

# **H1N1 Vaccine Distribution Response Plan**

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**CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH**

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## TABLE OF CONTENTS

I.	Introduction.....	2
II.	Planning Assumptions.....	2
III.	Concept of Operations .....	4
A.	Allocation.....	4
B.	Vaccine Supply.....	4
C.	Immunogenicity and Number of Doses .....	5
D.	Receipt of Vaccine .....	5
E.	Duration of H1N1 Vaccination Campaign.....	5
F.	Priorities for Shipping .....	6
G.	Hospitals.....	6
H.	All other Providers .....	6
I.	Communications.....	6
J.	Recordkeeping and Vaccine Tracking .....	8
K.	Adverse Events Monitoring.....	9
IV.	ROLES AND RESPONSIBILITIES .....	10
A.	DPH .....	10
B.	Mass Dispensing Areas (MDAs) .....	11
C.	Community Healthcare Providers (i.e., pediatricians, community health centers, school based health centers, Visiting Nurse Associations [VNAs]).....	12
D.	Hospitals.....	12
E.	Other Mass Vaccinators .....	12
V.	Planning Scenarios to target high-priority populations for vaccination .....	13
VI.	Plan Development and Maintenance .....	14
VII.	Attachments .....	15
A.	Table 1: Populations to be vaccinated and resources to perform vaccination ....	15
B.	Figure 1: Priority Populations for Vaccination Based on Limited Supply According to CDC ACIP Sub-Group Planning Scenarios. ....	18
C.	Figure 2: Priority Populations for Vaccination Based on Adequate Supply According to CDC ACIP Sub-Group Planning Scenarios. ....	19
D.	Figure 3: CT Department of Public Health H1N1 Vaccine Delivery Schematic ....	20

## I. INTRODUCTION

In April 2009, the first cases of a novel influenza virus (H1N1) were identified in the US. In June 2009, the World Health Organization upgraded the worldwide alert to a Phase 6, the pandemic phase. Phase 6 is characterized by sustained community level outbreaks in at least one other country in another WHO region. Designation of this phase indicates that a global pandemic is under way. In response to the above, the Centers for Disease Control and Prevention (CDC) began the process of contracting for the production of a novel H1N1 influenza vaccine.

In the fall of 2009, two different types of influenza vaccine are expected to be recommended for persons in the United States: seasonal vaccine and a separate vaccine solely for protection from the novel H1N1 virus (hereafter referred to as the "pandemic virus") that emerged in the spring of 2009, too late to be included in the seasonal influenza vaccine production process. CDC anticipates the vaccine to be licensed and ready for distribution by the mid fall of 2009.

The following plan is a modification of the Connecticut Department of Public Health's Pandemic Plan of June 2008. This plan addresses the current situation and outlines vaccine administration and data collection scenarios.

## II. PLANNING ASSUMPTIONS

- Connecticut Department of Public Health (DPH) will follow the response approaches and guidelines developed by the federal government for the distribution of vaccines.
- The CDC, with guidance from the Advisory Committee on Immunization Practices, will identify priority populations for the limited early vaccine supply. DPH will use the CDC guidance and recommendations as the baseline for our in-state activities, with the understanding that we will need to recognize and address Connecticut-specific issues.
- Priority groups will be vaccinated sequentially, in other words, all persons in a given tier (and priority within a tier, if any) will receive one dose before the next rank and tier will begin vaccination.
- The federal government will procure and distribute H1N1 pandemic vaccine to the state for redistribution, at "no cost" to those being vaccinated.
- Funding will be available to reimburse providers for an administration fee for this vaccine. CDC will determine the fee.
- The DPH will receive a vaccine allocation based on Connecticut's proportion of the U.S. population (about 3.5 million doses or 1.159% of the national supply).
- Based on the three vaccine supply scenarios, Connecticut will receive an initial shipment of 463,706 doses (based on a supply of 40 million doses), 927,413

doses (based on a supply of 80 million doses) or 1,854,825 doses (based on a supply of 160 million doses).

