



H1N1 Influenza (Swine Flu) SPECIAL Update

October 19, 2009

About this Special Update

In addition to our weekly H1N1 Influenza (Swine Flu) Situational Updates, we will periodically publish Special Updates with information or guidance related to H1N1 Influenza that compels us to share it immediately. These Special Updates will be released as needed throughout fall 2009 and early winter 2010 to assist healthcare and emergency medical services organizations and personnel in preparing for and responding to Novel H1N1 Influenza (Swine Flu) in Southern Maine.

This update contains:

- Influenza surveillance data for the U.S. and Maine
- Communications from Dr. Dora Mills regarding H1N1 vaccine delay and vaccine administration
- Updated Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel
- Strategies to keep you informed

Remember that the best ways to protect yourself from flu are:

- **WASH** your hands
- **COVER** your cough
- **STAY HOME** if you're sick
- **GET VACCINATED**

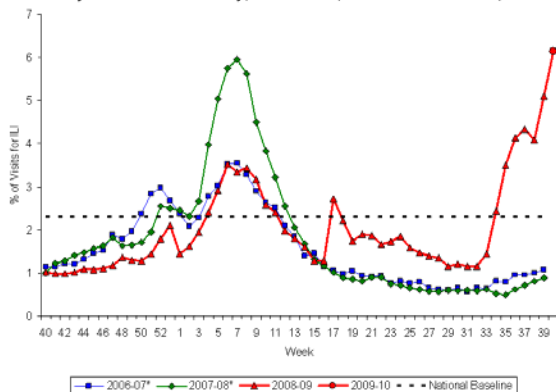
View all *SMRRC H1N1 Influenza (Swine Flu) Situation Updates* (including archives) at: www.smrrc.org

Surveillance

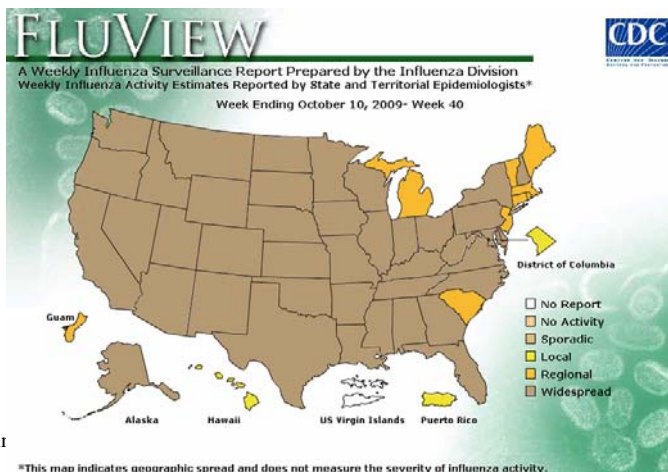
US CDC reports that influenza activity remained elevated in the U.S. during week 40 (October 4-10, 2009). A review of key indicators found that influenza activity increased in the U.S.

- [Visits to doctors](#) for influenza-like illness (ILI) continued to increase in the United States, and overall, are higher than what is expected for this time of the year. ILI activity now is equal to or higher than what is seen at the peak of many regular flu seasons.
- Total influenza [hospitalization](#) rates for laboratory-confirmed flu are climbing and are higher than expected for this time of year.
- The proportion of [deaths](#) attributed to pneumonia and influenza (P&I) based on the 122 Cities Report has increased and exceeds what is normally expected at this time of year. In addition, 11 flu-related pediatric deaths were reported this week; 10 of these deaths were confirmed 2009 H1N1, and one was influenza A virus, but untyped. Since April 2009, there have been 86 confirmed pediatric 2009 H1N1 deaths; 39 of these have been reported to CDC since August 30, 2009.
- Forty-one states are reporting [widespread influenza activity](#) at this time. This many reports of widespread activity are unprecedented during seasonal flu.
- Almost all of the influenza [viruses](#) identified so far are 2009 H1N1 influenza A viruses. These viruses remain similar to the virus chosen for the 2009 H1N1 vaccine, and remain susceptible to the antiviral drugs oseltamivir and zanamivir with rare exception. (Source: US CDC, 10/16/09)

Percentage of Visits for Influenza-like Illness (ILI) Reported by the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet), Weekly National Summary, October 1, 2006 - October 10, 2009



*There was no week 53 during the 2006-07 or 2007-08 influenza seasons, therefore the week 53 data point for those seasons is an average of weeks 52 and 1.



*This map indicates geographic spread and does not measure the severity of influenza activity.

