

Vaccine and Antiviral Priority Groups

When the U.S. confirms the first case of pandemic influenza disease, a decision must be made in regarding who will receive the available antiviral or vaccine. The decision will impact the mortality, morbidity, loss of quality of life, and economic damage to Helena. Current annual high-risk group recommendations are expected to change, because past pandemic influenza outbreaks have also affected the young and healthy people. The Executive Planning Committee will make the final decision based on CDC's recommendations.

On June 19, 2005, the National Vaccine Advisory Committee (NVAC) and the Advisory Committee on Immunization Practices (ACIP) made recommendations to the prioritization of vaccine and antivirals and purchase recommendations for pandemic influenza vaccine. The groups noted that this prioritization may change depending on disease epidemiology.

Goals

- 1. Minimize hospitalizations and deaths.
- 2. Preserve critical infrastructure and minimize social disruption.

Priority Groups

- 1. Health Care Workers.
- 2. Vaccine Manufacturing Personnel.
- 3. Highest Risk of Complications.
- 4. Critical Public Health Pandemic Responders.

Second Priority Group

- 1. High Risk Populations.
- 2. Public Health Emergency Responders.

Third Priority Group

- 1. Critical Infrastructure Workers.
- 2. Key Government Health Decision Makers.
- 3. Mortuary Services.

Fourth Priority Group

- 1. Remainder of the Healthy Population.

The NVAC and ACIP supported federal purchase of all vaccine, so as to best facilitate distribution and targeting, give states and localities maximal control, and guarantee purchase for manufactures. The recommendation also notes that when the pandemic is declared over, purchase and distribution of the vaccine would revert back to the mixed public/private system currently in place.

Antivirals

Priority Groups

1. Health Care Workers.
2. Highest Risk Outpatients.
3. Emergency Responders.

Second Priority Groups

1. Hospitalized Patients.
2. Outbreak Situations.

Mass Casualty

Mass casualty plans will be implemented through procedures outlined in the City of Helena EOP for other emergency events.

Guidelines for officials on how to plan for delivering health and medical care in a mass casualty event are outlined in a new report from an expert panel convened by HHS' Agency of Healthcare Research and Quality and Office of Public Health Emergency Preparedness.

Several recommendations for action related to planning a health and medical care response to a mass casualty event are identified below. The list of recommendations is not meant to be comprehensive, but it provides a starting point for discussion. These ideas suggest that a collaborative approach should be taken when developing new steps; both government and private organizations have unique roles and important contributions to make in moving forward.

1. Develop general and event-specific guidance for allocating scarce health and medical care resources during a mass casualty event.
2. Develop and implement a process to address non-clinical issues related to the delivery of health and medical care during a mass casualty event.
3. Develop a comprehensive strategy for risk communication with the public before, during, and after a mass casualty event.
4. Identify, analyze, and consider modifications of Federal, State, and local laws and regulations that may affect the delivery of health and medical care during a mass casualty event.
5. Develop means for verifying credentials of medical and other health personnel prior to and on-site during a mass casualty event.
6. Create strategies to ensure health and medical leadership and coordination for the health and medical aspects of system response during a mass casualty event.
7. Continue and expand efforts to train providers and others to respond effectively in a mass casualty event.
8. Develop and support a research agenda specific to health and medical care standards for mass casualty events.
9. Develop a Community-Based Planning Guide for Mass Casualty Care.
10. Identify and support States, health systems, and regions to develop mass casualty and health and medical care response plans based on the Planning Guide and to share their results widely.
11. A plan for coordination with receiving facilities (e.g., hospital emergency departments) and other EMS transport organizations to manage the transportation of large numbers of patients at the height of the pandemic.
12. A policy and procedure for transporting multiple patients with pandemic influenza during a single run.
13. The plan considers the possible necessity of sharing transportation resources or using vehicles other than those designed for emergency or medical transport.

Communications

The primary communications goal of the City of Helena during a pandemic will be to ensure a timely, accurate, and consistent flow of information. Information will primarily be provided to public health area (PHA) staff, CDH staff, health professionals, and the general public.

A system for phone triage of patients calling 911 or other emergency numbers that might be used that includes pre-established criteria and coordination protocols to determine who needs emergency treatment/transport. The system includes points of referral for patients who do not need emergency treatment/transport.

Workforce Support / Occupational Health

Develop a continuity of operations plan for health care providers, emergency services, and other essential city services in response to absenteeism among city employees during a pandemic.

Determine the minimum number and categories of personnel necessary to sustain EMS and non-emergent services on a day-to-day basis.

