

## 2023-2024 Influenza Season Talking Points Including COVID-19 and RSV

### Respiratory Season Outlook

- Influenza, RSV, and COVID-19 are now all considered as part of the respiratory virus season. Analysis from US CDC shows that with the addition of COVID-19, even an average respiratory season can place significant strain on our healthcare system.
  - <https://www.cdc.gov/respiratory-viruses/whats-new/2023-2024-season-outlook.html>

### Immunization

Getting vaccinated this year is especially important with three prominently circulating respiratory virus this fall. Influenza, COVID-19, and respiratory syncytial virus (RSV) will all be circulating at the same time; illness from these viruses can be prevented by vaccines. Getting vaccinated will protect you and your family from becoming sick from one of these viruses and may also potentially save healthcare resources in a season that could be particularly taxing.

### Influenza Vaccination

1. *Everyone six months of age and older should get a yearly flu vaccine.*
  - Children 6 months through 8 years of age, receiving the flu shot for the first time or those who have only previously gotten one dose of vaccine in this age range, should get two doses of vaccine this season—spaced at least 4 weeks apart.
  - Persons who are pregnant, who might be pregnant, or are postpartum during the influenza season should receive any licensed, recommended, and age-appropriate vaccine. LAIV4 should not be used during pregnancy but can be used postpartum. Vaccination during pregnancy is protective for the mother as well as infants during the first months of life.
  - Adults aged  $\geq 65$  years should receive quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated influenza vaccine (aIIV4)). If these vaccines are not available at time of administration, then any other age-appropriate influenza vaccine should be administered.
2. **Timing:** For most persons who need only 1 dose of influenza vaccine for the season, vaccination should ideally be offered during September or October. However, vaccination should continue after October and throughout the influenza season as long as influenza viruses are circulating, and unexpired vaccine is available.
  - **Children who require 2 doses:** Certain children aged 6 months through 8 years require 2 doses of influenza vaccine for the season, these children should receive their first dose as soon as possible to allow the second dose (which must be administered  $\geq 4$  weeks later) to be received, ideally, by the end of October.
  - **Children who require only 1 dose:** Vaccination during July and August can be considered for children of any age who need only 1 dose of influenza vaccine for the season as many children in this group might visit health care providers during the late summer months for medical examinations before the start of school. Vaccination can be considered at this time because it represents a vaccination opportunity.
  - **Pregnant persons in the first or second trimester:** Vaccination during July and August should be avoided unless there is concern that vaccination later in the season might not be possible.
  - **Pregnant persons in the third trimester:** Vaccination during July and August can be considered for pregnant persons who are in the third trimester during these months because vaccination at

this time may reduce the risk for influenza illness in their infants during the first months after birth.

- **For most adults (particularly adults aged ≥65 years):** Vaccination during July and August should be avoided unless there is concern that vaccination later in the season might not be possible.
3. Manufacturers now produce influenza vaccine for the U.S. market through different technologies (e.g., egg-based, cell culture-based, and recombinant hemagglutinin vaccines, inactivated vaccine, High Dose, Intradermal, Intranasal). All vaccines for the 2023-2024 season are quadrivalent.
  4. All of the 2023-2024 egg-based influenza and LAIV4 vaccine are made to protect against the following four viruses:
    - A/Victoria/4897/2022 (H1N1)pdm09-like virus; (Updated)
    - A/Darwin/9/2021 (H3N2)-like virus
    - B/Austria/1359417/2021 (B/Victoria lineage)-like virus
    - B/Phuket/3073/2013 (B/Yamagata lineage)-like virus
  5. For 2023-2024, cell- or recombinant-based vaccines contain:
    - A/Wisconsin/67/2022 (H1N1)pdm09-like virus; (Updated)
    - A/Darwin/6/2021 (H3N2)-like virus
    - B/Austria/1359417/2021 (B/Victoria lineage)-like virus
    - B/Phuket/3073/2013 (B/Yamagata lineage)-like virus
  6. Live attenuated influenza vaccine (LAIV) – or the nasal spray vaccine – is available for use during the 2023-2024 flu season.
    - The LAIV nasal spray is a quadrivalent vaccine that can be administered to people between 2-49 years of age without contraindications to the nasal spray vaccine.
  7. Recommendations for people with egg allergies have been updated for the 2023-2024 flu season:
    - It is no longer recommended that persons who have had an allergic reaction to egg involving symptoms other than urticaria should be vaccinated in an inpatient or outpatient medical setting supervised by a health care provider who is able to recognize and manage severe allergic reactions.
    - Egg allergy alone necessitates no additional safety measures for influenza vaccination beyond those recommended for any recipient of any vaccine, regardless of severity of previous reaction to egg.
    - All vaccines should be administered in settings in which personnel and equipment needed for rapid recognition and treatment of acute hypersensitivity reactions are available.
    - For more information on the changes regarding egg allergies:

