	✓	✓	✓
11/27/2018	Moore Medical LLC	(800) 234-1464 www.mooremedical.com/flu			✓	✓	IIV4	IIV4	✓	✓	✓	✓	✓	✓	✓	✓	✓
1/8/2019	Nationwide Medical Surgical, Inc.	(818) 997-8846 flu@emsincusa.com					IIV4	IIV4	✓	✓	✓	✓	✓		✓	✓	✓
10/26/2018	Sanofi Pasteur	(800) 822-2463 https://www.vaccineshoppe.com										✓			✓	✓	✓

Note: All information is provided by distributors and manufacturers on a voluntary basis and is not intended to endorse or promote one distributor's (or manufacturer's) product over another.

IIV3/IIV4 – trivalent/quadrivalent inactivated influenza vaccine; ccIIV4 – cell culture-based quadrivalent inactivated influenza vaccine; LAIV – quadrivalent live attenuated influenza vaccine; RIV4 – quadrivalent recombinant influenza vaccine

Thank you!

Diane C. Peterson
Immunization Action Coalition
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immunization action coalition
IAC
immunize.org

Immunizing HCP for Influenza in 2019: Why Does It Matter & What Works?

National Adult & Influenza Immunization Summit (NAIIS)

Influenza Working Group

Amy Parker Fiebelkorn, Amy Behrman, Kelly McKenna
NAIIS Influenza Working Group Co-Leads

Amy Behrman, MD
Medical Director, Occupational Medicine
University of Pennsylvania

National Adult and Influenza Immunization Summit

National Adult and Influenza Immunization Summit (NAIIS)

- NAIIS mission: Dedicated to addressing and resolving adult and influenza immunization issues and improving the use of vaccines recommended by the Advisory Committee on Immunization Practices

- NAIIS organized by: The CDC, Immunization Action Coalition, and the National Vaccine Program Office

- NAIIS comprises: >700 partners, representing more than 130 public and private organizations

National Adult and Influenza Immunization Summit

To provide some background, the National Adult and Influenza Immunization Summit, or NAIIS, is dedicated to addressing and resolving adult and influenza immunization issues and improving the use of vaccines recommended by the Advisory Committee on Immunization Practices.

There are 3 organizations that lead the Summit including the CDC, the Immunization Action Coalition, and the National Vaccine Program Office.

The Summit has grown over the past 5 years and now comprises more than 700 partners, representing more than 130 public and private organizations, including professional organizations, immunization coalitions, distributors, industry, state and local health departments, and academic institutions.

National Adult and Influenza Immunization Summit:
Influenza Working Group

Mission: Work to improve influenza vaccination coverage and promote best practices

2018- 2019 Working Group Goal:
Develop partnerships and materials to improve influenza vaccination coverage among healthcare personnel (HCP) in long-term care facilities (LTCFs)

https://phil.cdc.gov/Details.aspx?pid=9348

National Adult and Influenza Immunization Summit

There are currently 3 work groups that carry out the bulk of the work of the Summit, including the Access and Provider WG, the Quality Measures WG, and our WG, the Influenza WG.

The mission of our influenza working group is to improve influenza vaccination coverage and promote best practices. Our WG convened 3 years ago, and since then, we've been focused different goals.

Our most recent goal over the past year and into this coming year has been to develop partnerships and materials to improve influenza vaccination coverage among healthcare personnel in long-term care facilities.

Seasonal Influenza

- Highly contagious respiratory viral illness
- Complications include pneumonia, worsening chronic medical conditions (CHF, CAD, COPD, asthma, diabetes) and death
- Healthy adults may be able to infect others from 1 day before symptoms and up to 7 days after becoming sick
- 5- 20% of population affected each year
- Vaccination is the single most effective way to prevent influenza cases, hospitalizations and deaths
- Vulnerable patients (elderly, neonates, immune-compromised) have the least response to vaccination
- Non-elderly adults, including HCP, have the strongest response
- Influenza among HCP is common and often sub-clinical
  - Poses infection risk to patients and other HCP
- Vaccination of HCP can decrease transmission risk to patients

National Adult and Influenza Immunization Summit

1. https://www.cdc.gov/flu/keyfacts.htm
2. Wilde JA, McMillan JA, Serwint J, Butta J, O'Riordan MA, Steinhoff MC. Effectiveness of influenza vaccine in health care professionals: a randomized trial. JAMA 1999;281:908--13.

Influenza is a contagious respiratory illness caused by influenza viruses

It can lead to complications (pneumonia, worsening of chronic medical conditions, such as CHF, asthma, or diabetes) and death

Healthy adults may be able to infect others beginning 1 day before symptoms develop and up to 5 to 7 days after becoming sick

Best prevention is influenza vaccination

5- 20% of population affected each year

Influenza among HCP is common, and 28% ─ 59% of cases estimated are subclinical

This poses a cross-infection risk to patients or residents of LTCFs

Immunizing Healthcare Workers: What Works & Why Does it Matter?

Adult and Influenza Immunization Summit

THIS IS PARTICULARLY CRUCIAL FOR HCP BECAUSE IT IMPACTS PATIENT SAFETY AS WELL AS STAFF WELLNESS.

