

H1N1 FAQ for LHDs

Kentucky Department for Public Health Frequently Asked Questions on Novel H1N1

September 30, 2009

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Note: Some questions that may "cross" categories, if you don't see your question in one section it may be in another. Please send H1N1 questions and comments to the DOC inbox at: chfsdphdoc@ky.gov . It is listed on the Global as CHFS DPH DOC

What's new today

- **Pediatric Prescription of Oseltamivir (Tamiflu) for H1N1 Influenza Treatment**

The attached guidance gives crucial information on replacement of pediatric suspension of pre-packaged Tamiflu suspension in case of predicted shortages. Please distribute to your constituencies as appropriate.



Pediatric Prescription
of Oseltamivir (Tamiflu)

- **Fact Sheet for Older Adults**

This fact sheet for older adults regarding vaccine has been shared by the Dept. for Aging and Independent Living with the aging network in Kentucky. Other groups that work with older adults have also been given this information. Also attached is a contact list for the Area Agencies on Aging and Independent Living (AAAIL) just in case LHD's want to contact them about outreach to this population. AAAIL Directors were alerted by Commissioner Anderson that LHD's may be contacting them.



vaccine recs for
people 50andolder-05



ADD Map.ppt

- **Immunizations by pharmacists**

Brad Hall, executive Director and CEO of the Kentucky Pharmacists Association, provided this guidance regarding KRS 315.010 (19). This statute describes the circumstances under which a Kentucky pharmacist can immunize a specific patient. In accordance with KRS 315.010 (19), pharmacists can immunize pursuant to a protocol for individuals 18 years of age and older. For patients younger than 18 years of age, a pharmacist can immunize pursuant to a prescription from an authorized prescriber for a specific patient.

On a related issue, a few local health departments have received calls from pharmacies that state their agency uses "certified vaccine providers". Per Brad Hall, the American Pharmacists Association offers certification programs to train pharmacists who administer immunizations. However, he stated that Kentucky law does not mandate additional training for pharmacists who immunize individuals other than the requirement to be a licensed pharmacist (KRS 315.010 (19)).

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New from CDC

Antiviral guidance for obstetric care providers

http://www.cdc.gov/h1n1flu/pregnancy/antiviral_messages.htm

Information for Pharmacists

http://www.cdc.gov/H1N1flu/pharmacist/pharmacist_info.htm

This document provides 1.) background information on influenza activity to date and how pharmacists may be affected this season, 2.) an update on antiviral drug supplies, 3.) information about compounding an oral suspension from Tamiflu® 75mg capsules and 4.) information about the oral dosing dispenser provided with certain formulations of Tamiflu® oral suspension.

Updated Interim **Recommendations for the Use of Antiviral Medications** in the Treatment and Prevention of Influenza for the 2009-2010 Season was issued earlier this week. <http://www.cdc.gov/h1n1flu/recommendations.htm>

School-Located Vaccination

There are sections in a new CDC School-Located Vaccination (SLV) guidance document on FERPA and HIPAA:

<http://www.cdc.gov/h1n1flu/vaccination/slv/planners.htm#ferpa>
<<http://www.cdc.gov/h1n1flu/vaccination/slv/planners.htm#ferpa>>

<http://www.cdc.gov/h1n1flu/vaccination/slv/planners.htm#hipaa>
<<http://www.cdc.gov/h1n1flu/vaccination/slv/planners.htm#hipaa>>

Today's Updates

- Flu Mist
- Waiting periods for live virus vaccine
- Thimerosal-free vaccine availability
- Ancillary supply (syringes, needles, and alcohol pads) Kits for vaccination sites
- Provider enrollment questions
- H1N1 vaccine for pregnant women

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General

Question: I have been watching Youtube videos that claim that some states will be making the swine flu vaccine mandatory. They also claim that infants and children will be forcefully vaccinated first. I also have been keeping track of the many claims that vaccines are responsible for health problems in some vulnerable populations.

I hope that Kentucky is providing plenty of opportunities for vaccination, but not making it mandatory? I also hope that parents will be given the chance to provide fully informed consent prior to vaccine being given to their children?

Answer: The H1N1 vaccination, when it becomes available, will be voluntary rather than mandatory. As with all vaccines, parents and vaccine recipients will be provided with a Vaccine Information Statement that explains the benefits and risks of the vaccine, prior to vaccination.

For advice about whether you should receive the vaccine, please consult with your medical provider to determine if you have a medical contraindication, are in a high-risk group, etc... (9/9/09)

Question: We have been trying to make sure we are as prepared as we can be to combat the H1N1. Everything I have read talks about alcohol based hand sanitizer. We have a benzalkonium chloride hand sanitizer. What are your thoughts on this product? Is it as effective as the alcohol based?"

Answer: When antimicrobial spectrum against viruses is a concern, 'Benzalkonium chloride hand sanitizer' would **not** be recommended as a good alternative to alcohol-based hand hygiene agents when soap and water handwashing is not available.

Hand-hygiene antiseptic agents have primarily been evaluated for effectiveness in healthcare settings. See the appendix, <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a2.htm>, to the CDC "**Guideline for Hand Hygiene in Healthcare Settings - 2002**", <http://www.cdc.gov/handhygiene/> for additional information..

Quaternary ammonium compounds (like benzalkonium chloride) have 1+ activity against viruses compared to 3+ activity for alcohol-based products. Quaternary ammonium compounds have the additional disadvantage of a "slow" speed of action compared to a "fast" speed of action in the alcohol-based products.

Be cautioned that alcohol based sanitizers are not a substitute for proper handwashing. It is to be used in conjunction with proper handwashing or in the case of no water.

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Question: Who needs to be tested for H1N1?

Answer: Not everyone with influenza-like symptoms needs to be tested, since public health recommendations for novel H1N1 and seasonal influenza are much the same. Individuals who are ill enough that their condition warrants hospitalization, pregnant women, and individuals in institutionalized settings should be tested. Samples from patients who meet these criteria can be sent to the Division of Laboratory services. If clinicians feel patients that do not meet these criteria should be tested, specimens can be sent to a commercial reference lab for testing. Many commercial clinical labs can now test for H1N1.

Seasonal Flu

Question: When should seasonal influenza vaccine be given?

Answer: In general, health-care providers should begin offering vaccination soon after vaccine becomes available and if possible by October. To avoid missed opportunities for vaccination, providers should offer vaccination during routine health-care visits or during hospitalizations whenever vaccine is available. The potential for addition of a novel influenza A (H1N1) vaccine program to the current burden on vaccination programs and providers underscores the need for careful planning of seasonal vaccination programs. Beginning use of seasonal vaccine as soon as available, including in September or earlier, might reduce the overlap of seasonal and novel influenza vaccination efforts."

