

St. Teresa Rehabilitation and Nursing Center
Bishop Primeau Senior Living Community
519 Bridge Street
Manchester, NH 03104
T: 603-668-2373
F: 603-668-0059
stteresarehabcenter.org



December 16, 2020

Hello Families, residents, staff and Friends.

We tested Monday and result are back today. We did have a staff member test positive. It does not affect our standing unless more test positive. We will be doing Point of Care testing, (in house) with 15 Minutes results, for our second testing this week.

Vaccine update: Walgreens has called and they are scheduling our first vaccine clinic 12/28. The follow up clinic will be 3 weeks later. We are hoping to get staff and residents done.

- Only those of you who are the activated POA for your loved one, must sign the first page and return to us. If a POA is not activated, the resident may consent. Ellen Eldridge has reached out on separate email to the activated POAs. WE need the signed consents in our hands by 12/23 to be ready for our clinic. Please return to Ellen Eldridge, by scanning and email to her. stt.sw@nh-cc.org or mail it back to us ASAP, or
- If you need a hard copy mailed to you, please call 668-2373 ext. 4695 to request one via mail.
- If you want to stop by St. Teresa's, we will give you a copy to sign at the door. Just call and let us know.

We hope the education attached is helpful as well. Feel free to look at other resources that are annotated. If you have questions, we are happy to try to get you helpful answers.

Kindly,

A handwritten signature in black ink that reads "Luanne Rogers". The signature is fluid and cursive, with a large loop at the end of the last name.

Luanne Rogers
Administrator

Vaccine Administration Record (VAR)

Informed Consent for Vaccination in Long Term Care Facility (LTCF)



SECTION A-1 Please print clearly.

First name: _____ Last name: _____

Date of birth: _____ Age: _____ Gender: Female Male Phone: _____

LTCF Name: _____ Address: _____

City: _____ State: _____ ZIP code: _____ Patient Email address: _____

I want to receive the following vaccination(s): **COVID-19 Vaccination**

SECTION A-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Walgreens or Duane Reade and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above.

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable.

I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. Walgreens may disclose your vaccination information from this visit for public health purposes and will send this information to the Medical Director or Administrator of the LTCF identified above. If you are an employee of the LTCF, Walgreens will send your vaccination information to your employer as required.

Print Name: _____ Patient/Authorized Person signature: _____ Date: _____

SECTION B-1

SCREENING QUESTIONS. The following questions will help us determine your eligibility to be vaccinated today.

1. Do you feel sick today? Yes No Don't know
2. Do you have any health conditions, such as heart disease, diabetes or asthma? Yes No Don't know
If yes, please list: _____
3. Do you have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? Yes No Don't know
If yes, please list: _____
4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? Yes No Don't know
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem? Yes No Don't know
6. **For women:** Are you pregnant or considering becoming pregnant in the next month? Yes No Don't know

SECTION B-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/LTCF Representative: _____ Date: _____

SECTION C INSURANCE – PATIENT TO COMPLETE IF APPLICABLE

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed at Walgreens.

Non-Medicare:	Pharmacy Card	Medical Card	Medicare:	Medicare Part B
Insurance Plan/Plan ID:			Medicare Number*:	
Member/Recipient ID #:			*Medicare Claim Number for cards distributed earlier than 2018.	
RX BIN:		N/A		
RX PCN:		N/A		
Group Number:				

Is the patient the cardholder? Yes No

If no, please provide cardholders name, date of birth (MM/DD/YYYY) and relationship: _____

SECTION D HEALTHCARE PROVIDER ONLY

Complete **BEFORE** vaccine administration

- I have reviewed the **Patient Information** and **Screening Questions**. Initial here: _____
- I have verified that this is the **vaccine requested** by the patient. Initial here: _____
- This vaccine is appropriate for this patient based on the **Age Guidelines and Other Guidelines** provided by federal and/or state regulations and company policies. Initial here: _____
 - 3a. Does this patient have a high-risk medical condition? Yes No
 - If yes, please list medical condition(s): _____
- The **Vaccine NDC matches** the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (Perform **3-way NDC match**.) Initial here: _____
- I have verified the **Expiration Date** is greater than today's date and have entered the **Lot # and Expiration Date** in the field below. Initial here: _____