- ❑ Additional weekly allocations will be made as follows: 115,927 doses (based on 10 million doses), 231,853 doses (based on 20 million doses), or 347,780 doses (based on 30 million doses).
- ❑ Vaccination will occur at the local level, with minimal disruption to public daily activities.
- ❑ The vaccine will be a licensed product, so there will be no need for Investigational New Drug (IND) efforts or Emergency Authorization Use (EAU).
- ❑ Two doses of pandemic vaccine will be needed with receipt of the second dose 4 or more weeks after the first dose.
- ❑ An Immunization shot card will be provided to recipients who receive H1N1 vaccine for documenting vaccination that also includes a reminder that a second dose of H1N1 vaccine is needed to complete the series.
- ❑ Vaccine supply will be limited at the beginning but will increase as time goes on. The vaccination process will be an on going long term effort, with the entire US population eventually being offered vaccine.
- ❑ DPH will approach this vaccination effort as a non-emergency event. As such, there will not be a declaration of a civil emergency or a public health emergency by the Governor's Office, and DPH will need to follow all existing statutory and regulatory requirements for the State of Connecticut.
- ❑ While DPH may blend elements from both the DPH Public Health Emergency Mass Vaccination Plan and the DPH Pandemic Plan, DPH's approach will be to develop an enhanced version of existing plans for seasonal flu vaccinations. As is the case with the annual vaccination program, DPH will use a combination of public and private assets to complete this mission.
- ❑ The number of vaccine doses administered must be reported to CDC on a weekly basis, along with minimum data elements, in aggregate form by means to be determined.
- ❑ Each vaccinator will be required to report any Adverse Events from vaccination to a DPH or CDC designee.
- ❑ DPH will develop an enrollment and ordering process for vaccinators who will be using the vaccine.
- ❑ Vaccine will be commonly distributed mostly in 10 dose vials. A smaller portion of the vaccine will be in pre-loaded syringes and a live attenuated nasal spray formulation.
- ❑ CDC will provide ancillary vaccination supplies such as needles, syringes, and band-aids.
- ❑ There will be no separate vaccine allocation for Native American tribal communities or retired Military and their dependents. Vaccine for these populations will be part of the state's allocation.
- ❑ Consistent with past vaccination efforts, DPH will work with CDC and Local Health Departments to develop a communications plan.

### III. CONCEPT OF OPERATIONS

#### A. Allocation

- ❑ Allocations to vaccinating agencies and health care providers will be determined by DPH subject to approval from the Governor.
- ❑ DPH will retain the authority to redistribute allocations after initial distribution based on supply and the course of the pandemic.
- ❑ Each of the 31 acute care hospitals and the VA Hospital in West Haven will receive an allocation determined proportionally by their pre-pandemic bed-based share for Tier 1 direct care hospital staff.
- ❑ H1N1 vaccine will also be allocated and made available to local health departments, visiting nurse associations, private physician offices, OB/GYN, Community Health Center, mass vaccinators (e.g., Maxim), and School Based Health Centers as it becomes available. Each location will receive weekly allocations of H1N1 vaccine based on doses made available to the state.
- ❑ Mass Dispensing Area Leads (MDA's) coordinate, collaborate and communicate with the local health departments/districts and community health care providers for their respective area to develop and carry out H1N1 Influenza Distribution Plan, in accordance with the state's plan.
- ❑ The Immunization Program will initiate a pre-registration process for targeted licensed immunization providers interested in administering H1N1 vaccine.
- ❑ There is no cost to pre-register and registered providers are not committed to provide vaccine, but they will be engaged in the process and receive email updates and vaccine planning information. They will have the opportunity to order vaccine as it becomes available.
- ❑ Pre-registration will collect the shipping and contact information necessary for the state to ship vaccine to the provider.
- ❑ As H1N1 vaccine becomes available providers will order vaccine through the DPH Immunization Program's Vaccine Order Form.
- ❑ Vaccine orders will be processed by Immunization Program staff daily and transmitted electronically to a third party distributor for shipment.
- ❑ Providers can order vaccine on a weekly basis for the duration of the pandemic.

#### B. Vaccine Supply

- ❑ Vaccine is expected to be ready for distribution by mid-fall. Based on the three vaccine supply scenarios, Connecticut will receive an initial shipment of 463,706 doses (based on a supply of 40 million doses), 927,413 doses (based on a supply of 80 million doses), or 1,854,825 doses (based on a supply of 160 million doses).
- ❑ Additional subsequent weekly allocations based on three initial vaccine supply scenarios listed above will be either: 115,927 doses (10 million doses), 231,853 (20 million doses), or 347,780 (30 million doses).

- The majority of vaccine will be distributed in multidose 5ml/10 dose vials although approximately 15% of vaccine may come in pre-filled syringes or nasal sprayers (Live Attenuated Influenza Vaccine (LAIV) for the pediatric population.