<https://www.cdc.gov/mmwr/volumes/72/rr/rr7202a1.htm#:~:text=Regarding%20influenza%20vaccination%20of%20persons%20with%20egg%20allergy%2C%20ACIP%20recommends,health%20status%20can%20be%20used.>

8. Influenza Vaccination of Persons with COVID-19:
  - Those who have moderate or severe COVID-19, vaccination should wait until they have recovered from the acute illness.
  - Those with mild or asymptomatic COVID-19 may receive COVID vaccine though further deferral might be considered to avoid confusing COVID-19 symptoms with potential postvaccination reactions.
  - Other things to considerations for determination of when to vaccinate include current local influenza activity, an individual's risk for severe influenza illness, use of immunosuppressive therapeutic agents.
  - Information concerning precautions for persons with COVID-19 is available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>.

9. The Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend that all U.S. health care workers (HCW) get vaccinated annually against influenza. Since 2002, Maine state law requires that healthcare facilities report data on seasonal influenza vaccine coverage among healthcare workers in their facilities annually to the Maine Center for Disease Control and Prevention (Maine CDC). As of 2021, healthcare workers employed by a licensed nursing facility, residential care facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), multi-level healthcare facility, hospital, or home health agency licensed by the State of Maine are required to show proof of seasonal influenza vaccination.
  - <https://www.maine.gov/dhhs/mecdc/infectious-disease/immunization/providers/documents/Immunization%20Requirements%20for%20Health%20Workers.pdf>

## COVID-19 Vaccination

On September 12, 2023, ACIP approved the updated Fall 2023-2024 COVID-19 vaccine. The updated vaccine is monovalent and designed to target the XBB1.5 Omicron subvariant and boost a person's immunity to COVID-19. The updated vaccines are expected to work well against currently circulating variants of COVID-19, including BA.2.86. The bivalent vaccine is no longer authorized for use.

1. Everyone six months of age and older should receive the updated fall 2023-2024 COVID-19.
  - 1 dose for everyone 5 years of age and older
  - Children 6 months through 4 years of age
  - Initial Vaccination:
    - 2 Doses of Moderna
    - 3 Doses of Pfizer
  - Previously Vaccinated
    - 1 dose of the updated mRNA vaccine
    - Moderately or severely immunocompromised individuals:
  - Initial vaccination:
    - 3-dose series of updated Moderna or updated Pfizer-BioNTech COVID-19 vaccine
  - Received previous mRNA doses:
    - need 1 or 2 doses of either updated mRNA COVID-19 vaccine, depending on the number of prior doses
    - May receive 1 or more additional updated mRNA COVID-19 vaccine doses
2. Most people are able to be vaccinated now.
  - Individuals who have been recently vaccinated with another COVID-19 vaccine should wait two months post previous vaccination.
  - Individuals that have recently been infected with the COVID-19 virus: should wait three months post infection.
  - May consider administering the vaccine sooner if there is a strong likelihood the patient will not be back in the providers office at the end of the three-month suggested waiting period. Early vaccination does not pose a risk to the individual, though the immune response may not be as robust with early vaccination.
3. Presentations: Currently, both Moderna and Pfizer have updated mRNA vaccines for Fall 2023-2024. Storage and handling for these vaccines is the same as previous iterations. Most of the Fall 2023-2024 COVID-19 vaccines are packed in single dose vials/syringes except Pfizer under 5 (3 dose vials).
  - Pfizer/Comirnaty