SECTION E Complete DURING the patient interaction

- I confirm(ed) the patient's **Name, DOB and Requested Vaccine** and verified it matches the information on the VAR form. Initial here: _____
- I have reviewed the **Screening Questions** and answers. Initial here: _____
- I provided a **EUA Fact Sheet** to the patient or the LTCF representative. Initial here: _____

SECTION F

Complete **AFTER** vaccine administration

Vaccine	NDC	Manufacturer	Dosage	<input type="checkbox"/> Dose 1	Site of administration	EUA Fact Sheet published date
				<input type="checkbox"/> Dose 2		

Clinician's name (print): _____ Clinician's signature: _____ Title: _____

If applicable, intern/tech name (print): _____ Administration date: _____ Date EUA Fact Sheet given to patient: _____

COVID-19 VACCINE LOT# _____ COVID-19 VACCINE EXPIRATION DATE _____

- Update the patient's record with any new allergy, health condition or primary care provider information.
- Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.

COVID-19 VACCINE: ANSWERS TO YOUR QUESTIONS

A PRESENTATION FOR STAFF AND
RESIDENTS IN POST-ACUTE AND
LONG-TERM CARE



THE SOCIETY
FOR POST-ACUTE AND
LONG-TERM
CARE MEDICINE™



WHY SHOULD I GET VACCINATED?

- Protect myself and my family
- Keep my residents safe
- Help stop spread in the community
- Set the example for others, including residents, families, co-workers, and the community-at-large

COMMON QUESTIONS WE WILL ADDRESS:

- How do we know the vaccine is effective and safe?
- Why should we trust the vaccine?
- Is there new technology being used and is that dangerous to me?
- What is an EUA and what does that mean for me?
- When and how long will I be protected?
- Will I still need to wear a mask?
- What are the expected side effects?
- What if I've already had COVID-19?
- Where should I look to get accurate information?

ARE THE COVID-19 VACCINES SAFE?

- Safety is the most important priority in vaccine approval
- Most side effects occur within 6 weeks of vaccination. To be more cautious, the FDA (Food and Drug Administration) requires 8 weeks of safety monitoring of the COVID-19 vaccines
- Monitoring for safety will continue as the vaccine is distributed to the public
- To assess safety FDA typically advises that a minimum of 3,000 participants are included in the trial. The current COVID-19 vaccine trials include 30,000 to 50,000 participants

HOW EFFECTIVE ARE THE COVID-19 VACCINES?

	Pfizer (BNT162b2)	Moderna (mRNA-1273)
Efficacy Overall	95% protection from having an infection	94.1% protection from having an infection

Similar efficacy with different race, ethnicity and age

WHO WAS INCLUDED IN THE COVID-19 VACCINE TRIALS?