### **C. Immunogenicity and Number of Doses**

- Until the H1N1 pandemic vaccine strain is developed and tested, it will not be known whether a second dose of vaccine will be needed to achieve immunity in vaccinated persons.
- DPH will provide guidance and recommendations established by the CDC Advisory Committee on Immunization Practices (ACIP) regarding H1N1 vaccine administration that will include the appropriate immunization schedule, dosage and contraindications.
- If changes are made in the recommended number and timing of doses, information about vaccine administration will be communicated utilizing the Health Alert Network (HAN), the CT Flu Watch website ([www.ct.gov/ctfluwatch](http://www.ct.gov/ctfluwatch)) and blast fax and will be reflected in any protocols for vaccination distributed by DPH.
- DPH will post up-to-date educational materials for staff and vaccinees on second dose recommendations.

### **D. Receipt of Vaccine**

- All vaccine will be shipped directly to each provider location. Up to date shipping information will be maintained by the Immunization Program's Vacman software application.
- The Immunization Program will send an electronic file with all provider orders to the 3<sup>rd</sup> party distributor on a daily basis and receive a daily shipping log from the distributor on all orders sent out the previous business day.
- Pre-registration process for licensed immunization providers for receipt of H1N1 vaccine will include vaccine storage and handling requirements.
- The vaccine must be stored in a refrigerator at between 35<sup>o</sup>-46<sup>o</sup> F. Dormitory style refrigerators do not maintain consistent temperatures so vaccine will not be shipped to facilities with that type of unit.
- Immunization Program staff will be responsible for verifying that each location has a suitable storage unit and thermometer to record the temperature and is following standard vaccine storage and handling procedures.

### **E. Duration of H1N1 Vaccination Campaign**

- The H1N1 influenza vaccination campaign will take place over many months. Vaccine is expected to be available in mid-fall with vaccination efforts expected to continue into the following spring.
- Demand will exceed initial supply requiring careful control of vaccine distribution. Providers will need to vaccinate their patients based on CDC priority group recommendations. (attachment B & C – pages 18-19)

## **F. Priorities for Shipping**

- ❑ Timing of shipping will follow the priority scheme for allocation according to priority groups identified by CDC.
- ❑ Pre-registration of providers will identify potential vaccinators for the priority groups.
- ❑ The vaccinators of priority groups will receive H1N1 vaccines for priority groups, depending upon available vaccine supply.

## **G. Hospitals**

- ❑ Vaccines will be shipped to 31 acute care hospitals and the VA Hospital in West Haven to ensure that the medical providers with direct medical care responsibilities are promptly vaccinated according to priority groups identified by CDC.
- ❑ The 31 acute care hospitals will distribute vaccine to their own staff.
- ❑ Hospitals will use already developed smallpox vaccination/occupational medicine teams, space, and protocols for distribution within the hospital to priority staff. The latter can use the hospitals existing identification and security structures to match personnel against lists of prioritized persons.
- ❑ Cold chain, security, and recordkeeping will be maintained by the hospitals using pharmacy, security, and medical records staff and resources in accordance with their mass dispensing (smallpox) plans.

## **H. All other Providers**

- ❑ Local health departments, visiting nurse associations, private physician's offices, OB/GYN practices, Community Health Centers, mass vaccinators, and School Based Health Centers would prioritize patients based on the Priority List in accordance with CDC guidance and vaccine recommendations (attachment B & C – pages 18-19).
- ❑ Cold chain, security, and recordkeeping will be the same as for the hospitals.

## **I. Communications**

- ❑ The current structures and protocols noted in the state and local Public Health Emergency Communications Plans will be used to communicate content to the public explaining the rationale for vaccine distribution prioritization, when and where to go to be vaccinated, and the possible need for a second dose.
- ❑ A vaccination website providing vaccination information will be developed on the CT Flu Watch website ([www.ct.gov/ctfluwatch](http://www.ct.gov/ctfluwatch)) identifying priority populations, providing information on the vaccine, as well as any necessary documentation and where residents should go for vaccination. A link to this website will also be prominently posted on the DPH home page ([www.ct.gov/dph](http://www.ct.gov/dph)).
- ❑ Hotlines, such as Info Line (2-1-1), will be extensively employed to help inform the public and answer questions.