MEDICALLY FRAGILE PATIENTS, THE VERY YOUNG, AND THE VERY OLD ARE AT PARTICULAR RISK OF INFLUENZA COMPLICATIONS AND DEATH. WE VACCINATE HCP TO PREVENT TRANSMISSION IN THESE SETTINGS – OBVIOUSLY THE ONE ON THE RIGHT IS APPLICABLE TO THIS GROUP. I SHOULD MENTION THAT THE PICTURES ARE USED WITH PERMISSION. THE INFANT WITH THE NURSE IS A STOCK PHOTO FROM OUR HOSPITAL, AND THE ELDERLY MAN WITH RESPIRATORY COMPROMISE IS MY FATHER – WHO IS DOING BETTER NOW.

Impact of Seasonal Influenza in Adults ≥65 Years

- 54 – 70% of seasonal flu-related hospitalizations have occurred in people ≥65 years
- Risk is greatest in the oldest age group (≥85 years)
  - 16 times more likely than persons 65 – 84 years
- 70 – 85% of seasonal flu-related deaths have occurred in people ≥65 years
- Case fatality rates in long-term care facilities (LTCF) from influenza complications as high as 55%

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1.https://www.cdc.gov/flu/about/disease/65over.htm

2.https://www.cdc.gov/mmwr/preview/mmwrhtml/rr59e0729a1.htm

3. Nace DA, Drinka P, Mann J, Poland GA. LTC Information Series: Immunization in the Long-Term Care Setting. 2nd ed. Columbia, MD: American Medical Directors Association; 2010.

4. Morens DM, Rash VM. Lessons from a nursing home outbreak of influenza A. Infect control Hosp Epidemiol. 1995; 16(5):275-80.

Influenza is especially severe in older adults.

54 – 70% of seasonal flu-related hospitalizations have occurred in people ≥65 years

The risk is greatest in the oldest age group (≥85 years)

16 times more likely than persons 65 – 84 years

70 – 85% of seasonal flu-related deaths have occurred in people ≥65 years

Case fatality rates in long-term care facilities (LTCF) from influenza complications is as high as 55%

Influenza Outbreaks in Long-Term Care Facilities (LTCFs)

- Influenza outbreaks in LTCFs are common
  - In 2017-2018, from select states:
    - Minnesota had 184 confirmed influenza outbreaks in LTCFs
    - Kentucky had 124 confirmed influenza outbreaks in LTCFS

- Factors contributing to outbreaks in these settings:
  - Close living proximity
  - Immune senescence in older adults
  - Comorbidities
  - Reduced immune response to vaccine

Sign from Ottawa Health

National Adult and Influenza Immunization Summit

http://www.health.state.mn.us/divs/idepc/diseases/flu/stats/flustats10.pdf
https://healthalerts.ky.gov/Documents/fluactivity.pdf

Despite the availability of a vaccine, influenza is very common, and outbreaks in long-term care facilities are common.

In 2017-2018, from select states:

Minnesota had 184 confirmed influenza outbreaks in LTCFs

Kentucky had 124 confirmed influenza outbreaks in LTCFS

Factors contributing to outbreaks in these settings:

Close living proximity

Immune senescence in older adults

Comorbidities

Reduced immune response to vaccine

Influenza Outbreaks in LTCFs Associated with Low Vaccination Rates among Health Care Personnel

- Influenza outbreaks in LTCFs have been associated with low vaccination rates among health care personnel (HCP)
- Randomized controlled studies on the impact of HCP vaccination on resident morbidity and mortality in LTCFs have demonstrated substantial decreases in:
  - Influenza-like illness
  - All-cause mortality

1. Saito R, Suzuki H, Oshitani H, et al. The effectiveness of influenza vaccine against influenza a (H3N2) virus infections in nursing ho -1999 and 1999--2000 seasons. Infect Control Hosp Epidemiol 2002;23:82--6.
2. Lemaitre M, Meret T, Rothan-Tondeur M, et al. Effect of influenza vaccination of nursing home staff on mortality of residents: a Soc 2009;57:1580--6.
3. Carman WF, Elder AG, Wallace LA, et al. Effects of influenza vaccination of health-care workers on mortality of elderly people in controlled trial. Lancet 2000;355:93--7.
4. Hayward AC, Harling R, Wetten S, et al. Effectiveness of an influenza vaccine programme for care home staff to prevent death, m residents: cluster randomised controlled trial. BMJ 2006;333:1241.
5. Potter J, Stott DJ, Roberts MA, et al. Influenza vaccination of health care workers in long-term-care hospitals reduces the mortali 1997;175:1--6.

- ❑ Studies have shown that influenza outbreaks in LTCFs have been associated with low vaccination rates among health care personnel (HCP)
- ❑ Additionally, randomized controlled studies on the impact of HCP vaccination on resident morbidity and mortality in LTCFs have demonstrated substantial decreases in:
    - All-cause mortality
    - Influenza-like illness

Why Focus on Vaccinating Health Care Personnel against Influenza in LTCFs?