Maine CDC reports 415 confirmed and probable cases of H1N1 total to date

- 258 in Maine residents; 15 Maine residents have been hospitalized
- 157 in out of state residents tested in Maine; 5 Out of state residents have been hospitalized in Maine
- 1 death reported to date
- 91% of lab confirmed H1N1 cases in Maine residents and out of state visitors are under the age of 50 (range 0-81 years, mean of 22 years)

Characteristics of Lab Confirmed H1N1 Influenza Cases - Maine Residents, 2009

| Age | | | Gender | | At Risk | | Hospital Care | | | | Deaths | |
|--------------|------------|----------|------------------|------------------|-----------|----------|---------------|----------|----------|------------|----------|------------|
| Age group | N | % | Male | Female | HCW | Pregnant | Hospitalized | % | ICU | Ventilated | N | % |
| <5 | 12 | 5 | 8 | 4 | 0 | 0 | 1 | 8 | 0 | 0 | 0 | 0 |
| 5 to 24 | 154 | 60 | 76 | 78 | 4 | 0 | 4 | 3 | 0 | 1 | 0 | 0 |
| 25 to 49 | 62 | 24 | 25 | 37 | 12 | 2 | 5 | 8 | 1 | 1 | 0 | 0 |
| 50 to 64 | 28 | 11 | 15 | 13 | 5 | 0 | 4 | 14 | 2 | 2 | 1 | 3.6 |
| >65 | 2 | 1 | 0 | 2 | 0 | 0 | 1 | 50 | 0 | 0 | 0 | 0 |
| Total | 258 | ~ | 124 (48%) | 134 (52%) | 21 | 2 | 15 | 6 | 3 | 4 | 1 | 0.4 |

(Source: Maine DHHS/MCDC, 10/14/09)

For more information on influenza disease activity, visit: www.cdc.gov/h1n1flu/update.htm (US); and www.mainflu.gov (ME)

Important Dates

Updated News/Guidance from Dora Anne Mills, MD, MPH, State Health Officer & Director - Maine CDC

I was in DC Thursday and Friday with other State Health Officers meeting with top federal officials, primarily on H1N1. Top officials from DHHS, DHS, FDA, and CDC headlined the event. We also spent several hours with Dr. Frieden, the Director of US CDC, including a closed door breakfast meeting.

The overall theme of what I learned from the federal team this week was this:

We are in an unprecedented situation – with a pediatric and young adult pandemic, increasing numbers of children dying of H1N1 (more kids dying in the US of H1N1 this past month than the numbers who usually die of flu in a single year), and a vaccine that is just now trickling into states.

We need to do everything we can do to offer vaccine to the high priority groups as quickly as possible.

We need to mobilize all resources as much as possible to accomplish this.

This vaccine effort is the single most effective strategy to calm this pandemic.

The pandemic won't go away for a while – even maybe several years – but vaccine can prevent a surge on our health care system and most importantly save lives.

H1N1 VACCINE DELAY

As I emailed you on Thursday pm, I was just learning from federal officials about a delay in H1N1 vaccine. This delay was released publicly on Friday by US CDC, and I noticed it in Saturday's newspapers. Peter Smith, Tonya Philbrick (both in Maine CDC and overseeing H1N1 vaccine distribution), and I met by phone on Friday to review the new numbers of vaccine available for Maine and determine what this delay means for us. For right now, it appears this means that in our first 4 weeks of H1N1 vaccine in Maine (the month of October, basically), we will experience an overall delay of about a week. In other words, our detailed H1N1 vaccine distribution plans that take us out through October 30th, now take us out through November 6th.

At this point in time, we will preserve the vaccine going to obstetricians for pregnant women and try to preserve ordering vaccines for K-12 schools and pediatricians for pre-school aged children and for household contacts of young infants. For the most part, we believe we can accomplish this.

What this means is that there will be fewer new vaccine doses going for health care workers, high-risk adults, and residential schools. We have already distributed about 9,600 doses to hospitals for very high priority health care workers. We have distributed close to 5,000 to residential schools and also several thousands to health care providers for high-risk adults. As of Friday, two hospitals had not ordered any vaccine yet for their health care workers, and many residential schools have not

submitted orders (or at least orders that we can identify). We will continue to fulfill partial orders for residential schools (for their high-risk students) and the two hospitals that have not ordered.

SCHOOLS, SCHOOLS, SCHOOLS

So, we want to continue full steam ahead on offering vaccine in the K-12 schools – we believe this is the most effective strategy to reduce the upcoming surge. We also need to activate any and all resources to accomplish this – public health nursing, medical reserve corps, etc. Our Vaccine Coordinators are very available to assist schools in locating vaccinators. I have listed them below this email. Additionally, the phone bank (1-888-257-0990) is open weekdays 9am – 5pm with staff who can also assist schools with any challenges they are having. Flu.questions@maine.gov will also provide answers to questions.