- 6 months to 4 years has a yellow cap and needs to be diluted.
  - 5 years to 11 years has a blue cap.
  - 12 years and older has a gray cap.
  - Moderna/Spikevax
  - 6 months to 11 years has a blue cap and green label.
  - Moderna for persons 12 years and older has a blue cap and blue label.
  - New Novavax product expected to be approved soon (not mRNA).
4. Commercialization: The United States Government (USG), up until recently, supplied all COVID-19 vaccines in the United States free of charge to patients. With the transitions to commercialization, COVID-19 is no longer provided solely by the USG and is now available on the open market. The USG continues to provide COVID-19 vaccine in a more limited capacity for un and uninsured individuals at no cost to the patient and health insurance companies cover the cost for their beneficiaries.
- COVID-19 Vaccines are available to everyone 0 through 18 years of age in Maine at no cost. Vaccine for all routine childhood vaccines, including COVID-19 vaccine, is covered under the following programs: \*
    - The federal Vaccine for Children Program provides vaccines at no cost to patients that are un and underinsured children
    - Maine’s Universal Childhood Vaccine Program covers the cost for insured children.
  - Vaccine Access for Adults
    - Vaccine for insured individuals will be charged to their health insurance company.
    - The Federal Bridge Access Program supplies a limited number of vaccines at no cost to un and underinsured individuals.
    - The Bridge Access Program is administered by the Maine Immunization Program (MIP) as well as through the federal Pharmacy Program.
    - MIP Providers:
      - Providers can no longer be COVID only
      - Must meet all MIP requirements
    - MIP continues to recruit Bridge Access Providers in the following organizations:
      - FQHC’s
      - IHS
      - Public Health Departments
      - Community Pharmacy
      - Jails/Correctional Facilities
    - Pharmacy Program Providers:
      - CVS
      - Walgreens
      - eTrue North

\*This applies only to vaccine administered at a provider enrolled with the Maine Immunization Program or with the federal Bridge Access Program

## Respiratory Syncytial Virus (RSV) Vaccination

On June 21, 2023, ACIP voted to recommend that adults aged  $\geq 60$  years may receive a single dose of an RSV vaccine, using shared clinical decision-making. Later this year, in August of 2023, ACIP also voted to recommend a dose of nirsevimab to all babies under eight months old entering their first RSV season. ACIP also recommended a protective dose in their second RSV season for older babies, those 8 to 19 months old who remained at risk of severe RSV infection as well as for pregnant people in September of 2023.