- CDC recommends that HCP should be vaccinated annually against influenza
- Protects residents who are high-risk due to age and co-morbid conditions
  - HCP can serve as vectors
  - HCP have high contact with residents
- Improves quality of care by decreasing HCP absenteeism
  - Absenteeism in LTCFs is associated with reduced quality of care (physical restraint use, catheter use, pain management, & pressure sores)
- Benefits employees (personal protection of HCP and their families)

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1. Grohskopf LA, Sokolow LZ, Broder KR, et al. Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2017-18 Influenza Season. MMWR Recomm Rep. 2017;66(2):1-20.

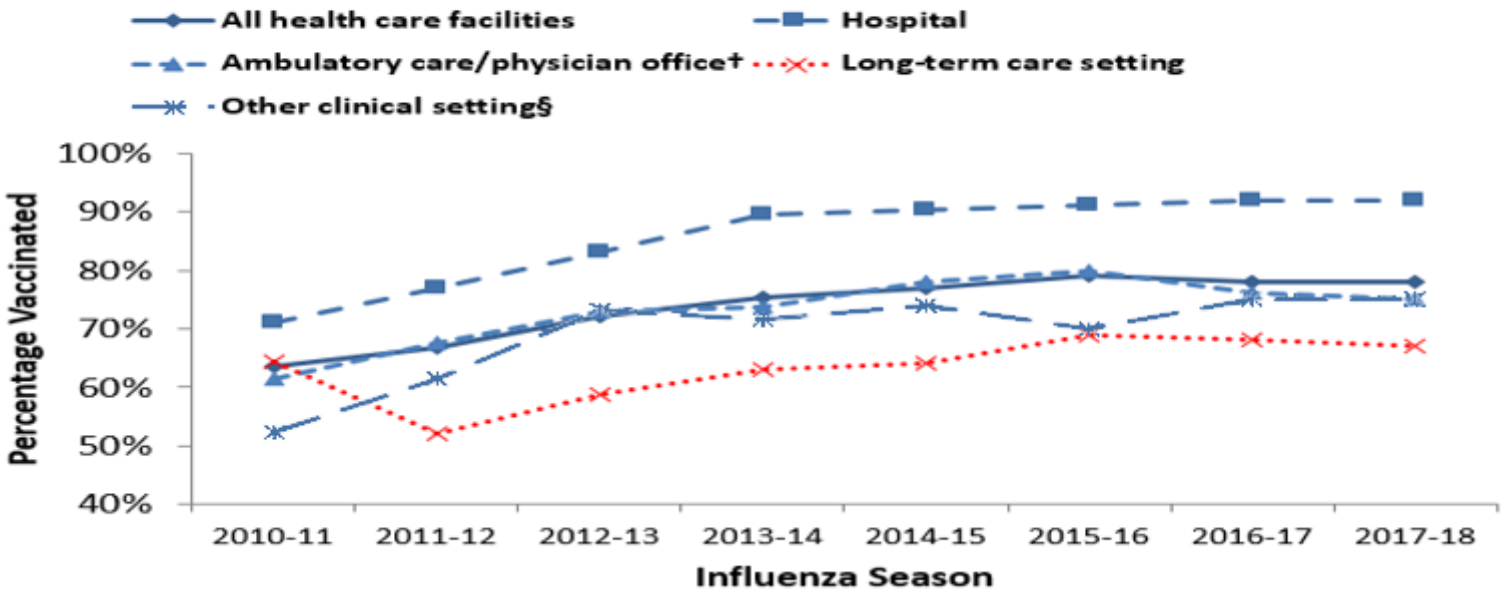
The question of today is why should we focus on vaccinating health care personnel against influenza in LTCFs?

A main reason is that CDC recommends that HCP should be vaccinated annually against influenza.

- This recommendation includes *a continued emphasis on vaccinating HCP who work in LTCFs*, because their patient population is at high risk for serious complications from influenza, and due to the risk of influenza outbreaks in these facilities.

Influenza Vaccination Coverage of HCP by Facility Type

Figure 1. Percent of HCP vaccinated by work setting*, Internet panel surveys, United States, 2010-11 through 2017-18 influenza seasons



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Black CL, Yue X, Ball SW, et al. Influenza Vaccination Coverage Among Health Care Personnel — United States, 2017–18 Influenza Season. *MMWR*. 2018; 67(38):1050-4. DOI: http://dx.doi.org/10.15585/mmwr.mm6738a2

Nonetheless, during the 2017–18 influenza season, influenza vaccination coverage was lowest among HCP working in long-term care settings (67%) (in red), compared with HCP working in hospitals (92%).

- *Healthy People 2020* annual target goal for influenza vaccination among HCP is 90%

Since at least the 2011–12 influenza season, HCP in long-term care settings have had the lowest reported influenza vaccination rates among all HCP.

Misconceptions about Influenza Vaccination from HCP

- Studies show that a large percentage of HCP in LTCFs hold inaccurate beliefs about the influenza vaccine: **~40% HCP believed that vaccination could cause influenza.**
  - Vaccination rates are almost 30 percentage points higher among HCP who believe that the vaccine is effective
  - Vaccination rates are 12 percentage points higher among HCP who believe that the vaccine does not cause influenza
- When asked why they do not receive the vaccine, HCP typically cite:
  - A fear of needles
  - Worries of side effects
  - Concerns that vaccination will give them influenza
  - Belief that they are not at risk of contracting influenza
  - Desire to avoid medications and foreign substances

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Daugherty JD, Blake SC, Grosholz JM, et al. Influenza vaccination rates and beliefs about vaccination among nursing home employees. Amer J Infect Control 2015; 43 (2): 100-6

This underscores the fact that despite all of the available resources on influenza vaccination there are still many misconceptions about the vaccine, even among HCP.

