

**Flu Advisory Board (FAB) Meeting  
May 12, 2005**

**Members present:** Maryann Kujava, Visiting Nurse Special Svcs, [mkujava@chs-mi.com](mailto:mkujava@chs-mi.com) ; Becky Tillman, Visiting Nurse Assoc, [rtillman@chs-mi.com](mailto:rtillman@chs-mi.com) ; Mark Magnuson, MedImmune Inc, [magnusonm@medimmune.com](mailto:magnusonm@medimmune.com) ; Lisa VanRoemdonck, Michigan Visiting Nurses, [lnbutler@umich.edu](mailto:lnbutler@umich.edu) ; Beverly Piskorski, Greater Oakland VNA, [bevpiskorski@yahoo.com](mailto:bevpiskorski@yahoo.com) ; Ann Shelton, MedImmune Inc, [sheltona@medimmune.com](mailto:sheltona@medimmune.com) ; M. Thirumoorathi, MD, St John Health, [m.thirumoorathi@stjohn.org](mailto:m.thirumoorathi@stjohn.org) ; Linda O'Leary, St John Health, [linda.oleary@stjohn.org](mailto:linda.oleary@stjohn.org) ; Peter Scuccimarri, Michigan Family Medicine, [pscuccimarri@pol.net](mailto:pscuccimarri@pol.net) ; Mark Mlynarczyk, MedImmune Inc, [mlynarczykm@medimmune.com](mailto:mlynarczykm@medimmune.com) ; Teresa Holtrop, MI AAP, [tholtrop@med.wayne.edu](mailto:tholtrop@med.wayne.edu) ; JoEllen Wolicki, MDCH, [wolickij@michigan.gov](mailto:wolickij@michigan.gov) ; Stacy Nunziato, sanofi pasteur, [stacy.nunziato@sanofipasteur.com](mailto:stacy.nunziato@sanofipasteur.com) ; Jan Koopman, MDCH, [koopmanj@michigan.gov](mailto:koopmanj@michigan.gov) ; Patsy Bourgeois, Monroe Co Health Dept, [patsy\\_bourgeois@monroemi.org](mailto:patsy_bourgeois@monroemi.org) ; Pat Krehn, Muskegon Co Health Dept, [krehnpa@co.muskegon.mi.us](mailto:krehnpa@co.muskegon.mi.us) ; Sue Schryber, Ottawa Co Health Dept, [sschryb@co.ottawa.mi.us](mailto:sschryb@co.ottawa.mi.us) ; Linda Lantry, MNA Washtenaw Co, [lantryl@ewashtenaw.org](mailto:lantryl@ewashtenaw.org) ; Carol Legwand, CHM/DMC, [clegwand@dmc.org](mailto:clegwand@dmc.org) ; Teri Lee Dyke, MDCH, [dyket@michigan.gov](mailto:dyket@michigan.gov) ; Cora Urquhart, MDCH, [urquhartc@michigan.gov](mailto:urquhartc@michigan.gov) ; Gary M. Kirk, MDCH, [kirkg@michigan.gov](mailto:kirkg@michigan.gov) ; JoAnn Clinchoc, Detroit LHD, [clinchocj@health.ci.detroit.mi.us](mailto:clinchocj@health.ci.detroit.mi.us) ; Melinda Dixon, Detroit Dept of Health & Wellness Promotion, [dixonm@health.ci.detroit.mi.us](mailto:dixonm@health.ci.detroit.mi.us) ; Talat Danish, Wayne Co Dept of Public Health, [tdanish@co.wayne.mi.us](mailto:tdanish@co.wayne.mi.us) ; Eden Wells, MDCH, [wellsed@michigan.gov](mailto:wellsed@michigan.gov) ; Rachel Potter, MDCH, [potterr1@michigan.gov](mailto:potterr1@michigan.gov) ; Liz Harton, MDCH, [hartone@michigan.gov](mailto:hartone@michigan.gov) ; Stephanie Mercer, Lapeer Co Health Dept, [smercer@lapeercounty.org](mailto:smercer@lapeercounty.org) ; Pat Vranesich, MDCH, [vranesichp@michigan.gov](mailto:vranesichp@michigan.gov) ; Bob Swanson, MDCH, [swansonb@michigan.gov](mailto:swansonb@michigan.gov) ; Basim Asmar, WAU/CHM, [basmar@wayne.edu](mailto:basmar@wayne.edu) ; Dianne McCagg, MPRO/AIM, [dmccagg@mpro.org](mailto:dmccagg@mpro.org) ; Dean Sienko, MALPH, [dsienko@ingham.org](mailto:dsienko@ingham.org) ; JoAnne Eakins, NAF/MALPH, [jeakins@ioniacounty.org](mailto:jeakins@ioniacounty.org) ; Roberta Peacock, Kent Co Health Dept, [bobby.peacock@kentcounty.org](mailto:bobby.peacock@kentcounty.org) ; Cara Knapp, Kent Co Health Dept, [cara.knapp@kentcounty.org](mailto:cara.knapp@kentcounty.org) ; Carolyn Bird, Oakland Co Health Division, [birdc@co.oakland.mi.us](mailto:birdc@co.oakland.mi.us) ; and Kathy Webster, Washtenaw Co Health Dept, [websterk@ewashtenaw.org](mailto:websterk@ewashtenaw.org) .