VACCINE ADMINISTRATION

It is also important that at this point in time the vaccine is very much used for those whom it is intended.

H1N1 vaccine these first several weeks should be limited to the following sub-priority groups:

- **Pregnant women;**
- **Persons who live with or provide care for infants aged <6 months (e.g. parents, siblings, and daycare providers of young infants);**
- **Children and young adults aged 6 months through 24 years;**
- **Persons aged 25 through 64 years who have significant medical conditions that put them at higher risk for influenza-related complications;**
- **Health care and emergency medical services personnel who have frequent direct contact with patients and infectious material and who work in hospital emergency departments, inpatient pediatric, maternity, and intensive care units. As vaccine supplies allow (if there are sufficient supplies for high-risk patients and the categories of health care workers above), then the vaccine can be offered to other health care workers.**

It is important to focus the vaccine on those who need it most. However, we anticipate this situation where demand outstrips supply will only last a while, and at some point in time in the coming weeks, the supply will be greater than the demand.

This does lead us to some unusual situations for the coming weeks. For instance, most vaccinators will not be vaccinated themselves. Most people who work or live with high-risk populations (school teachers, parents, group home professionals, etc) will also not be vaccinated. Many “essential” categories of professions will not be vaccinated for a while either. Even our own H1N1 team at Maine CDC will not be vaccinated. I don’t anticipate receiving the vaccine myself for several weeks, when it is my turn, though my children will be receiving it at their school.

The problem with trying to vaccinate “essential” professions at this point in time is that there is very little vaccine anticipated over the next 6 weeks – about 340,000 doses for a population of 1.3 million people. The data indicate that not only are children disproportionately dying and being hospitalized from H1N1, but by offering vaccine to them we can calm this pandemic most effectively since school children are our major transmitters of influenza. While ~340,000 doses provides sufficient vaccine for children (who number 300,000 in Maine) and a few adults, it does not provide sufficient vaccine for all the 5 priority populations, which total about 700,000

Thank you for your continued patience and work on this ever-changing situation! One important thing I learned in DC from state colleagues and federal officials was how fortunate we are in Maine to have such a great team working on H1N1 across our state – people from public health, health care, schools, emergency management, and many other professions working together to do what is right for all Mainers. While it was a great experience in DC, it was even nicer to step off the plane in Maine Friday evening. It is truly a special place with special people.

Dora

Infection Control and Personal Protection in Healthcare Settings

Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel

http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm

Q&A on New Guidance

http://www.cdc.gov/h1n1flu/guidelines_infection_control_qa.htm

The new guidance:

- Applies uniquely to the special circumstances of the current 2009 H1N1 pandemic
- Recommends the use of a "hierarchy of controls" including: 1) elimination of potential exposures, 2) Engineering Controls, 3) Administrative Controls, and 4) Personal Protective Equipment
- Places strong emphasis on vaccination as an effective Administrative Control.
- Defines **healthcare personnel** covered by this guidance as "all persons whose occupational activities involve with patients or contaminated material in a healthcare, home healthcare, or clinical laboratory setting...engaged in a range of occupations... and in the following settings: acute care hospitals, nursing homes, skilled nursing facilities, physician's offices, urgent care centers, outpatient clinics, and home healthcare agencies". It also includes..."school nurses or personnel staffing clinics in correctional facilities."
- Defines **close contact** as "working within 6 feet of the patient or entering a small enclosed airspace shared with the patient (e.g. average patient room.)"
- CDC continues to recommend the use of respiratory protection that is at least as protective as a fit-tested disposable N95 respirator for healthcare personnel who are in close contact with patients with suspected or confirmed 2009 H1N1 influenza.
- The guidance acknowledges that some facilities are currently experiencing **shortages** of respiratory protection equipment and that further shortages are anticipated. In the face of shortages, appropriate selection and use of respiratory protection is critical and a key strategy is to use source control, engineering, and administrative measures to reduce the numbers of workers who come in contact with patients who have influenza-like illness to reduce the consumption of respiratory protection equipment.
- Under circumstances where a shortage of respirators exists "**despite reasonable efforts to obtain and maintain a sufficient supply for anticipated needs**" ...a facility should consider shifting to a prioritized respirator use mode." In this mode, respirator use is prioritized to ensure availability for healthcare personnel at most risk from 2009 H1N1 influenza exposure, such as aerosol generating procedures. Prioritization should be adapted to local conditions, and should consider intensity and duration of exposure, personal health risk factors for complications of infection, and vaccination status. The objective is to reduce exposure while conserving supplies realizing that the flu season will last until May 2010 and we must also maintain a reliable supply for other highly communicable disease concerns such as TB.
- In a **prioritized respirator use mode**, respirators may be carefully reused or their use may be extended, their use may be temporarily discontinued for employees at low risk of exposure or lower risk of complicated infection, and suitable facemasks could be used. It must be emphasized that even under this operating mode, N95 or better respiratory protection must be provided during high risk (e.g. aerosol generating) procedures.