Studies show that a large percentage of HCP in LTCFs hold inaccurate beliefs about the influenza vaccine: ~40% HCP disagreed with the following statement: "Vaccine does not cause influenza."

Vaccination rates are almost 30 percentage points higher among HCP who believe that the vaccine is effective

Vaccination rates are 12 percentage points higher among HCP who believe that the vaccine does not cause influenza

When asked why they do not receive the vaccine, HCP typically cite:

A fear of needles

Worries of side effects

Concerns about contracting the virus from the vaccine

A belief that they are not at risk of contracting influenza

A desire to avoid medications

Strategies for Improving HCP Vaccination Rates in LTCF

- To an extent, vaccination rates among HCPs at LTCFs increase and HCP absenteeism decrease after:
  - Multifaceted interventions that engage stakeholders
  - Focus on creating an environment that supports risk reduction
- Education programs have a limited impact on vaccination rates
- Although rates at LTCF sites improved influenza vaccination coverage of HCP with voluntary measures, they mostly did not meet Healthy People 2020 goals and might require mandatory programs to reach 90% or higher
- Employer requirements for influenza vaccination, aka mandates, have been shown to dramatically increase HCP rates in acute care settings

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Ofstead et al: Moving the needle on nursing staff influenza vaccination in long-term care: Results of an evidence-based intervention. Vaccine. 2017

Rakita et al: Mandatory influenza vaccination of healthcare workers: A five year study. ICHE 2010

Babcock et al: Mandatory influenza vaccination of healthcare workers: Translating policy to practice. CID 2010

However, there are strategies for improving HCP vaccination rates in LTCFs.

Vaccination rates among HCPs at LTCFs increase and HCP absenteeism decrease after:

Multifaceted interventions that engage stakeholders

Focus on creating an environment that supports risk reduction

And although education programs generally have a limited impact on vaccination rates, compared with nurses who did not receive educational interventions, nurses exposed to the interventions were:

More likely to encourage others to be vaccinated, and

More likely to discuss vaccination with residents

****

In case anyone asks: In LJ's study of four LTCFs, all were able to improve their nursing staff vaccination rates using ecological interventions but 3 out of the 4 sites were still below 90% vaccination rates. Two of the 4 sites required vaccine receipt or masking throughout the season and they achieved 96% nursing staff vaccination and 82% nursing staff vaccination (the non required sites achieved 83% vaccination and 71% vaccination)

INFLUENZA VACCINE FOR Healthcare Personnel

Experience from a Large Academic Healthcare System

2004-2018

National Adult and Influenza Immunization Summit

MY GOAL NOW IS TO

- PRESENT PENN'S EXPERIENCE OF THESE 2 APPROACHES
- DESCRIBE THE EVOLUTION OF OUR CURRENT FLU PROGRAM

HCP and Vaccination 2004 onward: How were we doing with HCP?

- Measles, mumps, rubella, varicella required for all staff
  - HCP and patients are at risk if not immune
  - Long term immunity from disease or vaccine
  - Condition of employment, assessed at hire
  - **HCP compliance approached 100%**
- Influenza recommended for all staff
  - Free vaccine available to all HCP
  - Vaccination on-site in all units, all shifts
  - Vaccine at cafeteria and public hospital areas
  - “Flu fairs” with education, games, & incentives
  - Vaccine for walk-ins in OM clinic 8-12 hours/day
  - **Vaccination Rates <50%**
  - **Why were staff declining influenza vaccine?**

LONG STORY SHORT - WE WERE AND ARE DOING EXTREMELY WELL WITH MMR&V FOR WHICH PROOF OF IMMUNITY (WITH TITERS OR RECORDS OR VACCINATION) IS ASSESSED ON HIRE AND IS MANDATORY FOR ALL STAFF

SO RE MMRV, ALTHOUGH ALL THESE ARE LIVE-VIRUS VACCINES WITH KNOWN RISKS AND CLEAR MEDICAL CONTRAINDICATIONS FOR PREGNANT AND IMMUNE COMPROMISED STAFF AND ALTHOUGH ALL 4 HAVE LESS THAN COMPLETE EFFECTIVENESS, COMPLIANCE IS ESSENTIALLY PERFECT.

THESE ARE REQUIREMENTS OF EMPLOYMENT. APPLICANTS WITH NON-MEDICAL EXEMPTION REQUESTS HAVE THEIR OFFERS WITHDRAWN BY HR

Penn Med Voluntary Influenza Vaccine Program 2006-2007

Declination forms analyzed for HCP concerns

- **“Flu is not dangerous”**
- **“ The vaccine doesn‘t work”**
- **“The vaccine will make me sick”**
- **“The vaccine isn’t safe”**
- **“ I don’t like to put foreign things into my body”**
- **“I live a clean life so I won’t get flu”**
- **“This is a plot against the staff”**
- **“You must be making money from this”**

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THESE ARE ACTUAL QUOTES. READ

DO THESE SOUND FAMILIAR? THEY SHOULD. THEY LOOK LIKE THE RESULTS OF EVERY HCW SURVEY ON FLU VACCINE FROM THE US AND FROM AROUND THE WORLD ….