1. Respiratory Syncytial Virus (RSV) Vaccines for Infants.

- Nirsevimab, trade name Beyfortus, is the first vaccine/monoclonal antibody approved for the general population of infants up to 24 months designed to protect infants from severe RSV disease.
  - Children at greatest risk for severe illness from RSV include the following:
  - Premature infants
  - Infants up to 12 months, especially those 6 months and younger
    - Children younger than 2 years with chronic lung disease or congenital heart disease
    - Children with weakened immune systems
    - Children who have neuromuscular disorders, including those who have difficulty swallowing or clearing mucus secretions
  - Who should get the vaccine:
  - Infants born during or entering their first RSV season
    - Children up to 24 months of age who remain vulnerable to severe RSV disease through their second RSV season.
  - Administered by intramuscular injection.
  - Single dose vial/pre-filled syringe (50mg and 100mg)
  - Dosing
    - 50mg for those weighing less than 5kg
    - 100mg for those weighing over 5kg
    - For older infants, up to 24 months, who remain at increased risk for RSV in their second RSV season, a single 200mg dose is recommended
  - One Dose per RSV season
  - Provides protection for at least 5 months (the average length of one season)
2. Respiratory Syncytial Virus (RSV) Vaccines for Older Adult.
- ACIP and CDC recommend that adults ages 60 years and older may receive a single dose of RSV vaccine using shared clinical decision making. There is no preferential recommendation; give whichever vaccine is available.
- Arexvy (GSK) is a recombinant vaccine using the RSV F protein antigen
    - Dosing: Single dose, once reconstituted is .5ml
    - Efficacy of 86.2% for the first season
  - Abrysvo (Pfizer) is a recombinant vaccine using the RSV F protein antigen
    - Dosing: Single dose, once reconstituted is .5ml
    - Efficacy of 88.9% for the first season
3. Respiratory Syncytial Virus (RSV) Vaccines for Pregnant People
- ACIP approved administration of Abrysvo to pregnant people in the third trimester to provide protection to infants for the first five months after birth. Pregnant people should receive the vaccine between the 32 and 36 weeks of pregnancy.
4. State Supplied RSV Vaccine Roll Out
- Infants
    - Un and Underinsured Infants will be covered under the Vaccines for Children Program
    - The Maine Vaccine Board will vote on whether to include RSV Vaccine in the Universal Childhood Vaccine Program for insured children
    - State supplied RSV vaccine in anticipated later this month pending allocations from federal CDC.
  - Adults
    - MIP plans to carry adult RSV vaccine for un and underinsure adults.
    - Vaccine will likely towards the end of the calendar year.

Coadministration

Providers may simultaneously administer COVID-19, influenza, and respiratory syncytial virus (RSV) vaccines to eligible patients.

## Clinical Recommendations

### Influenza treatment

- Treatment is recommended as soon as possible for any patient with suspected or confirmed influenza who:
  - Is hospitalized;
  - Has severe, complicated, or progressive illness; or
  - Is at higher risk for influenza complications (including those  $\geq 65$  years).
- Treatment should not wait for laboratory confirmation of influenza.
- Oral oseltamivir, oral baloxavir, inhaled zanamivir, and intravenous peramivir can be used for older adults.
- Zanamivir not recommended for people with underlying respiratory disease (e.g., asthma, chronic obstructive pulmonary disease).
- Additional information on use of antivirals for treatment and chemoprophylaxis is available at: [Influenza Antiviral Medications: Summary for Clinicians](https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm) (<https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm>)

### COVID-19 treatment

- There is strong scientific evidence that [antiviral treatment](#) of outpatients at risk for severe COVID-19 reduces their risk of hospitalization and death.
- The antiviral drugs Paxlovid (ritonavir-boosted nirmatrelvir) and Veklury (remdesivir) are the preferred treatments for eligible adult and pediatric patients with positive results of direct SARS-CoV-2 viral testing and who are at high risk for progression to severe COVID-19.
  - Paxlovid is preferred, followed by Remdesivir. Lagevrio (Molnupiravir) is an alternative therapy for use only when neither preferred therapy is available, feasible to use, or clinically appropriate.
- Clinicians should consider COVID-19 treatment in non-hospitalized patients who meet all of the following:
  - Test positive for SARS-CoV-2 (with PCR or antigen test, including at-home tests)
  - Have symptoms consistent with [mild-to-moderate COVID-19](#). People with mild COVID-19 experience symptoms such as fever, sore throat, cough, or headache that do not affect the lungs and breathing. People with moderate illness have symptoms that affect the lungs like shortness of breath or difficulty breathing.
  - Are within 5 days of symptom onset for Paxlovid or 7 days of symptom onset for Veklury
  - Have one or more risk factors for severe COVID-19
- Risk factors for severe COVID-19 include:
  - Age over 50 years, with risk increasing substantially at age  $\geq 65$  years
  - Being unvaccinated or not being up to date on COVID-19 vaccinations
  - Specific medical conditions and behaviors
- Some people from racial and ethnic minority groups are at risk of being disproportionately affected by COVID-19 from many factors, including limited access to vaccines and healthcare. Healthcare providers can consider these factors when evaluating the risk for severe COVID-19 and use of outpatient therapeutics.