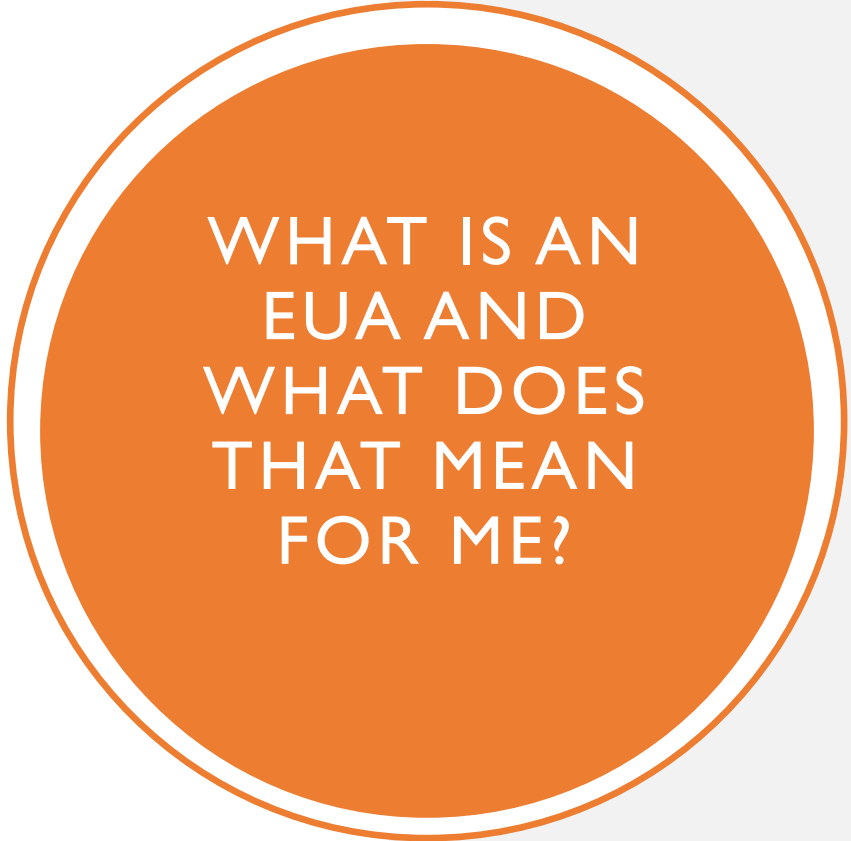
	Pfizer (BNT162b2)	Moderna (mRNA-1273)
Number of people enrolled	Over 40,000	Over 25,000
Race and ethnicity of participants	Total 30% racially diverse 10% black, 13% Hispanic	37% racially diverse 10% black, 20% Hispanic/Latino
Older adults	45% were 56-85 years	23% were >65 years

- **Notes:** Courtesy of Dr. Anuj Mehta, Data is accurate as of 11/18/2020. More information is constantly becoming available. Sub-group comparisons (e.g. comparisons about efficacy between races or age groups) may be less accurate due to smaller numbers. Sub-group numbers for the Pfizer vaccine are given for US participants with international percentages in parentheses.
- <https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biotech-conclude-phase-3-study-covid-19-vaccine>
- <https://www.pfizer.com/science/coronavirus/vaccine>
- <https://investors.modernatx.com/news-releases/news-release-details/modernas-covid-19-vaccine-candidate-meets-its-primary-efficacy>
- https://www.modernatx.com/sites/default/files/content_documents/2020-COVE-Study-Enrollment-Completion-10.22.20.pdf

WHY SHOULD WE TRUST THE COVID-19 VACCINE?

- The FDA is using the same strict standards that it has for decades
- No steps are “skipped”
- **Two independent advisory committees** are reviewing the results. Members and experts of these committees have no conflict of interest and are not associated with any vaccine manufacturers
 1. The Vaccine and Related Biological Products Advisory Committee (VRBPAC) that advises the FDA
 2. The Advisory Committee on Immunization Practices (ACIP) that advises the CDC

- **An Emergency Use Authorization (EUA)** for a vaccine is based on the need to use a vaccine quickly to save lives during a public health emergency
- EUA is a shorter process **but no steps are skipped in the safety evaluation process**
- The FDA will assess if the vaccine known and potential benefits outweigh the known and potential risks
- Two separate advisory boards (VRBPAC and ACIP) will also review the data and make recommendations
- **An EUA does NOT imply that the authorization was done too quickly or that the vaccine is not safe**



WHAT IS AN
EUA AND
WHAT DOES
THAT MEAN
FOR ME?

HOW WAS THE VACCINE DEVELOPED SO QUICKLY?