**Members on conference call:** Terrisca DesJardins, SE MI Partners Project, [tdesjardins@achp.org](mailto:tdesjardins@achp.org) ; Kevin Lokar, MALPH, [kevin.lokar@macombcountymi.gov](mailto:kevin.lokar@macombcountymi.gov) ; and Judy Ferguson, MALPH, [jergusonj@sanilachealth.com](mailto:jergusonj@sanilachealth.com) .

Gary M. Kirk called the meeting to order at 12:35 pm.

**New Business:**

After a brief welcome, the following items under “New Business” were discussed: 1) The development of a central information repository (cited under “Communication” at the

3/15 meeting), 2) The use of local health departments as a liaison to all partners (“Deployment of Resources”), and 3) The development of a defined crisis response team (“Leadership and Other Roles”).

As the board discussed the various issues surrounding the three topics, it was suggested that three subcommittees – Communication, Deployment and Leadership – be developed to develop the above items further. Once again, board members were reminded that the overarching purpose of the board and its subcommittees is to improve the communications, relationships and activities that surround the flu season each year – subcommittee work should hopefully expose opportunities for improvement.

Volunteers for the three subcommittees are as follows, with the MDCH staff manager assigned to facilitate the subcommittee listed last (in bold type) for each subcommittee:

#### Communication

Terrisca DesJardins  
Cora Urquhart  
Lisa VanRaemdonck  
Mark Magnuson  
Rachel Potter  
JoAnn Eakins  
Bobbie Peacock  
Carol Legwand  
Dianne McCragg  
Talat Danish  
**Pat Vranesich**

#### Deployment

Stephanie Mercer  
Beverly Piskorski  
Jan Koopman  
Kathy Webster  
Cara Knapp  
Pat Krehn  
Patsy Bourgeois  
Sue Schryber  
Dianne McCagg  
Stacy Nunziato  
**Gary M. Kirk**

#### Leadership

Teresa Holtrop  
Patsy Bourgeois  
Sue Schryber  
Linda O’Leary  
Carol Bird

Teri Lee Dyke  
Maryann Kujava  
**Bob Swanson**

It was suggested that the subcommittees meet in person or via conference call within one month to start to develop issues and work items. (Please note the inclusion of emails in the attendees' information above to facilitate communication.) It also was suggested that each subcommittee determine who their chair will be. Subcommittees will then report at each full FAB meeting. Please note: Others may join subcommittees. Please just let the MDCH subcommittee facilitator know that you are joining.

A discussion ensued about the accuracy of providers' contact information within MDCH's licensing information. This was a follow-up to an earlier question (at the 3/15 meeting) about the possibility of contacting providers urgently, if necessary, using MDCH contact information. Several limitations in the data were noted: 1) Since providers are licensed every three years, the contact data may be as old as three years and may not reflect attrition secondary to a recent move, retirement, death, etc., 2) The contact information lists the providers' names and addresses, which may be home or practice sites, i.e., no phone numbers or email addresses are listed, and 3) Providers are not listed by specialty. After further discussion, it was decided not to pursue getting the list of providers to the local health departments, although it was suggested that discussions start on how to make the contact information more useful. Gary volunteered to speak with Jean Chabut, the Director of MDCH's Public Health Administration, about this.