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5808a1.htm?s_cid=rr5808a1_e

Question: We have started with the push of seasonal flu vaccine and I have been getting questions, since it is early in getting the vaccine will there be a need to repeat the vaccine in Jan.?

Answer: A second seasonal flu vaccination is NOT indicated, except for those under 9 years who are receiving their first seasonal flu vaccination. Vaccination in Sept should provide immunity throughout the traditional flu season, i.e., on into Jan, Feb and Mar.



LHD Attachments
2009-2010 (3)...

Influenza Revaccination of Elderly Travelers: Antibody Response to Single Influenza Vaccination and Revaccination at 12 Weeks. Jane A. Buxton, Danuta M. Skowronski, Helen Ng, Steve A. Marion, Yan Li, Arlene King and James Hockin. *The Journal of Infectious Diseases*, Vol. 184, No. 2 (Jul. 15, 2001), pp. 188-191. <http://www.jstor.org/pss/30137164> (9/11/09)

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Question: Are there any changes in recommendations for pneumococcal vaccines?

Answer: No, the ACIP recommends that persons recommended for pneumococcal vaccine receive it in light of the potential for increased risk of pneumococcal disease associated with influenza. There are at present no recommendations to give pneumococcal vaccine to groups for whom it is not currently recommended. ACIP will revisit this question as epidemiologic data from the Southern hemisphere influenza season and from the U.S. become available. (9/11/09)

Question: Can the seasonal flu vaccine and the novel H1N1 vaccine be administered at the same time?

Answer: Simultaneous administration of inactivated vaccines against seasonal and novel influenza A (H1N1) viruses is permissible if different anatomic sites are used. However, simultaneous administration of live, attenuated vaccines against seasonal and novel influenza A (H1N1) virus is not recommended.

Normally 2 live vaccines can either be given simultaneously or separated by 4 weeks, however; MMWR, August 21, 2009 / Vol. 58, "Use of Influenza A (H1N1) 2009 Monovalent Vaccine Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2009", page 6 states:

Current studies indicate the risk for infection among persons aged >65 years is less than the risk for persons in younger age groups. Expanding vaccination recommendations to include adults aged >65 years is recommended only after assessment of vaccine availability and demand at the local level. Once demand for vaccine among younger age groups is being met, vaccination should be expanded to all persons aged >65 years. This recommendation might need to be reassessed as new epidemiologic, immunologic, or clinical trial data warrant and in the context of global need for vaccine.

ACIP makes the following additional recommendations about use of influenza A (H1N1) 2009 monovalent vaccine:

- The number of doses of vaccine required for immunization against novel influenza A (H1N1) has not been established. Because vaccine availability is expected to increase over time, vaccine should not be held in reserve for patients who already have received 1 dose but might require a second dose.
 - Simultaneous administration of inactivated vaccines against seasonal and novel influenza A (H1N1) viruses is permissible if different anatomic sites are used. However, simultaneous

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administration of live, attenuated vaccines against seasonal and novel influenza A (H1N1) virus is not recommended.

- All persons currently recommended for seasonal influenza vaccine, including those aged >65 years, should receive the seasonal vaccine as soon as it is available. Recommendations for use of the 2009–10 seasonal influenza vaccine have been published previously (12). (9/18/09)

Schools

Note: CDC has altered recommendation for exclusion of ill children and staff from child care. Recommendation was 7 days, but is now 24 hours fever-free, just like K-12 schools: <http://www.cdc.gov/h1n1flu/childcare/guidance.htm> This document refers to “early childhood programs” which includes center-based and home-based child care programs, Head Start programs, and other early childhood programs providing care for children in group settings. The guidance applies to all early childhood programs, even if they provide services for older children.

We have updated our guidance for the use of hand sanitizers in schools. This updated guidance allows for a more liberal use of sanitizers in light of and during the H1N1 situation. (9/9/09)



DOC090109.pdf

Question: Are there any guidelines for schools or businesses about sharing information with employees or students if they are aware of a confirmed case of someone in their facility?

Answer: Schools and businesses should not share info about confirmed cases, since it’s a violation of an individual’s protected health information. H1N1 activity is now widespread in KY, so it can be assumed that every community and business is potentially affected. Employees and schoolchildren should practice behaviors that would reduce their risk of illness. The CDC website contains additional information on the Family Educational Rights and Privacy Act (FERPA) which protects the privacy of student education records, including health records, maintained by educational agencies and institutions.

<http://www.cdc.gov/h1n1flu/vaccination/slv/planners.htm#ferpa>

Question: Some of our schools have preschoolers (who are <5yrs), would the same exclusion period apply as CHILDCARE FACILITIES for children less than 5 years of age or because they are in public school system they would have to follow the revised 24 hours exclusion?

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Revised Answer: CDC no longer recommends that a longer period should be used in childcare facilities for children less than 5 years of age. Children and caregivers with flu-like illness should remain at home and away from others until at least 24 hours after they are free of fever (100° F [37.8° C] or greater when measured orally), or signs of a fever, without the use of fever-reducing medications. Any pre-school classes within a public school system do not need to follow the 7-day exclusion period. (9/9/09)

Question: Do children in daycare and pre-school need to get both the seasonal and H1N1 flu vaccinations?

Answer: The best way to protect against the flu – seasonal or 2009 H1N1 – is to get vaccinated. The CDC Guidance for Child Care Programs Respond to advises that children less than 5 years of age are at increased risk of complications from influenza (flu); the risk is greater among children less than 2 years old. **Importantly, infants less than 6 months of age represent a particularly vulnerable group because they are too young to receive the seasonal or 2009 H1N1 influenza vaccine; as a result, individuals responsible for caring for these children constitute a high-priority group for early vaccination.** (9/9/09)

Question: The attendance folks at central school office asked if the state (either through Education or DPH) could come up with a standard physician's excuse specific to flu that would allow physicians to quickly provide this required documentation.

Answer: That will be up to the Department of Education, as we in Public Health do not regulate school attendance. However, our suggestion would be that during the pandemic school districts may need to relax attendance policies so that all children/staff that are ill can stay home until they have been 24 hours without a fever. In most cases, schools should take parents' word for this, instead of requiring a doctors' excuse on each child, thus subjecting them to a doctor's visit that might be an opportunity for others to become infected.

Question: How do we protect students with chronic medical conditions prior to the availability of H1N1 vaccine?

Answer: These children's' families and schools should also practice non-medical countermeasures such as handwashing, covering coughs, and staying home when ill. These children are recommended to receive seasonal influenza vaccine as soon as it's available. (9/11/09)

Question: The school district is considering a school-based H1N1 clinic, managed by the LHD. The school district employs several nurses, as does the

tech school. There was concern over how the school-employed nurses would be covered for liability when they are providing a LHD service.