## Infection Control

- Distinguishing between the different respiratory illnesses especially early in a person's illness can be very difficult. Patients, Residents, and HCP with respiratory infections may not have fever or may have fever alone as an initial symptom or sign. Therefore, facilities should have a comprehensive respiratory

management plan to promptly identify, respond, and manage patients, residents, and HCW who present with respiratory symptoms to prevent spread. The plan should minimally address the following areas:

- Respiratory hygiene and cough etiquette
- When source control for HCP, patients, and residents should be implemented.
- Process for rapidly identifying HCP, patients, and residents with respiratory symptoms.
- Process for implementing and discontinuing the appropriate transmission-based precautions for the disease of concern (*examples could include contact, droplet, or Airborne based on disease*).
- Workplace policies for work restriction for HCP with respiratory illnesses or fever by specific disease type guidelines. Noting, HCP with fever alone should follow workplace policy for HCW with fever until a more specific cause of fever is identified or until fever resolves. Manage ill healthcare personnel (HCP). Instruct ill personnel not to report to work and if at work to stop patient/resident-care activities, don a facemask and promptly notify their supervisor they are ill.
- Availability of personal protective equipment and HCP training/education
- Hand hygiene policies, education, and training for HCP, patients, residents, and visitors
- Policies and process to maintain a safe environment of care, including but not limited to cleaning & disinfection, air handling and of Airborne Infection Isolation Room capabilities.
- Vaccination (where applicable) promotion, education, and availability for HCP, patients, residents, and HCP.
- Testing capabilities
- Planning for potential surges with a facility
- Note, as of 2021, healthcare workers are required to show proof of seasonal influenza vaccination. Some facilities may choose to have vaccine exempt healthcare workers wear a mask. Initiation and discontinuing dates are dictated by facility policies, not by Maine CDC.
- Guidelines for Infection Prevention and Control of Respiratory illness and season outlooks for illnesses such as Influenza, SARS-CoV-2, and RSV can be found at the following websites:
  - SARS-CoV-2 Guidance: [U.S. CDC SARS-CoV-2 Infection Prevention and Control](#) & [U.S. CDC Guidance for Managing Healthcare Personnel with SARS-CoV-2](#)
  - Influenza Guidance: [U.S. CDC Influenza Infection Prevention and Control Guidance](#)
  - RSV Guidance: [U.S. CDC RSV for Healthcare Providers](#) & [U.S. CDC Appendix A Transmission-Based Precautions](#)
  - Respiratory Disease Season Outlook: [U.S. CDC Respiratory Disease Season Outlook](#)
  - General Education – Project Firstline: [Maine Infection Prevention](#)
- Updated 2023-2024 Prevention and Treatment of Influenza in Long-Term Care Facilities guidelines will be available at [Maineflu.gov](#)

## Laboratory

- HETL offers respiratory virus real time PCR testing that includes:
  - Influenza A/B (no charge)
  - SARS-CoV-2 (no charge)
  - Adenovirus
  - Enterovirus
  - Parainfluenza viruses 1-4
  - Rhinovirus
  - RSV
- The respiratory viral panel costs \$550 total, or \$110 per specific agent. Influenza and SARS-CoV-2 can be tested separately at no cost.
- All specimens must be accompanied by the HETL requisition form.

- HETL is requesting that laboratories send up to 3 influenza A and 1 influenza B positive specimen to HETL each week for further analysis.
- Any suspect novel, or influenza strains which do not type, must be sent to HETL for confirmation.
  - Please send any samples on patients who have swine or avian contact to HETL as they are the only lab that can determine if the illness is due to swine or avian influenza.
  - Also, please submit any positive influenza samples from patients who have traveled to China or neighboring countries, have been exposed to poultry and develop flu-like symptoms.
- Please forward any suspected co-infections (positive for both A and B on a rapid test) to HETL for confirmation.
- Consider sending samples for PCR testing on any hospitalized patient with a clinically compatible illness and a negative rapid test with no other etiology determined.
- Facilities may be asked to submit extra specimens if the circulating strains are found to be different from the vaccine strains.