Cora Urquhart, Licensing Officer Team B for the Division of Nursing Home Monitoring (MDCH) mentioned a link to a website that lists nursing homes by county. Many of the LHD officials in attendance said they thought such a link would be helpful to them to communicate efficiently with nursing homes in their jurisdictions. The link is [http://www.cis.state.mi.us/bhs\\_car/sr\\_car.asp](http://www.cis.state.mi.us/bhs_car/sr_car.asp)

The issue of flu vaccine pre-booking problems among VNS/VNAs in the State was briefly discussed; it seems that issue is resolved at present.

The *Planning for an Influenza Vaccine Shortage* draft was discussed very briefly; it was suggested that members read the document in its entirety and apply it, as appropriate, to future subcommittee and full FAB meeting discussions. The entire document is attached to the end of these minutes.

Pandemic influenza was mentioned as an evolving topic for the FAB. Eden Wells is in charge of assembling the groups to comment on MDCH's Pandemic Flu Plan and may seek the FAB's input at some point.

Several structural (i.e., process) issues were discussed. It was decided that the creation of a "Rapid Response Team", designed to respond quickly to issues that arise during the flu season, would fall under the domain of tasks for the Leadership subcommittee. It was

decided that MDCH staff would act as staff to the FAB. It was decided to delay the choosing of a chair for the FAB. Finally, the FAB agreed that it should meet eight times per year. Four of the meetings will be designed as face-to-face meetings (although conference calling will be offered) and will follow the MACI meetings (lunch will be offered). The other four meetings will occur via conference calls in between the MACI/FAB meetings.

The meeting was adjourned at 1:45pm.

**Next Meeting:** June 24, 2005 from 9-10:30am by conference call. (Please note the change from June 23<sup>rd</sup> to June 24<sup>th</sup>.) The dial-in number will be 1-888-791-4937 and the passcode will be 9438017.

## **Guideline: Planning for an Influenza Vaccine Shortage, Draft #3 – 11 April**

### **Goals**

- High risk and priority groups have high coverage
- Infrastructure established for preparedness and response if shortfall occurred
- Size of high risk/priority groups at state and local levels estimated
- Timely and equitable ordering of trivalent, inactivated influenza vaccine (TIV)
- Timely and equitable distribution of existing TIV stocks to public and private providers on the basis of population
- Providers, other stakeholder and public informed of high risk/priority groups and rationale for vaccination prioritization
- Providers aware of vaccine needed for their high risk/priority group clients
- Providers prioritize use of TIV according to degree of vaccine shortfall
- Vaccine redistributed and/or patients referred to enable high risk and priority group coverage
- Providers use live attenuated influenza vaccine (LAIV) for healthy person 5-49 years
- Providers, stakeholders and public kept aware kept informed and educated about influenza and influenza vaccine

### **Key Concepts**

- In the event of a vaccine shortage planners for 2005-2006 at state and local levels may expect population proportional distribution of TIV among states.
- Traditionally, 85-90 percent of influenza vaccines are administered by the private sector such as medical providers, long term care facilities (LTCs), hospitals, HMOs, corporate vaccinators.
- At this time only one of two US licensed producer of TIV has confirmed its expected production for the upcoming season; there is one producer of LAIV
- As of April 11, 2005 an estimated influenza vaccine supply for 2005-2006 season of up to 63 million doses , mostly TIV from one producer, is anticipated to be available and distributed from September through mid November. Additional TIV from a second currently licensed producer is possible, though amount and timeline are unknown. And, one or more currently unlicensed producers may seek licensing in time for this year's influenza season. Expected TIV amounts and timelines for these producers are unknown.
- The anticipated minimum supply of TIV is approximately equal to the total amount of TIV available during the 2004-2005 season; one that was characterized by mid-season vaccine shortage and distribution problems.
- The ACIP very strongly emphasizes that LAIV should be used for healthy 5-49 year olds in all priority and non-priority groups.
- TIV shortages have caused disruptions in 4 of the 5 previous influenza seasons as a result of production and/or regulatory reasons
- CDC has provided guidance regarding high risk and priority groups and their prioritization for TIV to be considered only with TIV shortages

- Vaccine use under an Investigational New Drug (IND) protocol would occur only in the event of a severe vaccine shortage (e.g., substantially less than 60 million doses of TIV available).
- The events of the 2004-2005 season strengthened collaboration and cooperation between national, state and local public health entities, public and private providers, manufacturers and distributors, and other stakeholder groups to ensure equitable distribution, redistribution among providers and equitable vaccination of high risk patients.
- The lessons learned and successful activities during 2004-2005 are a valuable resource and foundation to build plans for a future possible shortage situation.