Answer: All vaccinators are supposed to be covered under the federal PREP Act, if they are acting in good faith. However, since Kentucky's constitution is a bit different from other states, we are awaiting a legal opinion from our CHFS legal counsel as to how much protection the PREP is likely to give vaccinators in Kentucky.

Question: Do school and public health nurses have to be fit-tested for N-95 masks?

Answer: Fit-testing for wearing N95 respirators will be required for healthcare personnel, including school nurses, who come into direct contact with patients with influenza virus infections, based upon an Institute of Medicine report that was released yesterday.

"Healthcare workers who come into direct contact with patients who are infected with the pandemic H1N1 influenza virus or who may be infected should wear N95 respirator masks and not regular surgical masks, a special panel of the Institute of Medicine reported today." (9/8/09)

http://latimesblogs.latimes.com/booster_shots/2009/09/swine-flu-healthcare-workers-should-wear-n95-masks-iom-says.html. The actual reports can be downloaded, **http://www.nap.edu/catalog.php?record_id=12748**

Question: A school asked if they need to be concerned about a temperature until it is 100 or above. Would they need to send a child home with a temperature in the 99.0 to 99.9 range?

Answer: "Influenza Like Illness (ILI) is defined as fever (temperature of 100°F [37.8°C] or greater) and a cough and/or a sore throat in the absence of a KNOWN cause other than influenza."

<http://www.cdc.gov/flu/weekly/fluactivity.htm>

Question: I have received several questions from school regarding sanitizer use. What is the guidance regarding sanitizer in classrooms?

Answer: We think it's OK for children to have sanitizers as long as the child is 4th grade or older and school policy permits it. Remember that although hand sanitizer has its place, an old-fashioned scrubbing with soap and water is preferable.

Question: Should the school separate ill students and staff?

Answer: CDC recommends that students and staff who appear to have an influenza-like illness at arrival or become ill during the day be promptly

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separated from other students and staff and sent home. Schools should regularly update contact information for parents so that they can be contacted more easily if they need to pick up their ill child. Students and staff who appear to have flu-like illness should be sent to a room separate from others until they can be sent home. CDC recommends that they wear a surgical mask, if possible, and that those who care for ill students and staff wear protective gear such as a mask.

Question: for schools, how long should a sick student or staff member be kept home?

Answer: In the current flu conditions, students and staff with symptoms of flu should stay home for at least 24 hours after they no longer have fever or do not feel feverish, without using fever-reducing drugs. They should stay home even if they are using antiviral drugs.

Sick people should stay at home, except to go to the doctor's office, and should avoid contact with others. Keeping people with a fever at home may reduce the number of people who get infected. Because high temperatures are linked with higher amounts of virus, people with a fever may be more contagious." (For more information, see [CDC Recommendations for the Amount of Time Persons with Influenza-Like Illness Should be Away from Others.](#))

Question: What should schools do for cleaning if they have a H1N1 case?

Answer: School staff should routinely clean areas that students and staff touch often with the cleaners they typically use. Special cleaning with bleach and other non-detergent-based cleaners is not necessary.

Question: There is a general frustration amongst the teachers, principals, nurses and parents present on the lack of actual H1N1 confirmation through testing. There is a suggestion for physicians to test a limited number of children as a way to prove that the outbreak is what the CDC says it is.

Answer: At this stage, seasonal flu and H1N1 flu are being treated the same in terms of public health and school exclusion criteria, so how is knowing whether an influenza outbreak is one or the other going to change patient or public health management? According to our surveillance, almost all circulating flu in Kentucky at this time is the novel H1N1 strain. Perhaps the only reasons to get confirmatory testing for community outbreaks are a) to feed the media, or b) if the outbreak is not typical for influenza (atypical symptoms, very low percentage of positive rapid tests, etc...) Only the local community can decide about whether those are valid reasons.

Vaccine

Question: A Nursing home facility who wants the vaccine for its employees but their medical director won't sign the forms?

Answer: If the facility's medical director will not signoff on the protocol to administer the H1N1 vaccine, the facility could send their employees to a health department for vaccination or work out arrangements with another vaccine provider in the community, such as a hospital. (9/30/09)

Question: What is the approx target date for the info packets to be mailed out to K HELPS registrants, hospitals and VFC participants?

Answer: Most of the items are nearing the final draft stage. Some items such as the Vaccine Information Sheet are still waiting on clearance from CDC.

Question: What are the requirements to sign up on K-Helps? Several of our major employers (closed PODs) are asking if the CRI concept of pushing pills or shots is going to be used for H1N1 or is this limited to health care facilities.

Answer: Major employers can sign up on K-Helps for the H1N1 vaccine. They will need to have a Medical Director or responsible physician to order the vaccine and trained staff to manage and administer it. They should be allocated vaccine based on the target groups, after healthcare facilities, schools and similar facilities. (9/11/09)

Question: Do those individuals that have been previously vaccinated against the 1976 swine influenza need to get vaccinated against the 2009 H1N1 influenza?

Answer: The 1976 swine flu virus and the 2009 H1N1 virus are different enough that its unlikely a person vaccinated in 1976 will have full protection from the 2009 H1N1. People vaccinated in 1976 should still be given the 2009 H1N1 vaccine.

Question: One of my patients, confirmed H1N1's from this spring, wants to know if she has life time immunity to the disease. If not, is it recommended that she get the vaccine again at some point, when?

Answer: One of the most important points to address this question is to determine if the person really did have novel H1N1 influenza. We have only had about 317 confirmed cases in Kentucky so far, as most people are just being diagnosed on basis of symptoms or a rapid influenza test and aren't actually a confirmed case. In the situation where the case is not definitively laboratory confirmed, we would recommend he/she receive the vaccine. If a person does actually have a true laboratory-confirmed case of H1N1, it won't

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hurt them to have the vaccine, but they are probably protected from becoming re-infected this influenza season (and probably much beyond) so don't need to be vaccinated.

Antibody made to natural influenza infection should be protective in the short-term for reinfection, but it may not be protective long-term. Influenza viruses change often, but sometimes there is cross-reactivity in antibody protection from either prior immunization or prior infection. Without repeated antigenic stimulation, antibody will wane over time. (9/11/09)

- ***Clinical Execution and Vaccine Administration***

(Subject Matter Lead: Joy Hoskins – Joy.Hoskins@ky.gov)

Question: Will the first shipments of vaccine be Flu Mist and can it be used for all target groups?

Answer: Most of what we are being told is coming in the first shipment to states will be the live, nasal spray formulation of H1N1 vaccine. Obviously, there are restrictions on the live vaccine that are not present with the inactivated vaccine. The challenging part will be to get targeted groups vaccinated with the live vaccine, since pregnant women, children under 2, and folks with chronic illness are not recommended to receive live vaccine. Likely, we will need to focus initially on healthy healthcare workers up to age 49, healthy children and young adults 2 years through 24 years of age and healthy household caregivers of children under 6 months of age who are themselves aged 49 years or less. (9/29/09)

Question: Would a pharmacy/pharmacist complete Page 2, Section D of the Enrollment Form? Most pharmacies do not have an MD, OD, NP, PA? Is this completed page a requirement?