- ❑ Press releases will be developed and disseminated to media outlets using the Odyssey Document Delivery System.
- ❑ Thirty-second television and radio announcements will be developed informing the public that a vaccine is now available and directing them to visit the vaccination website, call United Way 211, or contact their provider for information on how to get the vaccine.
- ❑ DPH risk communication/public education materials and public service announcements are being translated into several languages. A web site specifically for local health is established for downloading materials for use. DPH will identify and refer to CDC resources as appropriate.
- ❑ DPH will utilize social media sites including Facebook and Twitter.
- ❑ Key populations to be addressed will be:

Healthcare providers

- ❑ A communication will be sent to targeted licensed physicians, local public health departments, hospitals, health care facilities, pharmacies, occupational health settings, etc., to gauge provider interest in participating in an H1N1 influenza vaccination campaign later this fall. Those who are interested in providing H1N1 vaccine will pre-register to receive vaccine when it becomes available. In addition communications will be distributed to physician associations and various health care organizations, e.g., American Academy of Pediatrics, CT State Medical Society, etc.

Priority populations

- ❑ Thirty-second television and radio announcements will be developed informing the public that a vaccine is now available and directing them to visit the vaccination website, call United Way 211, or contact their provider for information on how to get the vaccine.

Parents of school-aged children

- ❑ The DPH will provide a letter to the State Department of Education and Connecticut Association of Independent Schools identifying priority populations for vaccination and providing vaccination information.

Child Day Care Providers

- ❑ A letter with vaccination information will be sent to child day care centers/group day care homes and family day care homes.
- ❑ A parent letter will also be provided that programs can share with parents, which will contain general information and inform them on whom to contact to be vaccinated (local health department or private practitioner).
- ❑ The letter to day care centers/group day care homes will advise them that they may be contacted with an opportunity to become a vaccination site.

- A notice will be given to local health departments to consider utilizing licensed child day care centers/group day care homes as potential vaccination sites.

Special needs populations as identified by local health departments

- Local health departments will be responsible for reaching out to their special needs populations as identified in their plans

General public

- Thirty-second television and radio announcements will be developed informing the public that a vaccine is now available and directing them to visit the vaccination website, call Info Line 211, or contact their provider for information on how to get the vaccine.

## **J. Recordkeeping and Vaccine Tracking**

- DPH will provide those administering vaccine a data collection form to use to collect the required data fields for each person receiving H1N1 vaccine. It will also capture those not vaccinated because of contraindications.
- Given the large volume of vaccinations anticipated, each vaccinator location will collect the required data and forward the data collection forms to DPH or other designated locations for data entry. The method of form transmission will be determined as best suits each location's needs, and may include: email, courier, fax, pick up, etc.4
- Data will be entered into the Maven software application (DPH's disease surveillance and tracking application) either by direct manual entry or by using scanners and OCR software from scan forms to directly populate data fields into Maven.
- Maven will be used to generate reports, including aggregate reports required by CDC. Maven can be used to generate a file for upload into the CDC's Countermeasures Response Administration (CRA) application using the designated xml format.
- Critical and minimal data elements that will be collected and transmitted to CDC will be identified as required and may include:
  - Vaccine type (e.g., pre-pandemic, pandemic)
  - Date of administration
  - Age group
  - Dose number (1<sup>st</sup>, 2<sup>nd</sup>)
  - Zip code (or Town, which can be assigned to a county for federal reporting)
  - Other information including priority groups as needed
- All vaccine administrators will be required to use the designated data collection forms and report on a schedule determined by DPH during the H1N1 vaccination campaign.
- Data collected on vaccine administered may be used to assist DPH in vaccine inventory management as needed.

## **K. Adverse Events Monitoring**

- ❑ DPH has identified a Vaccine Safety Coordinator and back up staff that will be assigned to this role from the DPH Immunizations Program.
- ❑ DPH will implement active surveillance for cases of Guillain-Barre syndrome (GBS).
- ❑ Following the implementation of vaccination against novel H1N1, the Connecticut Emerging Infections Program will contact our 31 acute care hospitals on a weekly basis to determine if there were any admissions for GBS.
- ❑ DPH will also attempt to contact neurologists on a regular basis to ask if they have any patients recently diagnosed with GBS. EIP staff will review hospital charts to verify diagnosis and vaccination status, which may also require contact with the provider or the state-maintained H1N1 vaccination database.
- ❑ Vaccine safety will be monitored through the Vaccine Adverse Event Reporting System (VAERS). The Immunization Program monitors vaccine safety by ensuring that health care providers report suspected adverse events following vaccination through VAERS.
- ❑ DPH will provide all vaccination sites a copy of state policies on VAERS reporting, copies of the VAERS reporting form, instructions on which adverse events must be reported and which can be reported, and instructions on completing and submitting the form.
- ❑ Vaccine recipients will be passively monitored for adverse reactions to the vaccine. They will receive instruction on identifying and seeking care for adverse reactions.
- ❑ Vaccinators will be responsible for examination and care of persons with adverse events that occur immediately after vaccination (such as anaphylactic reactions).
- ❑ Each health care provider and local health jurisdiction that provides immunizations is required to provide the individual and/or parent/guardian information for reporting possible adverse reactions following administration. This includes the practice telephone number as well as the vaccine information statement (VIS) for the specific vaccine being administered.
- ❑ Reported vaccine reactions meeting adverse event criteria are to be submitted by all healthcare providers to the state Immunization Program on the Vaccine Adverse Event Reporting System (VAERS) form within 10 days of receipt of vaccine.
- ❑ Adverse events related to the vaccine may be made a reportable condition for the duration of the pandemic.
- ❑ DPH will use VAERS to report and investigate adverse events following vaccination with a H1N1 influenza vaccine.
- ❑ DPH will review existing policies for vaccine adverse event reporting and follow-up to ensure timeliness of reporting and will work with private provider