Penn Med Voluntary Influenza Vaccine Program 2006-2008

- Declination forms analyzed
- Outreach & education via hospital newsletter, email, intranet, & managers' meetings
- 2008 Flu shot music video using hospital staff

- http://www.youtube.com/watch?v=ruGgZbAVnko
- Results: Inadequate Improvement
  - 54% 2008-09 (60% of clinical staff)

SO WE REVVED UP OUR PROGRAM TO ADDRESS THESE DECLINATION CONCERNS WITH ENERGIZED MULTIMEDIA OUTREACH *VIA NEWSLETTER, EMAIL, LARGE AND SMALL GROUP MEETINGS, INDIVIDUAL APPOINTMENTS,* EVENTUALLY EVEN CREATING A MUSIC VIDEO IN WHICH HOSPITAL STAFF ADDRESSED CONCERNS FROM THE DECLINATION FORMS MUSICALLY

MAKING THIS VIDEO WAS A WONDERFUL EXPERIENCE. LEAD BY ONE OF OUR OHS NURSES, STAFF FROM ALL AREAS PARTICIPATED. THE VIDEO WAS INCREDIBLY POPULAR IN HOUSE. IT WAS PLAYED INCESSANTLY ON WR TELEVISIONS AND STAFF COMPUTERS. IT HAS ALMOST 40,000 HITS ON UTUBE (WHERE YOU CAN STILL SEE IT BTW - THERE'S THE LINK)

Should Flu Vaccine be Required? Pros & Cons

- Nobody likes being compelled – especially annually
- May reduce efforts to educate & improve voluntary measures
- May produce resentment
- Expensive to monitor and enforce
- Rare voluntary programs have achieved >80-90%
- There may be real limits to voluntary programs
- Even 80-90% coverage rates don't maximize risk reduction
- Compliance for mandated MMRV immunity approaches 100% with negligible objections
- Early mandatory influenza vaccine programs for HCP reported >95% - doubling prior rates (*Rakita 2010; Babcock 2010*)
- HCP are generally healthy younger adults with optimal vaccine responses- in contrast to medically fragile patients

WE SERIOUSLY CONSIDERED THE MANY LEGITIMATE ARGUMENTS AGAINST MANDATORY INFLUENZA VAX:

1. NOBODY LIKES BEING COERCED – ESPECIALLY ANNUALLY
2. THE CONCEPT THREATENS HCP AUTONOMY
3. MANDATES MAY REDUCE RESOURCES FOR VOLUNTARY VAX
4. IT MAY BE POSSIBLE TO CREATE GREAT VOLUNTARY PROGRAMS – BETTER THAN OURS
5. MANDATES MAY PRODUCE STAFF RESENTMENT
6. MANDATES CAN BE EXPENSIVE TO MONITOR AND ENFORCE

Should Flu Vaccine be Required?

- 2007-2008 - Consensus among IC and OM staff
- 2008 Institutional debate and discussion of mandates to enhance patient and staff safety
- 2009 HUP IM/EM Physician survey strongly supported a mandatory vaccine policy *(DeSante et al 2010)*
- Early 2009 Leadership commitment

  Medical Boards- CMO

  Nursing Leadership – CNO

  Human Resources - CHROs

  Administration

  General Counsel

National Adult and Influenza Immunization Summit

EARLY CONSENSUS BETWEEN IC AND OM PROGRESSED TO COMMITMENT BY HEALTH SYSTEM LEADERSHIP ACROSS THE SPECTRUM OF STAKEHOLDERS

INCLUDING *READ IF TIME*

Penn Med Influenza Vaccine Program 2009-2010

- New UPHS-wide policy requiring influenza vaccination for all HCP
- Scope: Staff, Physicians, Contractors, Volunteers, Students
- Resources - supported by
  - Educational programs, website
  - Interactive live and electronic Q&A
  - Exemption reviews, medical and religious
  - Multi-faceted outreach to all staff @ all locations