Answer: For pharmacists, we need the site to fill out the second page using the doctor's license # of the physician who authorizes their immunization protocols. (9/30/09)

Question: How much of a waiting period should there be between seasonal flu vaccine and the live virus forms of the H1N1 vaccine?

Answer: There should not be any "waiting period" necessary between administration of inactivated (injectable) seasonal vaccine and H1N1 vaccine or between an inactivated seasonal vaccine and a live H1N1 vaccine. However, the interval for 2 live vaccines (say, seasonal and H1N1 influenza vaccine) is usually a month apart. In addition, live seasonal flu vaccine and

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live H1N1 flu vaccine are not recommended to be given simultaneously.
(9/29/09)

Question: Have you seen anything regarding the Nasal Spray and the # days/hours that one who takes this must stay away from immunocompromised individuals? We have a concern that our EMS or other HCW who do not always know they are going to be in the presence of an immunocompromised individual may not wish to take this form of the vaccine.

Answer: From the PHPR:

Healthcare personnel or hospital visitors

- Who have received Influenza A (H1N1) 2009 Monovalent Vaccine Live, Intranasal should refrain from contact with severely immunosuppressed patients requiring a protective environment for 7 days after receipt of vaccine. Inactivated Influenza A (H1N1) 2009 Monovalent Vaccine is recommended for vaccinating household members, HCP, and others who have close contact with severely immunosuppressed persons (e.g. patients with hematopoietic stem cell transplants) requiring care in a protective environment.
- Hospital visitors who have received Influenza A (H1N1) 2009 Monovalent Vaccine Live, Intranasal should avoid contact with severely immunosuppressed persons in protected environments for 7 days after vaccination but should not be restricted from visiting less severely immunosuppressed patients.

From ACIP: "LAIV transmission from a recently vaccinated person causing clinically important illness in an immunocompromised contact has not been reported. The rationale for avoiding use of LAIV among HCP or other close contacts of severely immunocompromised patients is the theoretical risk that a live, attenuated vaccine virus could be transmitted to the severely immunosuppressed person."

Therefore, most healthy healthcare personnel under age 50 will be able to receive live vaccine, unless they work in units where patients are severely immunocompromised.
(9/30/09)

Question: What should we recommend for children with asthma?

Answer: Anyone with asthma is at higher risk for flu-related complications, such as pneumonia. CDC has released *Asthma Information for Patients and Parents of Patients* with a variety of steps that individuals with asthma should take, including developing with their physicians an Asthma Action Plan, and getting seasonal flu and H1N1 vaccinations. (9/29/09)
(<http://www.cdc.gov/H1N1flu/asthma.htm>)

Question: Does it depend what trimester a person is in to take the vaccine?

Answer: The 11th Edition of Epidemiology and Prevention of Vaccine-Preventable Diseases (Pink Book), page 145, states: *A study found that the risk of hospitalization for influenza-related complications was more than four*

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*times higher for women in the second or third trimester of pregnancy than for nonpregnant women. The risk of complications for these pregnant women was comparable to that for nonpregnant women with high-risk medical conditions, for whom influenza vaccine has been traditionally recommended. ACIP recommends vaccination of women who will be pregnant during influenza season. **Vaccination can occur during any trimester.***

Question: If we don't receive an item that we asked for on the weekly order sheet do we just still keep requesting it until we get it?

Answer: Each week health departments will get a spreadsheet of doses they can order...if it is not on that spreadsheet, do not put in an order for it. For example, in week one, only live nasal vaccine may be available. Let's say 1,000 doses are allocated. Please do not send in an order for 500 syringes or 2000 of any formulation of vaccine. Send an order for no more than 1000 doses of nasal vaccine. You may send in for less than 1,000 but not more. It must be in increments of 100. If for some reason McKesson doesn't ship the full amount ordered, we think it will be held & shipped later. (9/30/09)

Question: On the enrollment form, page 2; do you need the information for all our physicians that may order the vaccine for our inpatient or outpatient population?

Answer: On the Kentucky H1N1 Vaccine Program Enrollment Form, it is requested on page 2 to list all the medical providers of the enrolling facility who can prescribe vaccines. For larger facilities like hospitals, it is only necessary to list the top medical providers of the facility who will be responsible for the H1N1 vaccination program in each facility. No need to list all medical providers who have the ability to prescribe vaccine. (9/30/09)

Question: What types of syringes, needles and ancillary supplies will come with the vaccine?

Answer: Please refer to the updated information below on the length of needles that will be included in the ancillary supply kits.

Needles:

| Multi-Dose Vial Ancillary Support Kit | |
|---|--|
| NDC 08888-0003-10 Multi-Dose Vial Kit, 100 Dose Pack | |
| | |
| The items listed below represent the generic requirement for a multi-dose ancillary support kit. The allocation is one kit per 10 vials of vaccine. | |
| | |

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| | |
|--|-----------------------|
| Item #1. Integrated Needle and Syringe unit, Sterile, Single Use, Safety engineered, 1ml or 3ml, 23 or 25 gauge, 1.0 inch or 1.5 inch | Quantity per kit: 100 |
| | |
| | |
| Item #2. Integrated Needle and Syringe unit. Sterile, 5ml, suitable for aspirating adjuvant and transferring it to the multi-dose vaccine antigen vial. | Quantity per kit: 10 |
| | |
| | |
| Item #3. Isopropyl Alcohol Prep Pad, individually sealed | Quantity per kit: 100 |
| | |
| | |
| Item #4. Vaccination Card. | Quantity per kit: 100 |
| | |
| | |
| | |
| Pre-Filled Syringe Ancillary Support Kit | |
| NDC 08888-0001-10 Pediatric Pre-Filled Syringe Kit, 100 Dose Pack | |
| NDC 08888-0002-10 Adult Pre-Filled Syringe Kit, 100 Dose Pack | |
| | |
| The items listed below represent the generic requirements for a pre-filled syringe ancillary support kit. The allocation is one kit per 100 pre-filled syringes. | |
| | |
| Item #1. Needle, FDA approved, safety engineered, sterile, luer lock, 23G, 1.0 inch or 1.5 inch | Quantity per kit: 100 |
| <i>Note. The Pediatric kit will contain a 25G, 1.0 inch needle</i> | |
| | |
| | |
| Item #2. Isopropyl Alcohol Prep Pad, individually sealed | Quantity per kit: 100 |
| | |
| | |
| Item #3. Vaccination Card. | Quantity per kit: 100 |

(Source - CDC H1N1 Vaccine Implementation Team)

The sharps containers will be supplied separately. (9/18/09)

Question: With the prefilled syringes, we have information that the needle on the pediatric dose is a 5/8". On our little ones we give injections in the

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anterolateral thigh muscle and typically use a 1" needle. Do these prefilled syringes have a needle on it such that we can change it out to a 1"? Or is the syringe/needle all together and cannot be changed out? Or does the syringe even have a needle on it and we may need to have a supply of needles anyway?