organizations and mass immunizers to report all events to the state coordinator to minimize duplicate reporting of events to VAERS.

- ❑ Adverse events will also be monitored by CDC through CDC's Vaccine Safety Datalink, and Clinical Immunization Safety Assessment (CISA) network.

#### **IV. ROLES AND RESPONSIBILITIES**

- ❑ In general, roles and responsibilities are:
  - ❑ Intended to clarify which activities will be performed by the state, local and community health partners through a coordinated H1N1 Influenza Vaccine Distribution Response.
  - ❑ Consistent with Connecticut General Statutes for a non-emergency coordinated response.
  - ❑ Consistent with federal guidance, with the common overarching goals of reducing the impact of the pandemic on the health of Connecticut's citizens and minimizing the disruption to society and the economy.
- ❑ The following roles and responsibilities are either additional or are listed for purposes of reinforcing details:

##### **A. DPH**

- ❑ Oversees the procurement of the H1N1 vaccine as it is made available by the manufacturers over several months, for distribution through multiple phases as the situation unfolds.
- ❑ Coordinates the distribution of the H1N1 vaccine through established systems for the vendors to transport to the appropriate community services providers (i.e., hospitals, health care providers, or local health departments) in accordance with the CDC guidance to facilitate access for the specified priority groups.
- ❑ Monitors and provides recommendations for the administration of vaccine to the priority groups in accordance with CDC recommendations.
- ❑ The following agency programs will have particularly relevant responsibilities:
  - ❑ Immunization Program collaborates with the Communications Office regarding the status of the supply and distribution plan for the H1N1 Influenza Vaccine.
  - ❑ Communications – prepare and distribute information for the public and responders.
  - ❑ IT Section works with Immunization and Communications to provide needed informatics support
- ❑ Monitor and report vaccination distribution, tracking, inventory and adverse events data to CDC.

## **B. Mass Dispensing Areas (MDAs)**

- ❑ Each MDA and the respective local health departments/districts within each area should have an H1N1 Influenza Distribution Plan as a component of its pandemic influenza vaccination plan, which should be consistent with the state plan. This plan should specify methods consistent with the options outlined in this plan for use of the anticipated allocation of vaccine to the priority populations as defined by this state's H1N1 Influenza Vaccine Distribution Plan.
- ❑ MDA leads coordinate, collaborate and communicate with the local health departments/districts and community health care providers for their respective area to develop H1N1 Influenza Distribution Plan in accordance with the state's plan as it evolves.
- ❑ MDA leads will collaborate and communicate with DPH regarding the H1N1 Influenza Distribution Plan for their respective area, which should identify how administration of vaccine to prioritized target populations is to be accomplished in a timely manner.
- ❑ Upon activation, store, allocate, secure and monitor the use of vaccine distributed to the MDA.
- ❑ Distribute the proportion of the state's allocations of the H1N1 Influenza Vaccine in a manner consistent with the state vaccine operations plan and the MDA's own plan.
- ❑ Follow the state's instructions on which dispensing strategy to employ as the event evolves.
- ❑ Communicate with staff and volunteers on the rationale for priority groups and sub-groups, and the process for defining priority groups to for vaccination. Use Incident Command Structure (ICS) and established communication channels to communicate with prioritized first responders and infrastructure personnel.
- ❑ As consistent with local public health emergency plans, consider use of hotlines and websites to inform the public when various groups are prioritized for vaccination, and where to go to get vaccinated.
- ❑ Vaccinate individuals consistent with prioritized groups as listed in this state vaccine operations plan (attachment B & C – pages 18-19).
- ❑ Use DPH specified data collection forms and return forms as required to DPH for processing.
- ❑ Monitor vaccine-related adverse events and report on these according to the state and federal guidelines.
- ❑ In accordance with changes in DPH instructions, prepare and return unused vaccine immediately when requested.

