

Dear Colleague:

I am writing to update you on the 2009 H1N1 influenza virus, the target groups for the 2009 H1N1 vaccine, plans for distribution and monitoring of the vaccine, the CDC recommendations for the use of antiviral medications and liability protection.

As an internist, you have many patients with chronic disease and adults 25 – 64 years old with certain medical conditions are in a target population for the 2009 H1N1 influenza vaccine. I urge you to educate your patients about influenza and encourage them to implement frequent hand washing, use of alcohol based hand gel, cover their coughs and stay home when they exhibit influenza like symptoms. Your patients trust you and will look to you for advice about the vaccine.

### **2009 H1N1 influenza update**

The 2009 H1N1 influenza A virus continues to circulate throughout the country and has become the predominate subtype of influenza around the world. Currently in Indiana, the 2009 H1N1 influenza virus accounts for over 98% of all influenza A being confirmed at our sentinel sites for surveillance. Individuals with outpatient influenza like illness should be considered positive for 2009 H1N1 influenza and if clinically warranted they should be treated with oseltamivir (Tamiflu) or zanamivir (Relenza). We are only providing confirmatory testing for the 2009 H1N1 influenza on hospitalized patients or in the event of a death from influenza like illness. We will keep you informed of any changes in this recommendation as we continue to follow the epidemiology in Indiana and across the U.S.

### **Target Populations for Receiving Vaccine**

The Advisory Committee for Immunization Practices (ACIP) recommended the following target populations for the 2009 H1N1 vaccine and we will follow these recommendations:

- **Pregnant women** - They have been found at higher risk for complications from seasonal influenza in past pandemics, and several deaths have been reported among pregnant women during the current 2009 pandemic. Vaccination of pregnant women also is seen as a way to potentially protect infants who cannot be vaccinated, via transfer of maternal antibodies to newborns.
- **Household and caregiver contacts for infants younger than 6 months of age** - The aim is to provide a possible “cocooning effect,” providing indirect protection for young infants who cannot be vaccinated but are at higher risk for influenza-related complications.
- **Health care and emergency medical personnel** - (including emergency medical technicians, firefighters, and others whose jobs involve routinely providing emergency medical care in communities). These individuals are seen as a potential source of infection for vulnerable patients. In addition, increased absenteeism could reduce the health care capacity.
- **Children and adults from 6 months through 24 years of age** - Children have the highest incidence of illness, and “explosive” outbreaks in schools have been a prominent feature of the spring 2009 epidemiology of the novel influenza A (H1N1). Children younger than 5 years of age are at the highest risk for hospitalization, and are sources of infection for the community and in schools. Moreover, illness in children keeps parents home from work. Young adults also have high attack rates and are seen as vectors.
- **Adults aged 25-64 years with certain medical conditions that place them at greater risk for influenza-related complications** - These include chronic pulmonary, cardiovascular, renal,

hepatic, cognitive, neuromuscular, hematologic, and metabolic disorders, as well as immunosuppression caused by medications or HIV infection. About 70% of adults hospitalized thus far with 2009 H1N1 infections had one of these conditions.

If the CDC determines that vaccine supply is limited, subgroups of the larger group should receive priority. The first subgroups – pregnant women and household and caregiver contacts for infants younger than 6 months of age – remain unchanged as a priority. The next subgroups will be limited to health care and emergency personnel **in direct contact** with patients; children aged 6 months through 4 years of age; and children aged 5-18 with chronic medical conditions.

### **Vaccine Distribution**

As vaccine is produced it will be distributed to the counties and delivered either to the local health departments (LHD) or directly to physician offices, hospitals, pharmacies, or other vaccinators. The local health departments are responsible for orchestrating vaccine distribution in their counties. It is important that your local health department know which providers are willing to receive and administer vaccine for their planning purposes. Your local health officer or representative from the local health department may have already contacted you.

### **Vaccine Monitoring**

The CDC has asked all states to provide information about doses of vaccine administered within 24-48 hours. In Indiana, the Indiana State Immunization Registry (CHIRP) is the tool that will be used to collect this information. Practices giving the vaccination **must** work with their LHD to log each vaccine as it is administered in CHIRP. A special, easy-to-use program called Mass Immunization Module (MIM) is available for this. In order to access CHIRP, every person must have an individual username and password. These cannot be shared. If you do not currently have a username and password for CHIRP, please go to [https://chirp.in.gov/chirp\\_files/docs/52303.pdf](https://chirp.in.gov/chirp_files/docs/52303.pdf) to download the user agreement form. Complete the form and fax it to the ISDH at 317-233-8827.

If your facility is not currently using CHIRP, please print the Provider Site Enrollment Agreement form available at [https://chirp.in.gov/chirp\\_files/chirp\\_docs.htm](https://chirp.in.gov/chirp_files/chirp_docs.htm) and fax it in. If you need assistance with the CHIRP MIM program, please download the MIM Training Module at [https://chirp.in.gov/chirp\\_files/docs/MIM.pdf](https://chirp.in.gov/chirp_files/docs/MIM.pdf) or call the ISDH CHIRP Help Desk at 888-227-4439.