Answer: On a CDC conference call, we were advised that all needles have been changed to 1". The Pediatric Pre-Filled Syringe Ancillary Support Kit will contain a 25G, 1.0 inch needle, plus all needles included in the ancillary kits will be safety needles. (9/29/09)



Needle_Length_and_ Injection_Site_for_In

Question: There is a physician here in our County who was asking me today about the makeup of the H1N1 vaccine. He wanted to know if it was an oil based vaccine.

Answer: We are not sure what he meant by an oil-based vaccine. Both the injectable and nasal-spray vaccine are being made in the same way that seasonal flu vaccine is manufactured. It does not contain an adjuvant, and last week, the manufactured vaccine was approved by the FDA. CDC advised that "None of these influenza vaccines that will be used in the U.S. during the 2009-10 season will contain adjuvants". (9/29/09)

Question: How will we know if someone has received the H1N1 vaccine?

Answer: Here is a copy of the H1N1 "shot card" that will be included with the H1N1 vaccine packaging. Additional guidance regarding the implementation of these shots cards will be forthcoming as a part of the DPH clinical H1N1 information. (9/11/09)



Influenza Vaccination Record 082709.pdf

Question How much Thimerosal-free vaccine will be available?

Answer: It is anticipated that enough thimerosal-free vaccine in pre-loaded syringes will be available for young children and pregnant women. Various vaccine manufacturers will be producing some of the 2009 H1N1 influenza vaccine in single-dose units, which will not require the use of thimerosal as a preservative. In addition, the live-attenuated version of the

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vaccine, which is administered intranasally (through the nose), is produced in single-units and will not contain thimerosal. (Updated 9/29/09)

Question: Will LHDs receive vaccine from all 4 manufacturers?

Answer: LHDs and private providers may receive vaccine from any of the FDA approved providers. Currently there are 4 with 1 more still pending. All vaccine shipments will come through McKesson. (9/29/09)

Question: How do providers address the possibility of individuals wanting vaccine and mis-representing themselves as having a high-risk condition?

Answer: Self-declaration of a high-risk condition is acceptable. LHDs and other providers have the option of having people sign self-declaration forms.

Question: Should we be looking for the first shipment of vaccine to go to the “*Subset of Target Groups During Limited Vaccine Availability*” group? If this is the case, we will not be going into schools to give, initially.

Answer: Yes, you are correct the Sub-set group will be the initial group to be vaccinated when the supply of H1N1 vaccine is in limited supply. This group does not include school aged children without medical conditions that put them at higher risk for influenza-related complications. The CDC recommendations for the initial period are online at:
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5810a1.htm>

“If the supply of the vaccine initially available is not adequate to meet demand for vaccination among the five target groups, ACIP recommends that the following subset of the initial target groups receive priority for vaccination until vaccine availability increases (order of target groups does not indicate priority):

- pregnant women,
 - persons who live with or provide care for infants aged <6 months (e.g., parents, siblings, and daycare providers),
 - health-care and emergency medical services personnel who have direct contact with patients or infectious material,
 - children aged 6 months--4 years, and
 - children and adolescents aged 5--18 years who have medical conditions that put them at higher risk for influenza-related complications.”
- ***Vaccine Administration Fees, Billing, and Reimbursement***
(Subject Matter Lead: Rosie Miklavcic– Rosie.Miklavcic@ky.gov)

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Question: Is billing of third party payors/insurers permissible in public health clinics or mass vaccination sites/clinics conducted by a LHD?

Answer: It is permissible to bill third party payors/insurers in public health clinics or mass vaccinations sites/clinics conducted by, or on behalf of a public health entity. However, public health jurisdictions that do not currently have a robust billing system in place may not use PHER funds to develop billing systems. (Source - CDC H1N1 Vaccine Implementation Team, 'H1N1 Vaccine Administration Billing Q&As')(9/16/09) While LHDs may bill, they may not charge patients at the mass vaccination clinic (i.e., no cash should change hands). Please see question below.

Question: Is it permissible to charge patients a co-pay or any out-of-pocket charge in public health clinics or mass vaccinations sites/clinics conducted by a LHD?

Answer: It is not permissible to charge patients in public health clinics or mass vaccinations sites/clinics conducted by or on behalf of a public health entity. (Source - CDC H1N1 Vaccine Implementation Team, 'H1N1 Vaccine Administration Billing Q&As') (9/16/09)

Question: What is the definition of a 'public health clinic'?

Answer: A 'public health clinic' is defined as a clinic that is conducted by, or on behalf of a state or local health jurisdiction and receives PHER implementation funds to administer H1N1 vaccine in any setting. For example, this may include a commercial community vaccinators (CCV) or other private provider that has a formal agreement with the public health entity. (Source - CDC H1N1 Vaccine Implementation Team, 'H1N1 Vaccine Administration Billing Q&As') (9/16/09)

Question: Is the admin fee that was talked about an option for both providers and local health departments if they want to charge?

Answer: This is very complicated and still being worked on at the national level. No firm decision has been made. Medicare/Medicaid essentially have to rule how they are handling this first. Then all the other insurers will follow suit.

Just as health plans have provided extensive coverage for the administration of seasonal flu vaccines in the past, public health planners can make the assumption that health plans will provide reimbursement for the administration of a novel (A) H1N1 vaccine to their members by private sector providers in both traditional settings e.g., doctor's office, ambulatory clinics, health care facilities, and in non-traditional settings, where contracts with insurers have been established."

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Question: Is VFC reimbursement for the H1N1 vaccine possible?

Answer: CDC is trying to connect with insurers to find out what insurers plan. AHIP has reported that insurance plans seem to want to cover it. Medicare will likely cover it as well.

Question: Regarding insurance, most health departments can't bill insurance providers and it may complicate things to ask providers or mass vaccination clinics to bill insurance.

Answer: The model CDC suggested is to have a combination of public health clinics and private provider offices vaccinate; the public health clinics would not bill but the private provider offices would. CDC plans to discuss this further. If this model isn't followed, it will be difficult to get private providers reimbursed otherwise. It may be necessary to contract with private providers to provide vaccines to high risk groups, as it will be difficult to identify high risk people at a mass vaccination clinic.