**Rationale: Preparedness for Influenza Vaccine Shortages**

Given the variance in supply of vaccine over the past few years, states and local jurisdictions should of prepare for the possibility of another vaccine shortage. Last year’s response to the mid-year shortage of TIV demonstrated that collaborative planning and actions at national, state and local levels can accomplish and provide numerous lessons learned and best practices. The impressive and successful response called upon the participation of federal, state and local agencies, vaccine producers and distributors, providers (private, public, hospital, long-term care facilities), national and state professional associations and other stakeholders. The activities at each level should be reviewed, updated and included in preparedness planning for a future shortage. Likewise, the partnerships and coalitions that were operational during last year should be regrouped and charged with preparedness planning for this year. Preparedness should include various scenarios such as delays in the timeline for distribution, absolute decreases in vaccine supply (minor, intermediate, major), and reallocation of vaccine within your jurisdiction.

In preparedness planning, the following components and activities related to each should be considered and incorporated. It is likely each would be useful as well during periods of normal vaccine supply and in preparedness planning for pandemic influenza.

Preparedness Components for Planning for Influenza Vaccine Shortage
<ul style="list-style-type: none"> <li>▪ Infrastructure and Responsibility</li> <li>▪ Partnering and Collaboration</li> <li>▪ Communications</li> <li>▪ Priority Groups, Vaccine Prioritization and Estimating TIV</li> <li>▪ Prebooking and Ordering</li> <li>▪ Vaccine Reallocation and Patient Referral</li> <li>▪ Education and Information</li> </ul>

## **Planning Components**

### **Infrastructure and Responsibility**

At all jurisdictional levels preparedness for a TIV shortage requires a plan that can be activated rapidly. An effective infrastructure is needed to lay out the plan and to be responsible for its timely implementation in the event of an actual shortage. A functioning Executive Committee or Incident Command Structure (ICS) provides the technical, management, and organizational expertise and responsibility for planning, policy decisions and implementation of activities. ICS has been effective in preparedness planning and response strategy for bioterrorism and emergency response situations.

#### **Activity: (for both CDC and state/local jurisdictions)**

- Reactivate or form an executive group responsible for preparedness planning and intervention.
- Review other ICS or ‘command and control’ leadership alternatives.
- Determine legal foundation for emergency infrastructure and its activities.
- Ensure familiarity with jurisdiction’s last year vaccine shortage response including best practices, resources needed, and problems encountered.
- Determine components of preparedness and implementation activities.
- Designate persons or departments responsible for individual components of the plan and response activities.
- Establish timelines.
- Assure effective channels of communication.
- Determine personnel and other resource needs. Exercise and evaluate plan.
- Update plan as new information becomes available.

### **Partnering and Collaboration**

Last year’s TIV shortage led to the forming of a network of partnerships and collaboration among public health and hospital and healthcare providers and their associations, federal, state and local public health and other agencies, and vaccine producers and distributors. These networks rapidly evolved as decisions were needed to be made and implemented quickly. The success of last year’s responses can be traced to these strong and responsive collaborations at all jurisdictional levels. The partnerships enhanced information and technical expertise availability and exchange, decision making and dissemination of decisions, timeliness and quality of communications, and the levels of mutual trust. The experience and lessons learned from last year’s collaborations are a baseline for successful activities to prepare for future vaccine supply shortage years, normal vaccine supply years, and even for pandemic influenza responses. The progress made last year in partnership development and collaboration should be capitalized on.

#### **Activity: (for both CDC and state/local jurisdictions)**

- Catalogue and connect with last year’s national, state and local partners, agencies, associations, producers and stakeholders.
- Agree upon the need to prepare for the possibility of another shortage year.
- Review last year’s partnerships and actions re: successes, best practices, problems encountered, timelines, activity leaders, data sources and resources as a basis for this year’s preparedness planning and activities.

- Update partners on current year expectations for TIV and LAIV supplies, timelines, high risk and other priority groups, and rationale and criteria for instituting prioritization.
- Establish lead persons or organizations responsible for each component and its associate activities.
- Discuss various shortage scenarios, response activities, resource needs and preparedness timelines.
- Update providers as additional ordinary or extraordinary information becomes available.