### **Summary of Interim recommendations for Use of Antiviral Medications**

- Treatment with oseltamivir or zanamivir is recommended for all persons with suspected or confirmed influenza requiring hospitalization.
- Treatment with oseltamivir or zanamivir generally is recommended for persons with suspected or confirmed influenza who are at higher risk for complications (children younger than 5 years old, adults 65 years and older, **pregnant women**, persons with certain chronic medical or immunosuppressive conditions, and persons younger than 19 years of age who are receiving long-term aspirin therapy).
- Persons who are not at higher risk for complications or do not have severe influenza requiring hospitalization generally do not require antiviral medications for treatment or prophylaxis. However, any suspected influenza patient presenting with warning symptoms (e.g., dyspnea) or signs (e.g., tachypnea, unexplained oxygen desaturation) for lower respiratory tract illness should promptly receive empiric antiviral therapy.

- Clinical judgment is an important factor in antiviral treatment decisions for all patients presenting for medical care who have illnesses consistent with influenza.
- Treatment should be initiated as early as possible because studies show that treatment initiated early (i.e., within 48 hours of illness onset) is more likely to provide benefit.
- Treatment should not wait for laboratory confirmation of influenza because laboratory testing can delay treatment and because a negative rapid test for influenza does not rule out influenza. The sensitivity of rapid tests can range from 10% to 70%. Information on the use of rapid influenza diagnostic tests (RIDTs) can be found at [http://www.cdc.gov/h1n1flu/guidance/rapid\\_testing.htm](http://www.cdc.gov/h1n1flu/guidance/rapid_testing.htm).
- Testing for 2009 H1N1 influenza infection with real-time reverse transcriptase-polymerase chain reaction (rRT-PCR) should be prioritized for persons with suspected or confirmed influenza requiring hospitalization and based on guidelines from local and state health departments.
- Groups at higher risk for 2009 H1N1 influenza complications are similar to those at higher risk for seasonal influenza complications.
- Actions that should be taken to reduce delays in treatment initiation include:
  - Informing persons at higher risk for influenza complications of signs and symptoms of influenza and need for early treatment after onset of symptoms of influenza (i.e., fever, respiratory symptoms);
  - Ensuring rapid access to telephone consultation and clinical evaluation for these patients as well as patients who report severe illness;
  - Considering empiric treatment of patients at higher risk for influenza complications based on telephone contact if hospitalization is not indicated and if this will substantially reduce delay before treatment is initiated.
- In selected circumstances, providers might also choose to provide selected patients at higher risk for influenza-related complications (e.g., patients with neuromuscular disease) with prescriptions that can be filled at the onset of symptoms after telephone consultation with the provider.
- Antiviral chemoprophylaxis generally should be reserved for persons at higher risk for influenza-related complications who have had contact with someone likely to have been infected with influenza.
- Based on global experience to date, 2009 H1N1 influenza viruses likely will be the most common influenza viruses among those circulating in the coming season, particularly those causing influenza among younger age groups.
- Persons with suspected 2009 H1N1 influenza or seasonal influenza who present with an uncomplicated febrile illness typically do not require treatment. However, some groups appear to be at higher risk for influenza-related complications.
- Currently circulating 2009 H1N1 viruses are susceptible to oseltamivir and zanamivir, but resistant to amantadine and rimantadine; however, antiviral treatment regimens might change according to new antiviral resistance or viral surveillance information.
- Information on the dose and dosing schedule for oseltamivir and zanamivir is provided in this document. An April 2009 Emergency Use Authorization authorizes the emergency use of oseltamivir in children younger than 1 year old (<http://www.cdc.gov/h1n1flu/eua/>), subject to the terms and conditions of the EUA.

## **Liability Protection**

On June 15, 2009, the Department of Health & Human Services' Secretary Sebelius signed a declaration under the Public Readiness and Emergency Preparedness (PREP) Act to extend liability immunity against tort claims (except for willful misconduct) to individuals and entities involved in all stages of 2009 H1N1 influenza vaccine development, testing, manufacture, distribution, prescribing, administration, and use. Liability immunity means that there is no legal tort claim that can be pursued in state or federal court. Individuals and entities that receive liability immunity under the declaration include healthcare professionals or others authorized under State law to prescribe, administer, and dispense vaccines, when they are carrying out activities in accordance with the conditions stated in the declaration. Vaccines procured by the federal government for distribution are included. PREP Act declarations are

intended to encourage providers and other entities to participate in the distribution, dispensing, administration, and use of the vaccine.

### **Indiana Health Alert Network**

Health care providers are strongly encouraged to enroll in the Indiana Health Alert Network (IHAN). The IHAN is a secure alerting system for providing important public health information rapidly to providers, hospitals, local health departments, and others throughout Indiana. Participants can receive messages via e-mail, phone, and fax. There is no cost to participate. To enroll, please contact Chuck Berning, IHAN Coordinator, at [cberning@isdh.in.gov](mailto:cberning@isdh.in.gov).

Sincerely,

A handwritten signature in black ink that reads "Judith A. Monroe M.D." with a long horizontal flourish extending to the left.

JUDITH A. MONROE, M.D.  
STATE HEALTH COMMISSIONER