Question: Will private providers be charged for the vaccine, or will they receive it for free if they sign up on KHELPS?

Answer: Vaccine and ancillary supplies are free, but private providers will not be reimbursed by public health for administration costs. However, admin costs may be covered by many insurers.

Question: There are concerns for reimbursing providers we recruit to assist us in the vaccination efforts. Will there be a separate funding stream supplied to public health efforts for mass vaccination? Can we create a system to reimburse providers whose patients are not covered under private insurance or Medicaid?

Answer: CDC has a workgroup devoted to finance issues; they recognize it's a complex issue but the workgroup is working on all these questions.

- ***Vaccine, Adverse Events, and Inventory Tracking*** (Subject Matter Lead: Jeff Brock – Jeff.Brock@ky.gov)
- ***Logistics, Procurement, Security, and Cold Chain Distribution*** (Subject Matter Lead: Richard Dugas – Richard.Dugas@ky.gov)

Question: Where did DPH obtain the vaccine cooler/freezer units?

Answer: The vaccine refrigerators were purchased from a company called ENGLE USA and attached on of the invoices for reference. The sales rep's name is:

Denise Lilly
ENGEL USA
1555 Jupiter Park Drive, Unit 5
Jupiter, Florida 33458
Tel: 561-743-7419
www.engel-usa.com



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novative_M.PD...

The price is a year old and was based on a volume discount, so it may have changed. The portable unit is Engel Portable Fridge/Freezer - 43 Qt (MT45FU1).

Another refrigerator vendor to consider is the AcuTemp company. At least one LHD has purchased equipment from AcuTemp and has been well pleased with their product. The AcuTemp website is:
<http://acutemp.com/temperaturesensitiveshipping/pharmaceutical.asp>

Note: Franklin County HD just purchased two refrigerators from Lowe's that will work very well, and had alarms installed.
(9/16/09)

Question: How will H1N1 vaccine be distributed in Kentucky?

Answer: First of all, nothing is set in stone at this time because CDC has not finalized their plans. So, everyone must remain flexible. As of now this is what KDPH expects the H1N1 vaccine distribution in Kentucky to look like.

Initial bolus (beginning as early as 9/30/09 but more likely 10/15/09) will be 200K to 600K doses. Distribution will be from the McKesson warehouse directly to the approved providers*. (*process still under development but will mirror Vaccine For Children program) due to the minimum order size of 100 doses (set by CDC and McKesson) this may require some local or interregional distribution. For instance if x county has 15 providers that all want vaccine but none can handle 100 doses, the local HD may need to place the order and break it down for those 15 providers. KDPH does not plan on mandating this procedure. This will be completely a local/regional decision.

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Now, in the early stages if KDPH doesn't have enough vaccine to ship 100 doses to each county, initial shipments may go to the regional distribution sites. There would then need to be some intraregional distribution.

One thing to note is that the 100 doses must all be the same type of doses (i.e. pediatric, infant, prefilled, LAIV, etc). So, now you can see that some clinics may in fact need to order 500 doses, one of each type, in order to be able to vaccinate all eligible clients.

Follow on shipments – about 250K doses per week.

As always – we are asking you to be prepared to receive at your regional site. McKesson is being asked to add a tremendous amount of additional vaccine into there already precarious VFC shipping process. If there is any hiccup at all, Kentucky and other states may need to revert to using regional ship to sites.

Question: What happens to orders over 100 but not even numbered (example 551)?

Answer: All orders to McKesson must be placed in increments of 100 doses. Additionally all 100 doses must be the same type of vaccine (i.e. multi-dose vials, pre-filled syringes, intra-nasal spray). You can not mix and match to get 100.

Your LHD will have to adjust those quantities before approving them and passing on the KDPH. It is up to the LHD and/or the facility to work out a plan to deal with the less than 100 amounts (the 51 doses). The facility may reduce their order to 500 or the 51 doses could be to be added to the LHD order and delivered to the LHD.

This is not a KDPH policy. This is a stipulation in the CDC-McKesson contract and can not be changed. (9/11/09)

Question: Will the orders to those over 100 dose providers be delivered to us or directly to the provider?

Answer: Orders over 100 doses that are approved by the LHD for delivery directly to the facility can be delivered directly to the facility from McKesson. On the other hand, if the LHD so chooses, the orders can be delivered to the LHD for distribution to the provider. (9/11/09)

Question: Our County has grown at a higher rate than most counties. Will the basis for allocation be based on current US Census Estimates for 2008, rather than 2000?

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Answer: We are currently building the tool (excel spreadsheet) we will be using for allocation. We will be utilizing the 2008 est. from the US Census Bureau. (9/11/09)

Question: We have a large university population and a small college in our county with several thousand students, living in the dorms. These additional students from outside our County and not listed on the census, most of whom are Kentucky residents from other counties. The university wants to know if they will be included a designated allocation for the county.

Answer: Since, initial (first two weeks) allocations will be smaller; we will probably go with a straight population based allocation. However, by week 3 we expect to begin receiving an adequate supply of vaccine. Most likely significantly more than the state has capacity to vaccinate in those 3 weeks. So, by that time we should safely be able to address any population deviations from the Census numbers such as your university population. Please be sure to remind us of this situation once you begin receiving your allocation numbers and placing your vaccine orders. (9/11/09)

Question: Our local hospital and medical community employ staff that live in surrounding counties in significant numbers. How will this be handled?

Answer: We highly encourage regional collaboration in situations such as this. If the counties in question do not have sufficient population that are in the "priority group" in the first couple weeks, they can release a portion of their allocation to your county to be utilized to vaccinate the commuter healthcare population. Work with your neighboring LHDs to address problems like this. If this solution does not work then we are comfortable that by week 3 we should be able to meet your increased need to HCWs. (9/11/09)

Question: Our county has both parents and children that commute to the county. Most of the OB/GYN's have patients from the surrounding counties. How will you accommodate for these out of county people in our allotments.

Answer: If any county feels that they have a reason to request a modification to their allocation based on an extenuating circumstance then please notify KDPH in writing or email. Since we are not aware of every such incidence like this that are based on geography. (9/11/09)

Question: What should healthcare organizations, do in terms of provider enrollment, that have facilities in multiple locations, sometimes in multiple counties?

Answer: If an organization wants to register on the K-Helps website one time and then handle all vaccine ordering and reporting centrally, they need to be prepared to handle multiple issues;

- Having enough refrigerator capacity to handle vaccine storage at their central facility,
- Facilities and proper transport capabilities to maintain the cold chain,
- Data collection issues to get reports back from their facilities to the central office, aggregated and up to the local health department, and
- The problem of different facilities in different counties or health department jurisdictions, splitting who they would report to.