### **Communications**

There are several aspects to communications including what needs to be said, when, by whom, to whom and via what form(s) of media. Communication strategies need to be targeted to a variety of constituencies beginning with partners so that all have the same messages. Special messages need to be tailored to various groups such as providers and selected health workers, high risk and priority groups especially to the ethnic and other minority portions of these groups, and those providers who care for these groups. High visibility experts or personalities should be identified to be ‘champions’ of the messages. A good message can only be as effective as the effectiveness and reliability of the systems used to transmit the message. Special attention must be given to messages and the system used to communicate among partners. In addition, partners need to be able to contact and be responsive to their constituents. The system can be e-mail, telephone or web based, and must be complete and reliable. Last year’s TIV shortage forced agencies, health departments, producers and distributors and providers and their associations to establish responsive communications with their constituents so that shortage-related information could be rapidly disseminated and shortage-related data needs rapidly collected.

#### **Activity:**

##### **(for both CDC and state/local jurisdictions)**

- Review the status and history of the communications developed and used by state and local jurisdictions during the TIV shortage.
- Evaluate the completeness and effectiveness of these communication systems.
- Identify best messages and systems from last year’s communications. Update messages as more information becomes available.
- Develop and disseminate messages directed to private providers and their associations requesting their full participation in influenza vaccine delivery.
- Update the contact list of partners and provide them with an updated listing of state and local agency contacts.
- Urge partners to update constituent lists and capabilities for contacting and being contacted.
- Assure those partners serving priority groups that every effort will be made to provide timely and needed vaccine and other influenza-related information.
- Agree with partners on plan and system for keeping providers informed.
- Update federal agency partners with current state and local contact information.

##### **(State/local jurisdictions only)**

- Renew contacts with producers and distributors known to supply the state and local points of vaccination.

**(CDC only)**

- Arrange with producers and distributors to exchange information concerning vaccine supplies, estimated size of priority groups, estimated provider TIV orders for priority group and for non priority population, vaccine supply and distribution timeline and plan, plans for TIV reallocation and referring of patients, extent and location of provider ordering, and, eventually, amounts of vaccine delivered to your jurisdiction.

Sources for Up-to-date Provider Communication List

- Health care licensing agencies
- General/internal/pediatric/specialty (pulmonary, diabetes, etc) provider associations
- Public health clinics providing routine vaccine preventive services and/or influenza and pneumococcal vaccine to priority clients and accepting of referrals for vaccination
- Hospital associations, HMOs
- Community health center associations
- Long term care associations,
- Non-profit providers (NGOs such as Visiting Nurses Association)
- For-profit corporate vaccinators, and
- Producer/distributor provider lists
- State and local public health agencies managing terrorism preparedness may also have such lists

**Priority groups, TIV prioritization, and TIV estimates –**

If a significant TIV shortage occurs again, national prioritization of TIV use will be recommended. The degree of prioritization will reflect the severity and timing of the shortage. Persons at highest risk of complications of influenza disease and other priority groups were defined and recommendations for prioritization of TIV evolved during last year in response to the significant shortage of TIV.

ACIP Recommended Priority Groups by Tiers for Inactivated Influenza Vaccine (TIV), 2005-2006

- Tier 1a
  - Long term care facility residents
  - Persons 65+ years with co-morbid conditions
- Tier 1b
  - Persons 2-64 years with co-morbid conditions
  - Persons 65+ years without co-morbid conditions
  - Children 6-23 months
  - Pregnant women
- Tier 1c

- Health care personnel
- Close contacts of children <6 months
- Tier 2
  - Contacts of high risk children and adults
  - Healthy persons 50-64 years
- Tier 3
  - Persons 2-49 years without high risk conditions

The overall rationale for prioritization is to ensure TIV availability for all clients in high risk/priority groups. States made some adjustments to the national schema to reflect features unique to the state. These priority groups are recommended for the 2005-2006 influenza vaccination season as well

(<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5412a4.htm>). In addition, a schema is being considered that will rank priority groups for TIV receipt given vaccine shortages of increasing severity. Ranking will reflect each groups risk for serious influenza-associate complications among other considerations.

State and local health departments need to ensure that providers are aware of high risk/priority groups, their prioritization (when made available), the rational for prioritization and the conditions under which it will be instituted. In addition, plans should be formulated to monitor provider practices if and when prioritization is instituted.