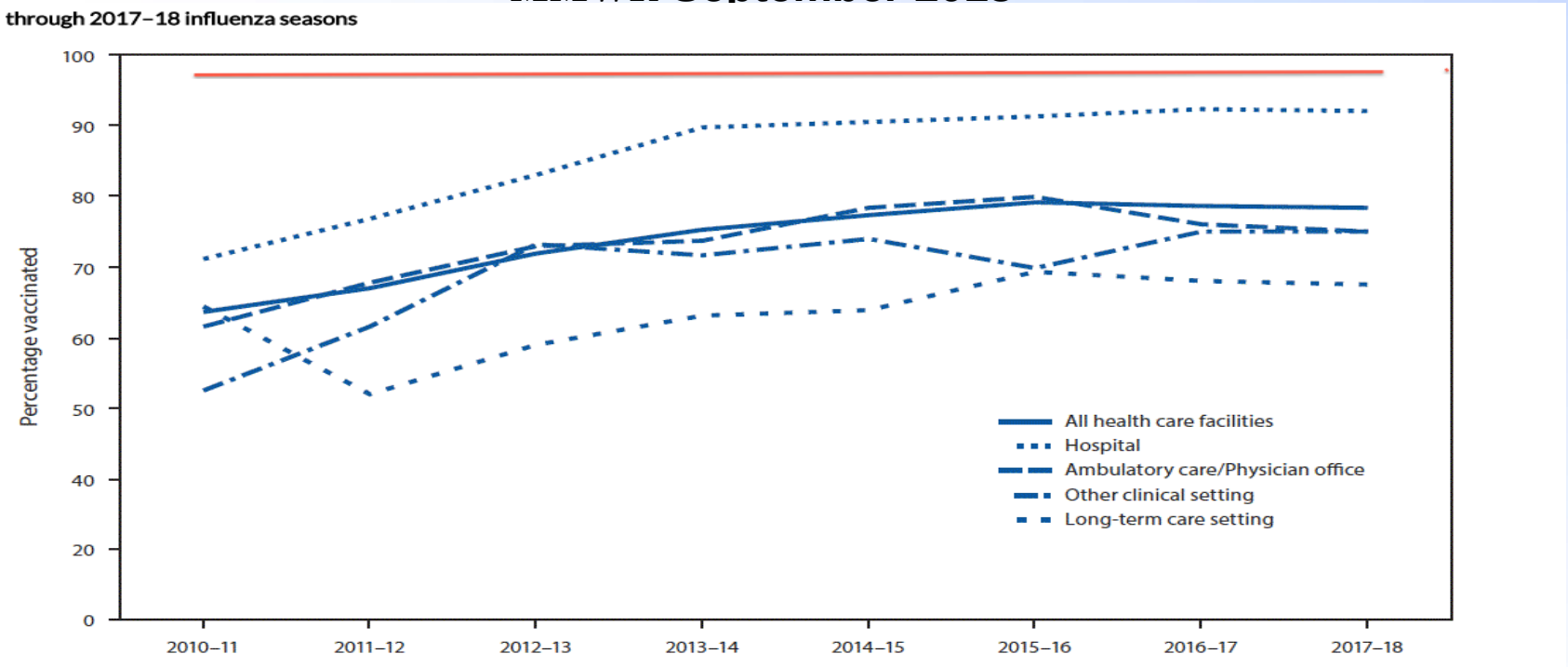
SO IN 2009 WE WROTE A NEW POLICY AND LAUNCHED A SYSTEM-WIDE MANDATORY FLU VAX PROGRAM WITH A WIDELY DEFINED SCOPE INCLUDING STAFF, PHYSICIANS, CONTRACTORS, VOLUNTEERS AND STUDENTS.

IT WAS RESOURCED WITH MULTIMEDIA EDUCATIONAL MATERIALS AND MANY MANY INTERACTIVE SESSIONS ONLINE AND LIVE

THE POLICY INCLUDED REVIEWS FOR MEDICAL AND RELIGIOUS EXEMPTION REQUESTS.

CDC HCP Influenza Vaccination

MMWR September 2018



Adult and Influenza Immunization Summit

WE HAVE MAINTAINED FLU VACCINATION COVERAGE WELL IN EXCESS OF RISING NATIONAL AVERAGES FOR HCP. I AM HAPPY TO TELL YOU THAT THE RED LINE IS PENN, OVERLYING THE SLIDE OF HCP IMMUNIZATION THAT YOU'VE NOW SEEN 3 TIMES..

OUR OVERALL EXEMPTION RATE, ACROSS THE HEALTH SYSTEM, WAS 1.2% LAST YEAR, OF WHICH 82% WERE MEDICAL AND 18% RELIGIOUS

Conclusions & Comparisons

- **Are influenza vaccines for HCP effective in reducing risk for patients and staff?**
  - **Analysis is complicated by**
    - **Other similar diseases**
    - **Year to year variability in vaccine characteristics**
    - **Roles of other IC interventions**
  - **More difficult to demonstrate in Acute Care**
  - **Clearly effective in LTCFs**
- **Are mandates effective in raising HCP rates? *YES***
- **Are employer requirements also achievable and desirable in LCTFs? *YES***

National Adult and Influenza Immunization Summit

READ AND COMMENT

Why Focus on Influenza Vaccination Requirements?

- Voluntary measures have generally NOT been successful in raising HCP influenza vaccination coverage to the Healthy People 2020 goal of ≥90% coverage
- In a national survey, the percentage of HCP in LTCFs who were vaccinated (by employer approach to influenza vaccination):
  - Work requirement (89%)
  - Promoted by employer (vaccine offered on-site >1 day at no cost to HCP), but not required (59%)
  - No employer requirement or vaccine promotion (42%)

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1. Hollmeyer H, Hayden F, Mounts A, Buchholz U. Review: interventions to increase influenza vaccination among healthcare workers in hospitals. Influenza Other Respir Viruses. 2013;7(4):604-621.
2. Black CL, Yue X, Ball SW, et al. Influenza Vaccination Coverage Among Health Care Personnel — United States, 2017–18 Influenza Season. *MMWR.* 2018; 67(38):1050-4. DOI: http://dx.doi.org/10.15585/mmwr.mm6738a2

Voluntary measures have generally NOT been successful in raising HCP influenza vaccination coverage to the Healthy People 2020 goal of ≥90% coverage, as I previously mentioned.