US Department of Labor's (OSHA) Position on Compliance and Enforcement:

- OSHA fully intends to enforce this guidance through its Respiratory Protection Standard (including training and fit testing) and through its General Duty Clause. Inspections will be done on a complaint basis and OSHA plans to release its detailed compliance directive in the next couple of weeks.
- OSHA will require facilities to demonstrate a good faith effort to acquire sufficient supplies of N95s in accordance with the CDC guidance and document such efforts and outcomes. Facilities unable to acquire sufficient quantities, substantiated by adequate documentation of effort, can shift to the prioritized use mode and would not be considered out of compliance as long as they also implemented the specified hierarchy of controls.

Declaring a Shortage - Some Options:

States may consider declaring a shortage when one or more facilities request supplies from the state cache as this may indicate that commercial supply has outstripped demand.

- Professional judgment should be used in determining how many facilities must begin requesting supplies from the state in order to declare a shortage situation - e.g., if several small providers request supplies and the state cache is sufficient to meet these requests, a shortage may not exist; however, if one large hospital serving a wide area requests a large amount of respirators and state resources cannot meet this request, a shortage may indeed exist.

Facilities may consider declaring a shortage when their supply chain is not adequate to meet their estimated need through May 2010. *Additional considerations and supporting statements:*

- Estimates of need should not include supplies from regional, state or federal stockpiles, as these are strategic resources which are intended to be immediately available and back-filled upon use for emergencies in addition to H1N1; in this instance, backfilling will likely not be possible due to anticipated shortages in the national supply chain.
 - States are making determinations for N95 respirator use in the context of all-hazards preparedness, which includes not only mass casualty events and natural disasters, but outbreaks of other infectious diseases such as tuberculosis.
- Additionally, estimates of need should not be based solely on total supply; a shortage may exist if a particular type or size of respirators is needed but no longer available. For example, if no small respirators are available, healthcare workers

requiring this size will need to seek alternate protective measures and cannot be bound to the regulations of wearing an N95 respirator as outlined in the CDC guidance.

- N95s require proper fit-testing of each individual who wears the respirator. Not only does a potential shortage of N95 masks exist, the shortage of staff trained to perform the fit-tests also exists, particularly if individuals need to switch between N95 products manufactured by different companies. Additionally, the new recommendations are so broad that they include individuals who have never before been fit-tested (e.g., healthcare workers in many private physician offices); this is an even more resource intensive proposition during an outbreak.
- A shortage of N95s may also result in attrition in the workforce, as healthcare workers may opt not to show up for work without the appropriate and recommended PPE.

An additional consideration when using these estimates to assess the adequacy of the current supply is that these numbers do not take into account the actual distribution of respirators and the relative ability (or lack thereof) to match supply with demand. (Source: US CDC, 10/14/09)

Complete **Q&A on New Guidance** is available at: http://www.cdc.gov/h1n1flu/guidelines_infection_control_qa.htm

Stay Informed

Maine CDC General Public Call-In Number: 1-888-257-0990 (M-F, 9-5)

Maine CDC Healthcare Provider Disease Reporting and Information Line: 1-800-821-5821 (24/7)

Maine CDC General Influenza Questions: flu.questions@maine.gov

Maine CDC Medical/Clinical Influenza Questions: disease.reporting@maine.gov

Maine CDC H1N1 Information: www.maine-flu.gov Press Releases: <http://bit.ly/2zSpJC>

U.S. CDC H1N1 Information: www.cdc.gov/h1n1flu and www.flu.gov

Maine CDC is now publishing an online [flu clinic calendar](#). To locate a clinic, visit www.maine-flu.gov, click on the “Public Influenza Vaccine Clinic Calendar” link. Info about all public or school H1N1 clinics will be listed on this site, and clinics offering just seasonal flu vaccine are also welcome to post, as well. If you’re a clinic organizer and need help posting a clinic, please email flu.questions@maine.gov for assistance.

Publisher

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