This includes the big pharmacy chains, like Kroger's, Wal-Mart, Kmart, and Walgreen's. Again in these cases, I think it might be better to have each individual facility that will distribute vaccine register so that the local health department can be aware of the possibility of vaccine being distributed via these chain pharmacies in their area.

Though there may be exceptions, in most cases, we think it might be better to have each individual facility register that will distribute vaccine so that the local health department can be aware of the possibility of vaccine being distributed to all the facilities in their area. (9/11/09)

Question: What about the VA Medical Centers, will they be getting H1N1 vaccine?

Answer: The only vaccine being shipped directly to the VA Medical Centers will be to vaccinate target group federal employees (critical emergency responders, healthcare clinicians, pregnant women, and so on). Everything else – non-patient care medical center staff, patients - will come through the states. The VA clinics should register on K-Helps and be included in the LHD's allocations. (9/11/09)

Question: Is DPH going to make special arrangements for Corrections for their facilities and inmates?

Answer: The Department of Corrections has requested to order and receive their vaccine centrally. They indicated that they will then distribute the vaccine to all their facilities. DPD recommended that they coordinate with the LHDs so that they can track all vaccination within their jurisdiction. Nationally, the Federal Bureau of Prisons had requested a similar arrangement for their facilities but we are still awaiting confirmation on this. Thus, your HD will coordinate with both the state and federal correctional facilities within the county. (9/11/09)

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Question: Will the vaccine be shipped to LHDs based on amount ordered or the population allocations only? We may not have storage space for everything at once.

Answer: The vaccine shipments to LHDs will be based on amount ordered by the LHD. The allocation amount is the maximum amount available to the county but you do not have to order that amount. Each facility should not order more that you can store and distribute safely.

PHER funding may be used to purchase additional equipment for proper storage and transport of vaccine. (9/11/09)

Question: Will needles and sharps containers and alcohol wipes be included in the vaccine delivery?

Answer: The ancillary supplies will be sent separately from the vaccine and will hopefully arrive close to the same time as the vaccine. HHS will provide needles, syringes, sharps containers and alcohol swabs.

Question: Will needles and sharps containers and alcohol wipes need to be ordered separate from the vaccine?

Answer: No, the ancillary supplies will be sent separately from the vaccine but do not need to be ordered separately. The ancillary supply order will be calculated based on the type of vaccine ordered (single dose vs. multi-dose).

Question: We've had several questions about PIN numbers.

Answer: Each site that will receive vaccine distribution from the McKesson warehouse will have to have a PIN number. In VACMAN each PIN has a specific location. Ex. in Pulaski County the health department has one PIN, the district office has one PIN & the school sites have one PIN. In Louisville all health departments have the one PIN per clinic...H156, H156B, H156C, H156F, H156H and H156T are currently active on the program. VACMAN cannot do this any other way & it will not let us enroll without a PIN and an address.

Anti-viral Distribution

Subject Matter Lead: Richard Dugas – Richard.Dugas@ky.gov)

Question: Who needs to be treated with antivirals for H1N1?

Answer: Not everyone with influenza-like symptoms needs to be treated, antivirals have their place, especially for high-risk folks, but they are not the

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magic bullet that some clinicians and the public might seem to think. Clinicians should consider treating those who are hospitalized or at risk for severe complications from H1N1 infection.

Question: What about the supply of antivirals for H1N1?

Answer: In terms of antiviral supply, there is likely a limited commercial supply, even though the manufacturer increased production substantially over the summer. Pharmacies do not stockpile large amounts of antivirals (most use just-in-time supplies from national distributors), so knowing how much your pharmacies have "in stock" does not answer the question about when supplies are running short--- since pharmacists can order more as long as commercial supplies are available in the US.

Individual pharmacies can let the Pharmacists' Association know when they are having difficulty obtaining antivirals. When that happens, we can consider either trying to obtain antivirals from other commercial sources or breaking into the remaining government-purchased stockpile. In the meantime, government-purchased antivirals should only be used for those who are unable to afford to get their prescription filled. That written KDPH policy is close to being finalized and will use local health departments as "gatekeepers", as described on the Preparedness video teleconferences.

Question: What about antivirals for first responders and health care workers who are at high risk for complications from disease or HCW in general?

Answer: Hopefully individuals are receiving a prescription because 1) they are ill with what the clinician thinks is novel H1N1 infection or 2) they are close contacts of someone with H1N1 and are either at high-risk for complications or are a HCW/first responder. We do not recommend that these groups (first responders and health care workers), receive "just-in-case" medication courses for prophylaxis or treatment.

Question: Are we (Public Health) to pay for antivirals now for indigent patients?

Answer: Until commercial supplies are exhausted, government-purchased antivirals should only be used for those who are unable to afford to get their antiviral prescription filled. The written KDPH distribution policy is close to being finalized and will use local health departments as "gatekeepers". In the meantime, before the policy is released, we can contact Pharmacists' Association and they can direct you to a participating pharmacy if you have indigent patients who have no other means of receiving the antivirals.

Question: Who picks the pharmacy for our county? We have 2 cities in our county, so having more than one Anti-viral distribution location will certainly

benefit our citizens as many would not be able to afford to travel long distances, etc.

Answer: The Kentucky Pharmacist Association has sent out a request for pharmacies to “Opt-In” if they wish to be an antiviral dispensing location. We are working closely with the KPhA to ensure we meet everyone’s needs. While KPhA will likely not be able to accommodate all requests, please let KDPH know if you have a compelling need for an additional pharmacy in your county. LHDs may want to wait to see the list of KPhA’s participating pharmacies before contacting KDPH. (9/16/09)

Healthcare, Healthcare Workers

(Subject Matter Lead: Mark Sizemore - JamesM.Sizemore@ky.gov)

Personal Protective Equipment (PPE)

Modifications of Existing CDC Recommendations about Infection Control Precautions, including Facemask and N95 Respirator Use, for Healthcare Personnel (HCP)

The Kentucky Department for Public Health (DPH) recommends the following modifications to the interim guidance and interim recommendations from the Centers for Disease Control and Prevention (CDC) for the care of patients with novel H1N1 influenza in all inpatient, outpatient, and pre-hospital healthcare settings:

- Patients with a confirmed, probable or suspected case of novel H1N1 influenza can be cared for with both standard and droplet precautions, rather than airborne precautions. Such patients *may* be placed in private rooms, rather than negative pressure rooms, with appropriate use of gloves, facemasks (e.g. *surgical* masks), gowns and hand washing by HCP. Face shields or eye protection should be used, as indicated, for patient care activities with risk for exposure to blood, body fluids, secretions or excretions. Patients on droplet precautions who must be transported or are likely to come into contact with the general public should wear a facemask if tolerated and follow procedures for respiratory hygiene / cough etiquette.
- Current use of N95 respirators or higher-level respirators should be limited and confined to instances of direct airway manipulation (e.g., bronchoscopy, intubation, nasopharyngeal suction).
- If N95 respirators are either not available or in short supply, please follow the **CDC Interim Domestic Guidance on the Use of Respirators to Prevent Transmission of SARS**, May 3, 2005: <http://www.cdc.gov/ncidod/sars/respirators.htm> .