Federal, state and local jurisdictions would benefit from estimating TIV needs of their priority groups to be able to best direct and reallocate TIV if a shortage occurred. As in last year's shortage, jurisdiction priority group estimates can be made by applying national percent estimates to the jurisdiction's population. Background information on populations, health status and socioeconomic status can be found in the Census and surveys done by various federal agencies. Additionally, directly or through various state provider association, vaccine providers of various types can be geographically located and contacted to provide estimates of their priority TIV needs. State associations usually exist for hospitals, provider specialties, public health clinics, long term care providers, etc.

#### Sources of Information to Estimate Priority Groups

- Demographic data and trends: census, birth certificate data, age groups (6-23 months, 2-64 years, 65 and greater), geographic density)
- Health status data and trends: Medicaid, Medicare, national and state-based health and cause of mortality data, insurance data,
- Age specific incidence of high risk conditions (2-64 years age)
- Estimates of long term care facility residents
- Healthcare worker estimates
- Estimates of contacts of high risk children and adults
- Estimates of healthy persons 50-64 years
- Vaccine manufacturers and distributors
- Providers and provider associations

An additional source of information on priority group estimates can be manufacturers and distributors as happened last year. These sources maintain details on practice size, type, location, previous order size, current TIV prebooking amounts for use in priority groups, and amounts of TIV actually sent to the provider. During last year a secure data network (SDN) was used to distribute this data to appropriate state and local recipients. These estimates were useful nationally and at state and local levels in estimating, targeting, allocating and monitoring TIV distribution and use.

**Activity:**

**(for both CDC and state/local jurisdictions)**

- Ensure that providers and partners receive the CDC information on priority groups and the rationale for prioritization under various levels of TIV shortages.
- Ensure that partners are aware that additional recommendations concerning priority groups are likely in the event of a shortage and will reflect its severity
- Review practices used last year to estimate TIV priority group needs.
- Determine what information and sources of information proved most productive.
- Discuss and determine modifications or additions that are needed.
- Renew contacts for data and discuss best practices and lessons learned for both collecting information and data and using them.
- CDC should lead connecting with vaccine manufacturers and distributors and work toward mutual agreement to collect and exchange information on TIV priority group estimates using provider, manufacturer/distributor, population data

**Prebooking/Ordering**

For most vaccine providers a base estimate of influenza vaccine needs can be determined from their last year's usage or client demand. The provider should estimate his TIV needs for high risk/priority groups clients and for entire clientele that the practice serves. The manufacturer/distributor will request both estimates. During an ordinary supply year the producer/distributor will likely provide some portion of the TIV order to all ordering providers early in the season and as much of the remaining order as the supply allows by the end of the vaccinating season. In a TIV shortage year depending on when awareness of the shortage occurs, manufacturers/distributors will likely target as large a portion of the prebooked priority group order as the supply permits; the non-priority part of the order will be cut back as needed or will be delayed until priority groups have been serviced. Information on prebooking, priority group estimates, orders distributed, amount and time when provider received vaccine, underserved provider/population during the 2004-2005 shortage were shared on a secure data network and used for distribution and allocation decisions to ensure some degree of TIV equity nationally and within states for priority groups at highest risk of influenza complications.

**Activity:**

**(for both CDC and state/local jurisdictions)**

- Solicit providers serving priority groups beginning with those from last year, to estimate the persons in priority groups and in their overall practices to be vaccinated

- Determine prebooked amounts of TIV and with whom. Also, record provider problems with prebooking vaccine.
- CDC will evaluate with manufacturers/distributors if it is feasible to again implement a secure data exchange to identify on a state by state basis who and what type of providers have ordered TIV, where the providers are located, how much was ordered for priority groups and overall how much was ordered and at the time of distribution how much and to whom was vaccine actually shipped.

### **Vaccine Reallocation and Referral for Vaccination**

During last year's TIV shortage most state and local jurisdictions established a system within and between jurisdictions to enable TIV reallocations between providers to ensure that persons in priority groups were vaccinated. While a national system evolved for interstate transfers of TIV, most states also worked out arrangements with neighboring states. These systems helped providers to find TIV supplies and also to find providers who needed TIV. Vaccine needs and specific reallocation information occurred and were confirmed through a secure data network. Overall, cooperation within and between jurisdictions was good.