Major reasons we were able to get these vaccines developed more quickly than usual include :

- Global effort with the world's leading scientists focused on a single task
- Nearly unlimited resources (money, knowledge, manpower, technology)
- A large pool of diverse adult volunteer trial participants

THE FIRST TWO
COVID-19
VACCINES

Both are mRNA vaccines

- Pfizer (BNT162b2)
- Moderna (mRNA-1273)

They Do NOT contain **COVID-19 virus**

mRNA COVID-19 Vaccines

- mRNA technology is new in vaccine production but is already being used in cancer treatment. It has been studied for more than ten years.
- COVID-19 mRNA vaccines give instructions for our cells to make a **harmless piece** that looks like the “spike protein.” The spike protein is found on the surface of the COVID-19 virus.
- Our bodies recognize that this protein should not be there, so they build antibodies that will remember how to fight the virus that causes COVID-19 if we are infected in the future.



COVID-19 VACCINE IS mRNA
VACCINE- WHAT IS THAT?

Can mRNA vaccine give me COVID-19? NO

Can mRNA vaccine change my DNA? NO

WHEN AND HOW LONG WILL I BE PROTECTED BY THE COVID-19 VACCINE?

- Most of the vaccines are **2 doses**, 3-4 weeks apart
- Protection occurs **1-2 weeks after the second dose**
- We will most likely not know how long the vaccine will be protective once we receive it. We will know more as more time passes in the current research
- May need to have vaccine shots for COVID-19 on a regular basis (like the flu shot)



**WILL I STILL NEED TO
WEAR A MASK?**

YES !

Similar to other vaccines, a large number of people in the community will need to get vaccinated before transmission drops enough to stop the use of masks

**WHAT
SHOULD I
EXPECT
WHEN I GET
THE
VACCINE?**

THE VACCINE CANNOT GIVE YOU COVID-19!

- You can expect to have short-term discomfort: fatigue, headache, muscle pain, chills, fever and pain at injection site after vaccination
- These reactions will last for 24-48 hours and are typically more pronounced after the second dose
- Side effects mean your body is doing its job and making antibodies (IT IS A GOOD THING)
- These side effects are normal, common and expected

MOST COMMON SIDE EFFECTS

BASED ON DATA FROM
CLINICAL TRIAL OF PFIZER
COVID-19 VACCINE

- Fever: 4-16%
- Fatigue 34-59%
- Headache: 25-52%
- Muscular pain: 14-37%

Side effects were more common after the second dose of the vaccine.

Reference: Data published in the New England Journal of Medicine:

<https://www.nejm.org/doi/full/10.1056/NEJMoa2034577>

WHAT
SHOULD I
EXPECT
WHEN I GET
THE
VACCINE?

- **YOU MUST GET THE SECOND DOSE** because the vaccine will not protect you if only get one dose
- It is important to get the **SAME VACCINE** as the first dose

- It is safe to get the COVID-19 vaccine even if you have had COVID-19
- Even if you have had COVID-19, it is important to get vaccinated. It could give you longer or better protection against the disease
- Even if you have positive antibodies, you should get the COVID-19 vaccine

SPECIAL
CIRCUMSTANCE

WHAT IF I
ALREADY HAD
COVID-19?

WHERE SHOULD I LOOK TO GET ACCURATE INFORMATION?

It is important to get information from reliable sources (CDC, AMDA, medical directors, providers) **Social media is full of misinformation and opinions based on that misinformation**

Here are some link to information:

- CDC: <https://www.cdc.gov/vaccines/hcp/covid-conversations/answering-questions.html>
- CDC: About COVID-19 vaccines: <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/about-vaccines.html>
- CDC: Provider Resources for COVID-19 Vaccine Conversations with Patients and Answering Patients' Questions: <https://www.cdc.gov/vaccines/hcp/covid-conversations/>

VACCINES ARE
THE ONLY WAY
TO CONTROL
THE COVID-19
PANDEMIC

- Everyone has to do their part and get vaccinated to get back to a normal life



QUESTIONS?