**C. Community Healthcare Providers (i.e., pediatricians, community health centers, school based health centers, Visiting Nurse Associations [VNAs])**

- ❑ Vaccination sites will maintain cold chain, security, and record keeping in accordance with this plan and any further instructions from DPH.
- ❑ Inform their patients about the status of the vaccination campaign and the rationale for prioritization in accordance with DPH guidance.
- ❑ Vaccinate individuals consistent with prioritized groups as listed in this state vaccine operations plan and recommendations as the situation evolves (attachment B & C – pages 18-19).
- ❑ Report on vaccination in their practice per instructions from the DPH.
- ❑ Use DPH specified data collection forms and return forms as required to DPH for processing.
- ❑ Follow and comply with state instructions on the monitoring and reporting of adverse events, which may be associated with vaccination.
- ❑ Return vaccine to the DPH immediately when requested.

**D. Hospitals**

- ❑ Have a H1N1 Influenza Vaccine administration plan as a component of its Pandemic Influenza response plan consistent with this state plan.
- ❑ Store, allocate, secure, and monitor the use of the vaccine distributed to the hospital, as vaccine is made available.
- ❑ Administer vaccine to priority groups among staff in accordance with this plan and state guidelines pursuant to this plan. Communicate with staff the rationale for target groups and priority sub-groups, and the process for defining priority groups to be vaccinated.
- ❑ Use DPH specified data collection forms and return forms as required to DPH for processing.
- ❑ Monitor vaccine-related adverse events and report on these according to state and federal guidelines.
- ❑ Prepare and return any unused vaccine when requested in accordance with DPH instructions.

**E. Other Mass Vaccinators**

- ❑ Mass vaccinators provide on-site immunization clinics and health screening at retailers such as CVS, Target, Rite Aid, Costco and other retail grocery/pharmacy chains.
- ❑ Mass vaccinators may also provide immunization clinics in corporations, senior living communities, physician offices and schools.
- ❑ Mass vaccinators work with community organizations to provide resources needed within the timeframe specified.

- ❑ Mass vaccinators can supply staff to supplement existing immunization plans dependent on need.
- ❑ Vaccination sites utilizing mass vaccinators will maintain cold chain, security, and record keeping in accordance with this plan and further instructions from DPH.
- ❑ If mass vaccinators are contracted for services within a MDA, they:
  - ❑ Shall distribute a proportion of the state's allocations of the H1N1 Influenza Vaccine in a manner consistent with the state vaccine operations plan and the MDA's own plan.
  - ❑ Communicate with mass vaccinator's staff on the rationale for priority groups and sub-groups, and the process for defining priority groups to access vaccine.
  - ❑ Inform their patients about the status of the vaccination campaign and the rationale for prioritization in accordance with DPH guidance.
  - ❑ Vaccinate individuals consistent with prioritized groups as listed in this state vaccine operations plan and recommendations as the situation evolves (attachment B & C – pages 18-19).
  - ❑ Report on vaccination data in the setting used by the mass vaccinator per instructions from the DPH and in coordination with the MDA lead.
  - ❑ Use DPH specified data collection forms and return forms as required to DPH for processing.
  - ❑ Follow and comply with state instructions on the monitoring and reporting of adverse events, which may be associated with vaccination.
  - ❑ Return vaccine to the DPH immediately when requested.

## **V. PLANNING SCENARIOS TO TARGET HIGH-PRIORITY POPULATIONS FOR VACCINATION**

Based on the time vaccine becomes available and distribution begins, planning scenarios to target high priority populations include the following assumptions:

- ❑ Severity of illness is unchanged from what has already been observed.
- ❑ Risk groups affected by this virus do not change significantly.
- ❑ Adequate supplies of vaccine can be produced
- ❑ No major antigenic changes are evident that would signal the lack of likely efficacy of the vaccines being produced.

The following planning scenarios that have been recommended by the CDC Advisory Committee on Immunization Practices (ACIP) as of July 29, 2009 are based on vaccine supply.

If there is a sufficient supply of vaccine initially, vaccination efforts should focus on as many people as possible in the following target groups:

- ❑ pregnant women,
- ❑ people who live with or care for children younger than 6 months of age,
- ❑ health care and emergency services personnel,
- ❑ persons between the ages of 6 months through 24 years of age, and
- ❑ people from ages 25 through 64 years who are at higher risk for novel H1N1 because of chronic health disorders or compromised immune systems.