These Kentucky modifications of current CDC recommendations are consistent with World Health Organization recommendations and Canadian guidelines for care of cases

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of novel H1N1 influenza. Other states have also implemented similar modifications since May 2009. These Kentucky modifications enable the practicable implementation of respiratory protection programs during the current influenza pandemic, considering that equipment and resource availability may be limited.

These Kentucky modifications should also be appropriate for all inpatient, outpatient and pre-hospital healthcare settings with a confirmed, probable or suspected case of seasonal influenza. (9/21/09)



2009 DPH Public
Health Advisory - H1N1

Question: A local ICN called and they are planning for the H1N1 vaccination of their hospital staff. They are wondering if there will be any standard data the State or the Federal government would like to see or will require to be collected on those receiving vaccination. I assume she is referring to tracking for adverse events, Guillan-Barre, etc.

Answer: Providers will be required to sign a provider agreement in which they will agree to report doses administered and perhaps the ages of those who received doses. As with any vaccine, they should report any known adverse events to VAERS. Once provider agreement is finalized, we will disseminate it. In the meantime, providers can register their interest in giving vaccine at khelps.chfs.ky.gov

Clinician Guidance

Question: What type of education is being done with the physicians on H1N1 testing criteria? We are still getting patients with orders for testing but no criteria listed.

Answer: DPH published an "Updated Novel H1N1 Clinician Guidance document" on 20 Aug. That document is also available online, <http://healthalerts.ky.gov/swineflu/healthpros.htm>. Additionally, the Kentucky Medical Association and medical specialty groups have distributed the updated guidance to their membership. Please circulate as widely as possible to providers in your jurisdiction.

Question: Is there a form with the criteria listed that the physician can check and be sent with the specimen to state lab?

Answer: Not yet. However, the hospital laboratory should only submit specimens to the State Lab for novel H1N1 virus testing from those patients that meet the "*Criteria for Submission of Laboratory Specimens to the Division of Laboratory Services*" (DLS) as described in the updated clinician

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guidance. Medical providers certainly can order testing for novel H1N1 virus for patients that do not meet those criteria. HOWEVER, specimens from those additional patients should be sent to national reference laboratories, e.g. Quest, rather than DLS.

Question: We were asked if we would mandate that our employees who have direct patient contact take the Novel H1N1 vaccine, when available.

Answer: Dr. Hacker has stated that the vaccine cannot be mandated, just as other recommended vaccines are not mandated. Hopefully, all HCWs will be using appropriate PPE in patient care settings. Local health department directors may want to consider furloughs for those HCW employees that decline to be vaccinated, since sick employees who spread illness could damage a department's reputation and lead to potential medicolegal issues. Attached is a declination form that was originally designed for seasonal flu.



Declination of
Influenza Vaccination

Question: Is the VA going to be supplied separately or are we dependent on the state supply?

Answer: VA patients are considered part of the civilian population and will be subject to state allotment

Question: We have a patient who is positive Influenza A, and on antivirals how long should they be in isolation?

Answer: Seven days for hospitalized patients and ill staff.

"CDC Recommendations for the Amount of Time Persons with Influenza-Like Illness Should be Away from Others. ", <http://www.cdc.gov/h1n1flu/guidance/exclusion.htm> "This guidance does not apply to health care settings where exclusion period should be continued for 7 days from symptom onset or until the resolution of symptoms, whichever is longer; see http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm for updates about the health care setting."

"CDC recommends this exclusion period regardless of whether or not antiviral medications are used. ", <http://www.cdc.gov/h1n1flu/guidance/exclusion.htm>

Question: SCL group homes, although the caregivers at these homes are not direct 'patient' providers, they are direct care providers. Would these caregivers be considered, with regards to priorities for H1N1? They provide an array of services including medications as well as personal care services, etc.

Answer: If the SCL caregivers are providing medications and assisting with activities of daily living, they are giving direct care---- just like in a long-term

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care facility. It would be reasonable for you to include them as HCWS for H1N1 purposes.

CDC has definitions for Healthcare workers in a couple of publications:

From the August 21st guidance on H1N1 vaccine use,
<http://www.cdc.gov/mmwr/pdf/rr/rr58e0821.pdf> :

“Health-care personnel (HCP) include all paid and unpaid persons working in health-care settings who have the potential for exposure to patients with influenza, infectious materials, including body substances, contaminated medical supplies and equipment, or contaminated environmental surfaces. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, maintenance, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP. The recommendations in this report apply to HCP in acute-care hospitals, nursing homes, skilled nursing facilities, physicians’ offices, urgent care centers, and outpatient clinics, and to persons who provide home health care and emergency medical services (27). Emergency medical services personnel might include persons in an occupation (e.g., emergency medical technicians and fire fighters) who provide emergency medical care as part of their normal job duties.”

Epidemiology/Surveillance

- ***Planning and Modeling*** (Subject Matter Lead: T.J. Sugg - Tennis.Sugg@ky.gov)

- ***Evaluation***
 (Subject Matter Lead: Jim House – JamesR.House@ky.gov)

Training and Education

(Subject Matter Leads: David Knapp and Barbara Fox – David.Knapp@ky.gov and BarbaraJ.Fox@ky.gov)

TRAIN courses & Archived Webcasts

- Summaries of the September 23 Joint ITV and H1N1 briefing are attached. To view a recorded version of this session please use the link below to access the archived webcast.

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<http://kennect.chfs.ky.gov/Play.dyn?m2=2ois4igzft33xz88x3y2g4dx0zd7o2hsxln3alfiasefx3wl4dw> The "Private code" is: 8d7B2666



Weekly LHD H1N1
ITV Summary 092320



How to Access
WEBCAST 1019283.c

Also attached information on how to access the KDPH: H1N1 Provider Enrollment and Vaccination Management Webcast. The archived TRAIN Course ID is 1019283

Please note that there are 7 downloadable documents just beneath the red triangle play button on the webcast page. Printing these and following along with the presenter will help you get the most out of this presentation.

- Much of the material is applicable to a Mass Vaccination campaign as well as a Mass Prophylaxis campaign.
KY DPH Strategic National Stockpile-SNS 210: Developing a Dispensing Campaign Module -1017001 has been approved for nursing continuing education as follows:
Kentucky Board of Nursing Provider Number:
7-0038-01-2013-702
Contact Hours =1.2

H1N1 Grant/Funding

(Subject Matter Lead: Katie Robinson - Katie.Robinson@ky.gov)