### Reporting Requirements

- Influenza outbreaks are required to be reported.
  - Outbreak definitions differ by facility type, but any sudden or unusual increase should be reported.
  - Long-term care facilities
    - Two or more residents with respiratory illness when at least one has lab confirmation
      - Suspect an outbreak with one laboratory-confirmed influenza positive case (by any testing method).
    - Influenza and SARS-CoV-2 testing should occur when any resident has signs and symptoms that could be due to influenza or COVID-19, especially when two residents or more develop respiratory illness within 72 hours of each other.
  - Acute care facility nosocomial outbreak
    - One or more patients with laboratory-confirmed influenza with symptom onset greater than or equal to 48 hours post-admission.
  - School or childcare facilities
    - Greater than or equal to 15% absenteeism among students where the majority of those absent report influenza-like illness and no other etiology has been identified.
- COVID-19 outbreaks are required to be reported. COVID-19 outbreaks are defined by the facility type.
  - Acute care facilities
    - 5 or more cases of COVID-19 in staff or patients admitted at least 4 days prior to infection within a 14-day period.
  - K-12 schools
    - Greater than or equal to 15% absenteeism among students where the majority of those absent are due to COVID-19 and no other etiology has been identified.
  - All other facilities
    - 5 or more COVID-19 cases, from different households, within a 14-day period
- RSV outbreaks are required to be reported.
  - Childcare facilities
    - 3 or more cases, from different households, within an 8-day period
  - All other facilities
    - A sudden increase of RSV over the normal background rate in this population.
- Please report all outbreaks by phone at 1-800-821-5821 or by e-mail to [disease.reporting@maine.gov](mailto:disease.reporting@maine.gov) (no confidential information by e-mail).
- Pediatric influenza-associated deaths are required to be reported. Please report by **phone at 1-800-821-5821** or by **fax to 207-287-6865**.

- Laboratory confirmed influenza hospitalizations are required to be reported. These can be reported as they occur or in aggregate on a weekly basis.
  - Reporting through REDCap survey is the preferred method for reporting.
    - A reporting reminder and access to REDCap will be sent through the APIC listserv.
    - Please email [Influenza.DHHS@Maine.gov](mailto:Influenza.DHHS@Maine.gov) for access or questions.
  - Individual lab reports with the hospitalization status (or patient location) indicated is sufficient.
  - Line lists submitted weekly are acceptable and preferred for facilities with high volume.
    - Minimum information to be included on a line list is:
      - Facility name
      - Test date
      - Test result (A, B, subtyping if available)
      - Patient name (if lab submits reports electronically patient initials are sufficient)
      - Patient DOB
      - Gender
      - Some geography indicator (patient address, patient city, or patient zip)
      - Hospitalization status
  - If your facility reports influenza results through Electronic Laboratory Reporting (ELR), check with your IT department to determine what field in your electronic medical record could be used to denote hospitalization status (ie. patient status, patient class, patient location etc.). This field can then be mapped to the HL7 message used for reporting laboratory results.
    - For any IT questions regarding this requirement, contact your HealthInfoNet representative.
    - The HL7 field that will need to be populated is PV1 2 PatientClass.
    - ELR message will only include the status at the time of collection, so if a patient is tested in the ER and then admitted, the ELR might not be sufficient for reporting hospitalized cases.
  - Even if your facility reports electronically, a verification of hospitalizations is required. ELR information is not always correct and cannot be relied on as the sole information source.
- Novel influenza is reportable. Cases with high suspicion for novel influenza include patients with known agricultural exposures (swine, domestic birds, wild birds). Please notify Maine CDC and forward the sample to HETL for typing.
- CLIA approved or waived SARS-CoV-2 positive laboratory results are required to be reported to Maine CDC.
- Maine CDC appreciates reports of **all positive influenza** tests, by any testing method. These can be reported by fax to 207-287-6865, by phone to 1-800-821-5821, or through electronic laboratory reporting.