1. Have an updated part-time list of employees.
2. Have mutual-aid agreements with other jurisdictions.
3. Notify CERT members.
4. Ensure availability of psychosocial support services for employees who participate in/or provide for the response to public health emergencies such as influenza pandemics.
5. Develop workforce resilience programs, such as annual vaccinations, and ensure readiness to deploy to maximize responders' performance and personal resilience during a public health emergency.
6. A liberal/non-punitive sick leave policy for managing EMS and non-emergent personnel who have symptoms of or documented illness with, pandemic influenza.

The policy considers the following:

- Handling of staff who become ill at work.
- When personnel may return to work after recovering from pandemic influenza.
- Personnel who need to care for their ill family members.
- A system for evaluating symptomatic personnel before they report for duty that has been tested during a non-pandemic period.
- A list of mental health and faith-based resources available to provide counseling during a pandemic.

- Management of personnel who are at high risk for influenza complications (e.g., pregnant women, immunocompromised workers) by placing them on administrative leave or altering their work locations.
 - The ability to monitor seasonal influenza vaccinations of personnel.
7. A plan is in place to ensure that education and training on pandemic influenza is provided to ensure that all personnel understand the implications of, and control measures for, pandemic influenza and the current response plan.
 8. Language and reading-level-appropriate materials for professional and non-professional personnel on pandemic influenza have been identified and a plan is in place for obtaining these materials.
 9. Education and training include information on infection control measures to prevent the spread of pandemic influenza.
 10. Differences between responding to pandemic influenza and a mass casualty event have been incorporated into education and training programs.
 11. Anticipate consumable resource needs (e.g., gloves, masks, hand hygiene products).

Infection Control

An infection control plan is in place and includes the following:

1. Implementing Respiratory Hygiene/Cough Etiquette for patients with a possible respiratory illness.
2. Distributing masks to symptomatic patients who are able to wear them (adult and pediatric sizes).
3. Providing facial tissues and receptacles for their disposal.
4. Providing hand hygiene materials for all employees.
5. A policy that requires healthcare personnel to use Standard Precautions.

For more information on infection control recommendations for pandemic influenza, see www.hhs.gov/pandemicflu/plan/sup4.html.

Appendix A: Influenza Infection Control Measures

Influenza viruses are spread from person-to-person, primarily through inhalation of small particle aerosols and large droplet transmission. Transmission may also occur through direct and indirect contact with infectious respiratory secretions. Persons can be infectious starting the day before symptoms begin through approximately five (5) days after illness onset. Children can be infectious for a longer period of time. The main option for controlling influenza is immunoprophylaxis with the inactivated vaccine. Use of antiviral drugs for treatment is an important adjunct to vaccination.

The general public will have to consider "isolation in place" to reduce the risk of spreading the pandemic influenza to others.

Special guidelines for infection control should be in place during pandemic influenza, taking into account the likelihood a high proportion of the population will be affected and secondary infections are a major source of morbidity and mortality. In offices, airborne precautions should be followed:

1. Staff education: Staff should be educated annually about the prevention and control of influenza, focusing on transmission of infection. Staff should be reminded that they can transmit the virus via their hands, clothes, or office supplies.
2. Hand washing: Hands should be washed after touching contaminated items, whether or not gloves are worn. Hands should be washed with plain soap or detergent for at least 10-15 seconds under running water.
3. Gloves: Clean, disposable gloves should be worn when touching blood, body fluids, secretions, and contaminated items. Gloves should be removed after use, before touching any non-contaminated items, or before touching another person. Hands should be washed immediately with soap and water or an alcohol-based hand-rub.
4. N-95 Masks: Mask may be considered to use to limit the spread of airborne particles.

Appendix B: Pandemic Influenza Overview

Organism	<ul style="list-style-type: none"> * Influenza virus: types A; (A is further categorized into subtypes); type B; type C – rare cause of disease. * Frequent mutations of surface glycoprotein genes result in new influenza virus variants. <ul style="list-style-type: none"> ~ Antigenic shift---emergence of completely new subtypes (type A only; leads to pandemics). ~Antigenic drift---minor changes (all types; leads to frequent outbreaks and epidemics).
Reservoir	Type A – humans; swine; birds; types B & C - humans
Communicability	<ul style="list-style-type: none"> * Person-to-person, primarily through coughing and sneezing of infected persons. * Communicable 1 day before onset of symptoms until approximately 5 days thereafter. * Disease usually peaks in U.S. from December to March. * In pandemics, entire population susceptible; attack rates high among all ages.
Mortality Rates	<p>Deaths result from pneumonia and exacerbations of cardiopulmonary and other chronic conditions.</p> <ul style="list-style-type: none"> * Interpandemic years: 1972 through 1992 – 9.1 deaths per 100,000 Americans per season. * Pandemics: 1918 Spanish flu – 218.4 deaths per 100,000 Americans; 1957 Asian flu – 22 deaths per 100,000; 1968 Hong Kong flu – 13.9 deaths per 100,000.
Incubation period	1 – 3 Days
Symptoms	<ul style="list-style-type: none"> * Influenza A – Abrupt onset of fever, myalgia, headache, severe malaise, sore throat, rhinitis, nonproductive cough (symptoms last limited number of days; cough can persist for 2 weeks). * Influenza B – Similar but milder symptoms than type A; occurs primarily in children.
Complications	<p>High risk: Age 6 – 23 months; >65yrs.; nursing home residents; persons with chronic cardiac, pulmonary, metabolic & renal conditions and hemoglobinopathies; immunocompromised; and >12 wks of pregnancy.</p> <ul style="list-style-type: none"> * Pneumonia – secondary bacterial (most frequent) and primary influenza viral. * Worsening of underlying medical conditions. * Rarely associated with Reye syndrome (occurs primarily in children with Influenza B taking aspirin); myocarditis; encephalopathy; transverse myelitis; myositis; pericarditis.
Laboratory tests	Rapid antigen tests; viral culture; RT-PCR; serology.

