# Webinar Recap for October 18th, 2021

LTC+ Acting on Pandemic Learning Together

## TOPIC

Planning for Influenza and COVID-19

## KEY AREA(S)

Planning for COVID-19 and NON-COVID-19 Care

## SPEAKER(S)

- Bryna Warshawsky, Medical Advisor, Public Health Agency of Canada

## OBJECTIVES

- To share information regarding the upcoming respiratory virus season, as well as the influenza and COVID-19 vaccines

## SUMMARY

- Various respiratory viruses circulate in a given year, all of which can cause outbreaks in LTC. While droplets and to a lesser extent, contact, have generally been considered the main route of transmission, we have learned that COVID-19 and influenza and perhaps other viruses can also be transmitted by aerosol. By controlling COVID-19 through IPAC measures, the transmission of other respiratory viruses is likely to also be prevented.
- The influenza virus consists of two main types – A and B. Influenza A contains many subtypes. A/H1N1 and A/H3N2 are the main influenza A subtypes that cause infection in people. Influenza B contains two lineages B/Yamagata and B/Victoria. One or more A/H1N1 or A/H3N2 strains with one or more B lineages tend to circulate in any given influenza season. Mutations occur in all subtypes and lineages, impacting the strain(s) in circulation in any given year. This is why the strains to include in the influenza vaccine are reviewed each year for the upcoming season's influenza vaccines.
- This past year, COVID-19 was the main virus in circulation. Lack of circulation of other viruses may increase the population's susceptibility to a more substantial influenza and other respiratory virus season in 2021-2022 due to a reduced immunity to other respiratory viruses from last year.
- In Canada, influenza is estimated to result in approximately 12,000 hospitalizations and 3,500 deaths in a year, of which older adults are the most impacted. It tends to be introduced between November and April, and cause disease in a community for 2-3

months before subsiding. Symptoms typically last 2-7 days and includes a fever, cough, runny nose, muscle aches, fatigue and sore throat.

- The most common complication of influenza is pneumonia, and influenza can also worsen other underlying health conditions (i.e., heart and lung disease). Those most at risk for complications include people with chronic underlying medical conditions, the elderly, infants and young children, pregnant women, Indigenous populations and those suffering from obesity.
- While COVID-19 and influenza have some commonalities, important differences exist regarding symptoms, communicability, severity, types of vaccines, and antiviral medications available.
- Vaccination for both influenza and COVID-19 is important to prevent the circulation of the viruses simultaneously. This can potentially decrease the burden on our health care system, decrease illness that can be confused with COVID-19 therefore decreasing need for COVID-19 testing, reduce the chance of outbreaks in LTC homes and decrease the chance of co-infection in individuals, and reduce the chance of outbreaks with both viruses in the same facility.
- The influenza vaccine is made each year in anticipation of the influenza strains that are likely to circulate. The vaccines are approximately 50% effective, depending on the match between vaccine strain and circulating strain, vaccine type, underlying medical conditions and age. Those who are not infected cannot spread infection to others.
- The most common influenza vaccine is quadrivalent, which contains four, inactive, strains: two strains influenza A (one each of the H1N1 and H3N2 subtype) and two influenza B strains (one from the B/Victoria and the other from the B/Yamagata lineage) (15 micrograms per strain). The following two products are available specifically for adults 65 years of age and over: the Fluzone high dose quadrivalent vaccine (60 microgram per strain), and Fluad trivalent adjuvanted vaccine containing two strains of influenza A and one of influenza B. The high dose vaccine in older adults enhances the immune response and will be available for all those 65 years or older in LTC this year, and potentially to other older adults as well.
- The COVID-19 vaccine can be administered at the same time as, or before and after, the influenza vaccine and other vaccines.
- In preparing for the upcoming respiratory virus season, LTC homes should continue to prevent the introduction of COVID-19 and other respiratory viruses, and facilitate early detection through screening, rapid testing and ensuring ill staff stay at home. Further, IPAC measures (i.e., physical distancing, universal masking, PPE use, etc.) should be continued for source control and risk reduction. Further, LTC homes should:

- Administer both the influenza vaccine and booster dose of the COVID-19 vaccine; these vaccines can be administered at the same time if helpful for the efficient delivery of vaccines.
- Involve your local public health unit or authority, including an understanding of how to contact the local health unit at all times in the case of a suspected or confirmed influenza or COVID-19 outbreak, protocol for isolating residents with respiratory symptoms until receiving direction from the local health unit, summarizing key information about residents through tools such as a line list
- Determine the testing protocol for SARS-CoV-2, influenza and other viruses
- Identify an outbreak management team, as well as set clear roles and responsibilities for its members
- Prepare to use antiviral medication for influenza in LTC or retirement homes to treat ill residents, prevent influenza in residents who don't have influenza symptoms and control the outbreak. As antiviral medications should be instituted quickly when an influenza outbreak is identified, this requires advanced planning and rapid dispensing of antiviral medications. For example, oseltamivir is commonly prescribed and taken orally twice a day for five days for ill residents during an influenza outbreak or for well residents, once a day until the outbreak is over or for 10 or 14 days, following the local public health unit's advice.
- Prepare to cohort ill residents, particularly during a COVID-19 outbreak, and to use staff cohorting (i.e., designated staff for patients with similar diagnoses).
- Have a communication plan in place in case of an outbreak including: sharing information with staff, residents, families, other LTC homes, community healthcare facilities and emergency services workers; accessing and sharing information with the local public health unit; and interacting with the media while coordinating responses with the local public health unit

- COVID-19 vaccine effectiveness declines over time; however, vaccination remains quite protective against severe illness for most people. The National Advisory Committee on Immunization (NACI) recommends additional doses for those with immunocompromising conditions (the third dose is given at least 28 days after the second), and booster doses for those living in LTC, RH and other congregate living settings at least 6 months from the last dose. NACI is considering additional recommendations regarding booster doses.
- Among emerging COVID-19 interventions to watch for is molnupiravir, an oral treatment that reduces the risk of hospitalization or death by 50% in those with mild-to-moderate COVID-19 infection, and AZD7442, which provides passive protection against COVID-19 for up to a year in individuals who may not respond well to the vaccine or are at high risk.

## RESOURCES SHARED

- Effectiveness of mRNA BNT162b2 COVID-19 vaccine up to 6 months in a large integrated health system in the USA: a retrospective cohort study
- The Safety and Immunogenicity of Concomitant Administration of COVID-19 Vaccines (ChAdOx1 or BNT162b2) with Seasonal Influenza Vaccines in Adults: A Phase IV, Multicentre Randomised Controlled Trial with Blinding (ComFluCOV)

## WEBINAR RECORDING

- Watch the full webinar here!