### Emergency Preparedness

- As in years prior, Maine's Public Health Emergency Preparedness (PHEP) will conduct statewide bed availability polls upon request. You can contact the Emergency Communication Systems Coordinator (Nate Riethmann / [nathaniel.riethmann@maine.gov](mailto:nathaniel.riethmann@maine.gov) / (207) 287-6551) to request a poll. We are already capturing some bed availability data via our ongoing COVID-19 daily polls, but we can easily create a new event for any influenza-related surges that occur and can include additional bed types as needed.
- The Health Care Coalition of Maine may be able to provide logistical support to healthcare facilities in the event that a novel influenza strain is identified resulting in an abnormally high surge event.
  - Logistical support may include: emergency communications, strategic national stockpile (SNS) resources such as medical countermeasures, medical volunteers, personal protective equipment (PPE), and supplies.
- The Maine CDC Pandemic Influenza Operations Plan can be accessed on line at [www.maineflu.gov](http://www.maineflu.gov).

- In the event of local or spot shortages of antiviral medications, please contact the Northern New England Poison Center (NNEPC) at 1-800-222-1222 to report any above-average antiviral shortages.
  - The poison center will work with local providers and Maine CDC to identify sources of antiviral medications
  - Please provide the NNEPC with the following information:
    - What drug and formulation are you having difficulty ordering?
    - How much are you attempting to order?
    - From what pharmaceutical vendor(s)?
    - Have you contacted any other facilities in the area?
    - Any other supporting information; how long it's back-ordered, etc.

## Resources

- Weekly surveillance reports are available at [www.maine.gov/dhhs/flu/weekly](http://www.maine.gov/dhhs/flu/weekly). If you would like to automatically receive these reports, please subscribe at <https://public.govdelivery.com/accounts/MEHHS/subscriber/new?preferences=true>
- Maine COVID-19 data can be found at <https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus/data.shtml>
  - General COVID-19 information can be found at <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- Maine and National RSV trends are published at <https://www.cdc.gov/surveillance/nrevss/rsv/state.html>
  - General RSV information can be found at <https://www.cdc.gov/rsv/index.html>
- Notifications of significant public health events and updates are sent through The Maine Health Alert Network System (HAN). This is the primary communication method for influenza events, including conference calls, widespread notices, and antiviral recommendation changes. If you're not already a member, joining the HAN is as simple as heading to [www.mainehan.org](http://www.mainehan.org), clicking the "Register Now" button, and filling out the registration form. If you have any questions about the registration process or the Health Alert Network in general please contact the Maine Health Alert Network Coordinator at [nathaniel.riethmann@maine.gov](mailto:nathaniel.riethmann@maine.gov)
- Information on provider group specific testing, reporting, and influenza management, as well as information regarding vaccines, non-seasonal influenza, and general influenza facts and materials can be found at [www.maineflu.gov](http://www.maineflu.gov).
  - Additional information on influenza vaccines can be found at <https://www.immunizeme.org>
- Influenza and respiratory season-related posters can be ordered from our website at <https://www.maine.gov/dhhs/order>.
- Maine CDC's influenza specific email address, [influenza.dhhs@maine.gov](mailto:influenza.dhhs@maine.gov), can be used for any influenza related questions, or to send de-identified line lists. This e-mail is not secure so please do not send any patient identifiable information without utilizing a secure protocol (locked spreadsheet, log in required etc.).

## Questions

Q: Is there a program within Maine to help cover the RSV vaccine for uninsured or underinsured individuals?

A: Un and Underinsured Infants will be covered under the Vaccines for Children Program. The Maine Vaccine Board will vote on whether to include RSV Vaccine in the Universal Childhood Vaccine Program for insured children. State supplied RSV vaccine is anticipated later this month pending allocations from federal CDC.