In a national survey, the percentage of HCP in LTCFs who were vaccinated (by employer approach to influenza vaccination):

- 89% of HCP in LTCFs where there was a work requirement
- 59% of HCP in LTCFs where vaccination was Promoted by the employer (vaccine offered on-site >1 day at no cost to HCP), but not required
- And only 42% when there was no employer requirement or vaccine promotion

Professional Societies that Support Influenza Vaccination Requirements for HCP

-- American Academy of Family Physicians (AAFP)
-- AMDA - The Society for Post-Acute and Long-Term Care Medicine
-- Association of Occupational Health Professionals in Healthcare (AOHP)*
-- American College of Physicians (ACP)
-- American Hospital Association (AHA)
-- American Nurses Association (ANA)
-- American Pharmacists Association (APhA)
-- American Public Health Association (APHA)
-- Infectious Diseases Society of America (IDSA)
-- National Foundation for Infectious Diseases (NFID)
-- National Patient Safety Foundation (NPSF)
-- Society for Healthcare Epidemiology of America (SHEA)
-- Association for Professionals in Infection Control and Epidemiology (APIC)

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Other professional societies have taken a similar stance, as shown here.

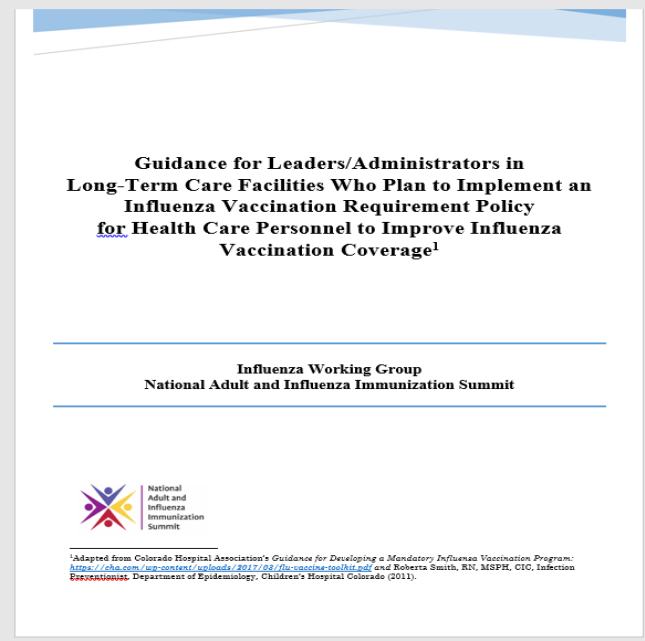
Influenza Working Group Goal to Increase Influenza Vaccination of HCP in LTCFs

- Developed a guidance document for leadership in LTCFs who are considering implementing an influenza vaccination requirement for HCP in their facilities
- Partnered with Gerontological Society of America, May 2018 meeting on increasing influenza vaccination rates of HCP in LTCFs
- Partnered with CMS and presented to Quality Improvement Networks/ Quality Improvement Organizations (QIN/QIOs)
- Partnered with AMDA and sponsored an October 2018 meeting with LTCF Executives and Stakeholders
- Presenting to NVAC today to update & seek collaboration

We've been working to achieve this goal in several ways:

- Developed a guidance document for leadership in LTCFs who are considering implementing an influenza vaccination requirement for HCP in their facilities
- Partnered with Gerontological Society of America and participated in the May 2, 2018 meeting focused on increasing influenza vaccination rates of HCP in LTCFs
- Partnered with CMS and presented to Quality Improvement Networks/ Quality Improvement Organizations (QIN/QIOs)
- Today's meeting with LTCF Executives and Stakeholders

NAIIS Guidance Document for Developing a Vaccination Requirement for HCP in LTCFs



Guidance for Leaders/Administrators in Long-Term Care Facilities Who Plan to Implement an Influenza Vaccination Requirement Policy for Health Care Personnel to Improve Influenza Vaccination Coverage[1]

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[1]Adapted from Colorado Hospital Association's *Guidance for Developing a Mandatory Influenza Vaccination Program:* https://cha.com/wp-content/uploads/2017/08/flu-vaccine-toolkit.pdf and Roberta Smith, RN, MSPH, CIC, Infection Preventionist, Department of Epidemiology, Children's Hospital Colorado (2011).

Purpose of document:

- **To provide guidance and information for developing an influenza vaccination requirement policy HCP in LTCFs**
- **Provides a framework for major areas that should be considered when adopting an influenza vaccination requirement policy**

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https://www.izsummitpartners.org/content/uploads/2018/08/guidance-for-developing-a-flu-vax-requirement-policy-for-hcp-in-ltcf-v1.pdf