If the initial supply of vaccine available is in limited quantities. The ACIP committee recommends that the following groups receive vaccine before others:

- ❑ pregnant women,
- ❑ people who live with or care for children younger than 6 months of age,
- ❑ health care and emergency services personnel with direct patient contact,
- ❑ children 6 months through 4 years of age, and
- ❑ children 5 through 18 years of age who have chronic medical conditions.

Once the demand for vaccine for the prioritized groups listed above has been met, the ACIP recommends expanding vaccination efforts to include everyone from ages 25 through 64 years. Current studies indicate the risk for infection among persons age 65 or older is less than the risk for younger age groups. Once vaccine supply and demand for vaccine among younger age groups has been met, vaccination efforts can be expanded again to include people over the age of 65.

## **VI. PLAN DEVELOPMENT AND MAINTENANCE**

- ❑ This plan will be updated annually or more often as conditions change, as the science advances, as countermeasures improve, and as planning evolves.
- ❑ This H1N1 Vaccine Distribution Response Plan will be publicized through posting of excerpts on the Connecticut FluWatch website <http://www.ct.gov/ctfluwatch>.

## VII. ATTACHMENTS

**A. Table 1: Populations to be vaccinated and resources to perform vaccination**

Category	Target Group	Estimated Number *	Vaccinated By **	Vaccination sites
Healthcare and community support services	Public Health Personnel	3,310	Mass Dispensing/Local Health/VNAs/Maxim	Local Health Departments/Mass Dispensing sites
	Inpatient healthcare providers	75,000	Hospitals will be given a supply of vaccine to provide vaccinations for each employee that wants to be vaccinated	Hospitals
	Outpatient, Community Health Center and Home Health Providers	22,000	VNAS/Maxim/Local Health/CHC	Agency homes, local health departments
	Healthcare providers in LTCFs	8,800	Long Term Care Providers	Long Term Care Facilities
Critical Infrastructure	Emergency Medical Service Personnel	22,000	PODS/Mass Dispensing group Maxim (private groups) VNAs, local health departments	Mass Dispensing locations, schools, EMT agencies
	Law Enforcement personnel			
	Fire Service Personnel	550	VNAs/Maxim	Local identified site, Legislative Office Building
	Key Government Leaders			
General Population	Pregnant women	36,000	CHC, OB/GYN, Private providers	Private Practitioners' office***/Community health centers
	Infants & Toddlers 6-35 Mo. old	113,310	Pediatric provider groups, CHCs	Private Practitioners' offices, CHCs, Daycare facilities
Homeland Security	Essential support & sustainment personnel	7,150	Mass Dispensing/Maxim/VNAs/Local Health	DEMHS identified Locations
	National Guard personnel	5,500	Medical National Guard providers	National Guard bases

Connecticut Department of Public Health  
H1N1 Vaccine Distribution Response Plan

8/11/09

Healthcare and community support	Community support and emergency mgmt.	6,600	Mass Dispensing, LHD, Maxim, VNAs	Local Agency sites
Critical Infrastructure	Electricity sector personnel Natural gas personnel Communications personnel Water Sector personnel Critical government personnel	20,900-48,400	Mass Dispensing/LHD/Maxim/VNA	Mass Dispensing sites (schools/local meeting areas)
Homeland Security	Other active duty & essential support	16,500	Military (own supply)	Military locations
Healthcare and Community Support	Other important healthcare personnel	5,500	Private Providers/VNA/Maxim/Mass Dispensing/CHC	Local Provider offices, community sites
Critical Infrastructure	Transportation sector personnel Food and agriculture sector personnel Banking and finance personnel Pharmaceutical sector personnel Chemical sector personnel Oil sector personnel Postal and shipping personnel Other important government personnel Funeral directors and embalmers	15,400 to 38,500	Mass Dispensing/VNAs/Maxim/Local Health	Local identified Mass Vaccination sites(schools. Arenas)
General Population	Household contacts of infants < 6 mo	60,000	Private Providers/Local Health Departments/CHC	Private Providers Offices Community Health centers Schools, Day Care