MIP plans to carry adult RSV vaccine for un and underinsure adults. Vaccine will likely be available towards the end of the calendar year.

Q: When will RSV vaccine be available for children?

A: MIP anticipates vaccines will become available in later October month pending allocations from federal CDC.

Q: Does LAIV nasal spray influenza vaccine cover the vaccine requirement for healthcare workers?

A: Yes, nasal spray is available for this flu season and would cover the requirement for healthcare workers.

Q; Why should individuals wait to get a COVID-19 vaccine if they had been recently vaccinated with another COVID-19 vaccine or were recently infected with COVID-19? We are trying to get a vaccination clinic together for my facility just coming out of outbreak. Should we wait?

A: Early vaccination does not pose a risk to the individual, though the immune response may not be as robust as it would if they waited. However, you can offer the vaccine now. There will be people who did not just recover from infection. You can give people the option to wait longer and get it elsewhere if they prefer.

Q: Any idea when we may be able to purchase COVID-19 vaccine from our vendors such as vaxserve or Henry Schein?

A: Vaccine is commercially available, but slowly rolling out. Unsure about the individual vendor policies.

Q: Is there a way for a Long-term care facility to have a clinic for the COVID-19 and RSV vaccines for our residents? The cost of the vaccines is a barrier and our pharmacy is saying we will have to incur the cost they are not able to bill individual insurances. Most of our residents would have MeCare as their payment source?

A: Vaccine clinics are encouraged, but there are no state resources to support at this time.

Q: Should we be calling RSV monoclonal antibodies a "vaccine" when discussing it with parents?

A: Federal CDC uses the term vaccine, but more education may be helpful or necessary for certain parents.

Q: Who is billed for respiratory viral testing?

A: The bill would go to the provider facility but can then be billed against the patient's insurance. Influenza A/B screening and subtyping tests are at no charge. SARS-CoV-2 testing is also at no charge.

Q: Does the hospital or the LTC facility report influenza hospitalization?

A: It is the hospital's responsibility to report influenza hospitalizations.

Q: Are positive point of care (POC) SARS CoV-2 rapid tests done at a walk-in clinic also reportable?

A: Yes, all SARS-CoV-2 POC tests done by providers should be reported. You can do this through the REDCap online reporting system. Information on that system can be found here:

<https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/documents/POC-Reporting.pdf>

Q: What is the definition of a hospital onset COVID-19 case?

A: Healthcare-acquired COVID-19 in hospitals is a laboratory confirmed COVID-19 case in a patient 4 or more days after admission.

Q: Fit test kits are expensive - are there resources available to obtain fit test kits at low or now costs?

A: District Liaisons have resources for facilities to do fit testing. Please contact your local District Liaison. Contact information can be found at <https://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/index.shtml>

Q: Is there any specific COVID-19 vaccine brand requirement for individuals concerned with Guillain-Barre syndrome?

A: No, there is no brand requirement.

Q: When do you anticipate the influenza weekly surveillance reports becoming available?

A: The first report this season will be available October 17. You can access the reports at [www.maine.gov/dhhs/flu/weekly](http://www.maine.gov/dhhs/flu/weekly).

Q: Will Maine CDC be tracking uptake of updated COVID vaccine across the state and is this data available publicly or through federal CDC?

A: While Maine continues to collect data on COVID-19 vaccinations, the publicly facing dashboard is no longer updated. For the updates please refer to CDC COVID DATA TRACKER: <https://covid.cdc.gov/covid-data-tracker/#vaccine-delivery-coverage>

Q: No longer having access to ImmPact has been a barrier in finding vaccine status for our new admissions. It has made it a lot more difficult. Would MIP reconsider recent changes to restrict access to ImmPact?

A: Access to ImmPact has always been limited to fully enrolled Vaccines for Children (VFC) Providers until the public health emergency occurred. At that point, allowances were made for the outside entities to view and obtain COVID-19 information for their patient, staff, or clients. Now that the public health emergency has ended, this access is once again limited to fully enrolled providers.