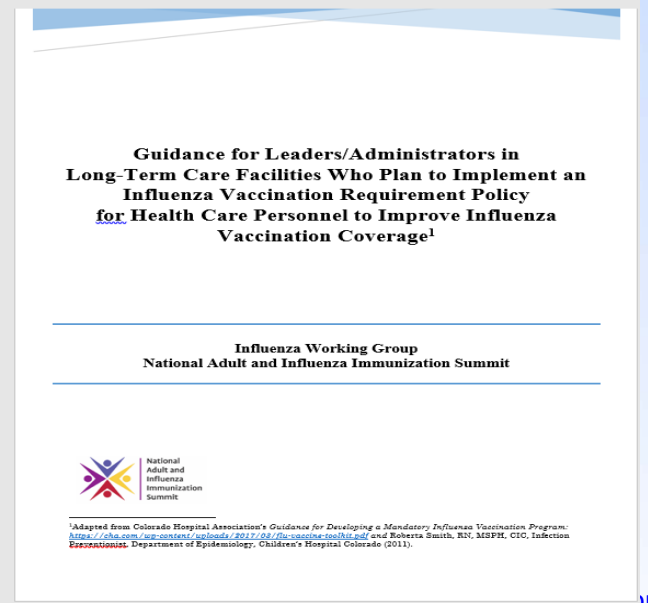
As a result of the data we just shared, and with the support of professional organizations almost across the board, our WG decided last year to develop guidance for any LTCF that was interested in implementing requirements for HCP to receive influenza vaccination.

This document provides a framework for major areas that should be considered when adopting an influenza vaccination requirement policy.

NAIIS Guidance Document for Implementing Influenza Vaccination Requirement for HCP

Includes sections (in modular format) on:

- ❑ **Rationale and supporting evidence for HCP vaccination**
- ❑ **Implementing a vaccination requirement policy**
- ❑ **Employee engagement**
- ❑ **Ethical considerations**
- ❑ **Resources**
- ❑ **FAQs**
- ❑ **Sample Policy**
- ❑ **Sample Exemption Form**



Guidance for Leaders/Administrators in Long-Term Care Facilities Who Plan to Implement an Influenza Vaccination Requirement Policy for Health Care Personnel to Improve Influenza Vaccination Coverage[1]

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[1]Adapted from Colorado Hospital Association's *Guidance for Developing a Mandatory Influenza Vaccination Program:* https://cha.com/wp-content/uploads/2017/08/flu-vaccine-toolkit.pdf and Roberta Smith, RN, MSPH, CIC, Infection Preventionist, Department of Epidemiology, Children's Hospital Colorado (2011).

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https://www.izsummitpartners.org/content/uploads/2018/08/guidance-for-developing-a-ha-vax-requirement-policy-for-hcp-in-ltcf-v1.pdf

The document includes sections on:

Rationale and supporting evidence for HCP vaccination

Implementing a vaccination requirement policy

Employee engagement

Ethical considerations

Resources

FAQs

Sample Policy

Sample Exemption Form

Immunization Action Coalition and AMDA Influenza Vaccination Honor Roll

- The Immunization Action Coalition and AMDA recognize facilities that have influenza vaccination mandates for HCP
- To be included in this honor roll, a facility must require influenza vaccination for employees and must include serious measures to prevent transmission of influenza from unvaccinated workers to patients/residents (e.g., mask or reassignment to non-patient-care duties)
- October 2018: 6 LTCF recognized on the honor roll
- **September 2019: 130 LTCF recognized on the honor roll**

PA/LTC Influenza Vaccination Honor Roll
The Immunization Action Coalition recognizes PA/LTC settings that require flu vaccines for employees.

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http://www.immunize.org/honor-roll/influenza-mandates/ltc.asp

The Immunization Action Coalition and AMDA recognize facilities that have influenza vaccination mandates for HCP

To be included in this honor roll, a facility's mandate must require influenza vaccination for employees and must include serious measures to prevent transmission of influenza from unvaccinated workers to patients/residents (e.g., mask requirement or reassignment to non-patient-care duties)

Currently only 6 LTCF recognized on the honor roll. Granted this might be an underrepresentation, considering some states, such as Minnesota, have their blue ribbon panels of long-term care facilities that have 90% coverage or greater (that might not have submitted to be on the IAC honor roll), but when you consider that there are more than 600 hospitals and acute care facilities on the honor roll, it does make us realize how far we have to go in the long-term care environment.

Summary

- Influenza can lead to severe complications in LTCF residents
- Vaccination is the best method of preventing influenza
- LTCFs have the lowest vaccination rates among all HCP
- Voluntary measures, easy access to vaccination, staff engagement can increase rates but generally not enough to Healthy People 2020 90% goal
- Vaccination requirements for HCP are supported by professional societies and can help achieve 90% coverage
- **New Tool:** IWG Guidance Document for Post-Acute & LTCFs seeking to create employer requirements
- **New Incentive:** IAC Honor Roll for LTCFs
- **New Opportunity:** Speaking to NVAC today!

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We covered a lot of ground, but in summary:

Influenza can lead to severe complications in LTCF residents

Vaccination is the best method of preventing influenza

LTCFs have the lowest vaccination of HCP (of all healthcare facility types)

Voluntary measures, easy access to vaccination, staff engagement can help increase rates

But generally not enough to reach Healthy People 2020 goal of 90% (and not sustained)

Vaccination requirements for HCP are supported by professional societies and might help achieve 90% coverage

Questions?

Interested in joining the Influenza Working Group?

Email Amy Parker Fiebelkorn: dez8@cdc.gov

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Contact Information for NAIIS Influenza Working Group Leads:

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For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

Thank you.

Thank you to our many working group members!

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