Infection control	Standard precautions, strict hand washing. Airborne precautions may be advised during special circumstances such as a novel virus alert.
Prevention	<p>Primary strategy: Annual vaccination before influenza season.</p> <ul style="list-style-type: none"> * Antigenic drift necessitates annual reformulation of flu vaccine to incorporate >1 new strains. * Contraindications – allergy to egg or vaccine; avoid in persons with previous severe reaction. * Delay vaccination of persons with acute febrile illness but not minor illness, with or without fever. * Inactivated (i.e., killed) trivalent vaccine; approved for ages >6 months old; provides 70-90% protection in healthy adults; reduces complications by 50-60% and death by 80% among elderly in nursing homes. * Live attenuated influenza vaccine; approved only for healthy individuals ages 5 – 49 and not for persons with underlying medical conditions, immunocompromised persons, persons with asthma, reactive airway disease or other cardiac/pulmonary disorders, pregnancy, or children receiving aspirin therapy or other salicylates. Such individuals should receive the inactivated vaccine. <p>Adjunct strategy: Chemoprophylaxis with antivirals for unvaccinated high risk and advanced HIV.</p>

Antiviral Recommendations

Antiviral Agent	Trade Name	Flu type	Use	Age Restrictions
Amantadine	Symmetrel	A	Prophylaxis/ Treatment	>1 year
Rimantadine	Flumadine	A	Prophylaxis/ Treatment	Only adult for treatment. >1 year for prophylaxis.
Zanamivir	Relenza	A and B	Treatment only	>7 years
Oseltamivir	Tamiflu	A and B	Prophylaxis/ Treatment	>1 year for treatment. >13 years for prophylaxis.

- Treatment: Can reduce duration of uncomplicated illness if given within 48 hours of symptom onset.

Surveillance

State regulations require the reporting of influenza cases to the health department within 7 days.

For more information, refer to: Center for Disease Control and Prevention. Prevention and Control of Influenza; Recommendations of the Advisory Committee on Immunizations Practices, MMWR 2003; 52 (RR08): 1-36.

Appendix C: Risk Communications Sample Messages

Key messages: 7-9 second sound bites (21 – 27 words)

1. Because we are faced with a limited supply of vaccine, we will look at ways to do the most good for the most people.
2. To make sure healthcare providers are available to care for those who develop influenza it is imperative that we vaccinate healthcare workers immediately.
3. To ensure that our community is safe and has water, electricity and other services we all rely on, we must prioritize vaccinating essential services workers.
4. (Fill in age group)-olds are more seriously affected by this strain of influenza. They are high risk and, therefore, must be vaccinated early.
5. Although this influenza vaccine has not been approved by the FDA, it will be given as an investigational new drug. Its benefits far outweigh the risks.

Gathering Supporting Facts:

1. Track case numbers and mortality by age group and by locality.
2. Identify groups of essential services workers.
3. Develop clear explanations of risks associated with the disease and vaccination.
4. Develop credible community sources that will validate the key message.
5. Establish relationships and agreements with infectious disease specialists.

Contact Information

Administration:

Fire / EMS:

Phone triage personnel / dispatch center:

State / Local Emergency Management Officer:

State / Local Health Department Official:

Law enforcement:

Emergency Transport Organizations:

Healthcare entities (hospitals):

NOW, THEREFORE, BE IT ORDAINED by the City Council of the City of Helena, Alabama, that this ordinance shall take effect and be in force from and after its passage, the public welfare requiring it and upon being published and posted as provided by law.

ADOPTED and APPROVED by the Mayor and City Council of the City of Helena, Alabama on the 18 day of December, 2006.



ATTEST:

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