A second approach to ensuring priority group members do get vaccinated also involves providers who have TIV supplies and are willing to accept and vaccinate priority group clients referred by those who do not provide vaccination or who may have inadequate TIV supplies. Generally, this activity involves local area providers and coordination through the local health department.

### **Activity**

#### **(for both CDC and state/local jurisdictions)**

- Encourage all providers, public and especially private, to continue to be providers of influenza vaccinations.
- Establish or resurrect a reallocation system within your jurisdiction that can be made operational if TIV shortages occur.
- Include other states and jurisdictions as appropriate.
- Communicate the purpose, availability and operational details of the system to all who may provide influenza vaccine services.
- Solicit the help of local health departments to expedite vaccine exchanges as needed at local levels and of other partners when TIV exchanges need to be made over greater distances.
- Determine legal issues concerning payment and liability for TIV reallocation.
- Solicit local health departments to arrange to operate a telephone exchange for patient referrals that would become operational with a TIV shortage.
- Inform all local providers.

### **Education and Information Materials and Activities**

Providers, the public and other shareholders need to be made aware of and educated about influenza vaccine priority groups, their prioritization for receiving TIV during TIV shortages, the rationale and conditions for enacting prioritization and effective interventions leading to improved vaccination coverage. Materials available from CDC need to be tailored to specific constituencies by states and local agencies, public and private provider organizations, community support groups, and other stakeholders. These

partners then need to ensure that materials reach their constituents. State and local public health may need to establish information telephone lines or websites as well.

Associations need to promote vaccination through educational seminars, mailings, conferences, and news letters..

Levels of influenza coverage among adults in high risk/priority groups remain well below YR2010 goals. With the exception of children 6-23 months of age for whom routine vaccination was instituted only 2 years ago, increases in influenza coverage have been slow and appear unaffected by the adequacy or inadequacy of the influenza vaccine supply. The causes for continued low coverage especially among adult high risk group may be lack of knowledge and indifference among both clients and the providers, while barriers such as ethnicity, race and socioeconomic factors also contribute. Disparate coverage is easily documented, but even the highest coverage levels are still unacceptable. As evidence of indifference among providers, health care workers have unacceptably low influenza vaccine coverage levels. Higher levels of coverage among priority groups can only be reached by increasing the demand for vaccination within the priority groups. And improved priority group demand requires the support and encouragement of their providers. The public and providers need additional education about influenza disease and complications, disease transmission, influenza vaccine and groups at highest risk of influenza disease. Reaching the public and the providers calls upon public health agencies, public and provider associations, the media, and other stakeholders to take responsibility, and for educational initiatives to be undertaken at the state and local levels. This general issue of awareness and acceptance of influenza vaccination is also important in annual influenza vaccination planning and as a component of pandemic influenza preparedness.

**Activity:**

**(for both CDC and state/local jurisdictions)**

- Review the previous year's efforts to provide information and education materials to providers and the public. Determine last year's best education practices.
- Emphasize need to increase demand and acceptance for vaccination especially among the high risk groups and their providers.
- Emphasize to providers that the most frequent reason given by clients for receiving an influenza vaccination is that the provider suggested it
- Solicit partners to determine their education needs, capabilities and commitment.
- Determine what types of educational materials and methods of dissemination to pursue. Agree upon individual partner group responsibilities.
- Build or support websites for disseminating influenza vaccine materials and to provide linkages for materials produced by other partners and agencies such as CDC.
- Provide information to providers and partner organization concerning expected influenza vaccine supplies, priority groups and prioritization in the event of a TIV shortage and seek their support.
- Encourage provider and their associations to include information on vaccine effectiveness, cost effectiveness, disease morbidity, mortality and high risk groups, and the need for medical providers to be vaccinated in websites, mailings, newsletters and updates.

- Work with state and local media to develop state fact based materials on influenza and influenza vaccine for use by newspapers, journals, TV, radio and talk shows.
- Assemble and provide providers with state specific information on effective interventions such as standing orders, reminder/recall, provider reminders, educational materials: web links for CDC, state and association newsletters.
- Develop and promote an 'expert speaker' network to provide talks to and discussions with professional, social, and other public groups on the benefits of influenza vaccination.
- Establish an 'Influenza Outreach' hotline for the general public.
- Develop and distribute state logo education materials to providers, partner organizations, and public service organizations,
- Solicit private organizations such as HMOs, pharmacies and corporations to co-sponsor the development and distribution of vaccine and disease vaccine fact sheets to their constituents.