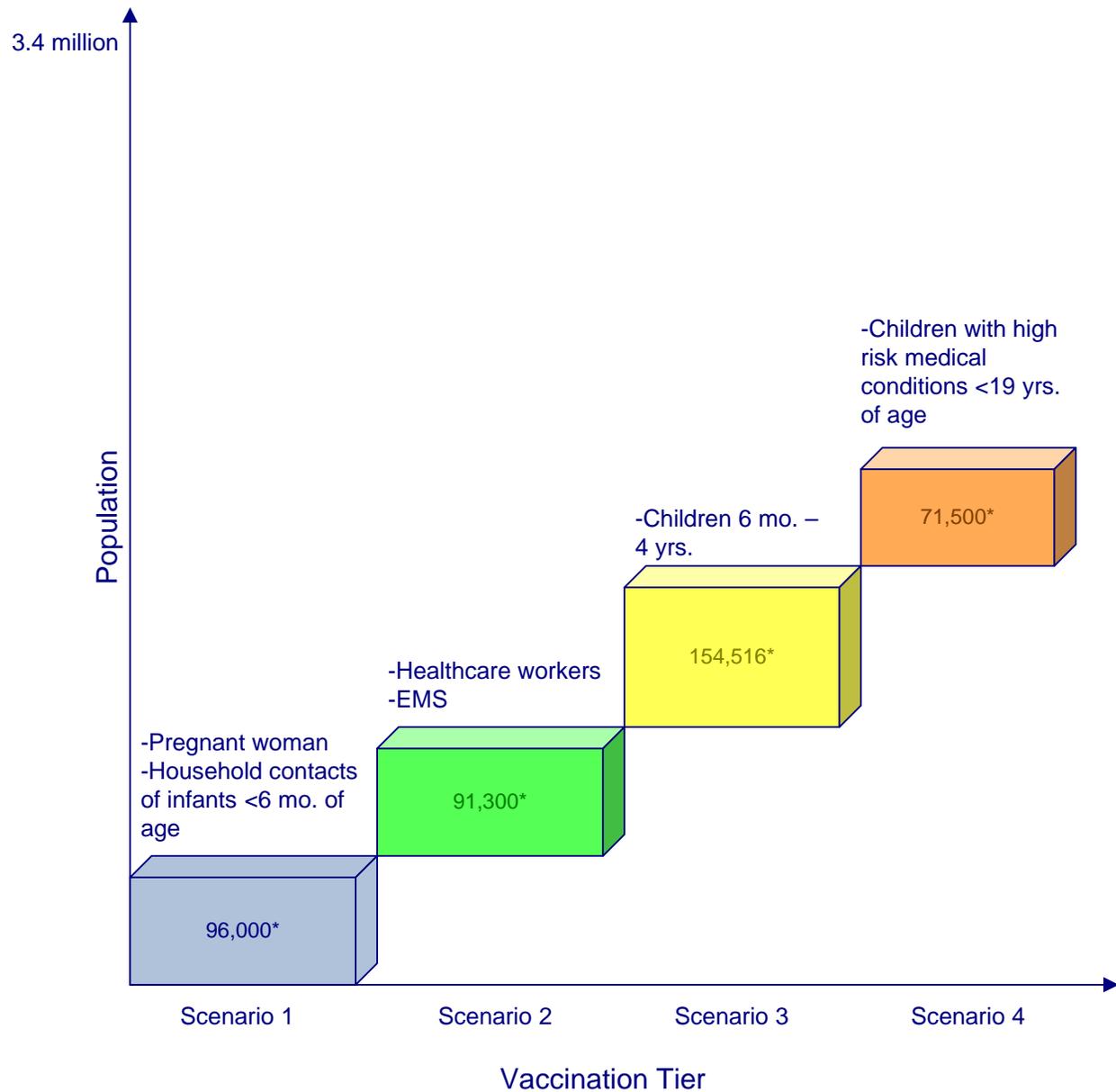
	Children 3-18 yrs with high risk cond.	71,500	Pediatric Providers/SBHC/schools	Centers, Private Practitioners Offices
General Population	Children 3-18yrs without high risk	643,500	SBHC/Schools/Local Health Departments/Maxim	Day Care Facilities Schools Community Health Centers
General Population	Persons 19-64 with high risk cond.	396,000	Private Health Care Providers Mass Dispensing/VNAs/Maxim/Local Health Departments	Local Mass Vaccination sites (schools, large public buildings) Private Practitioner offices
General Population	Persons $\geq$ 65 yrs old	418,000	Mass Dispensing/VNAs/Maxim/Local Health Departments	Local Mass Vaccination sites (schools, large public buildings)
General Population	Healthy adults 19-64 yrs old	1,339,800	Mass Dispensing/VNAs/Maxim/Local Health Departments	Local Mass Vaccination sites (schools, large public buildings)

\* Based on numbers 1.1% US population

\*\* Follow state instructions on which dispensing strategy to employ, including prioritization and definitions of target groups for vaccination.

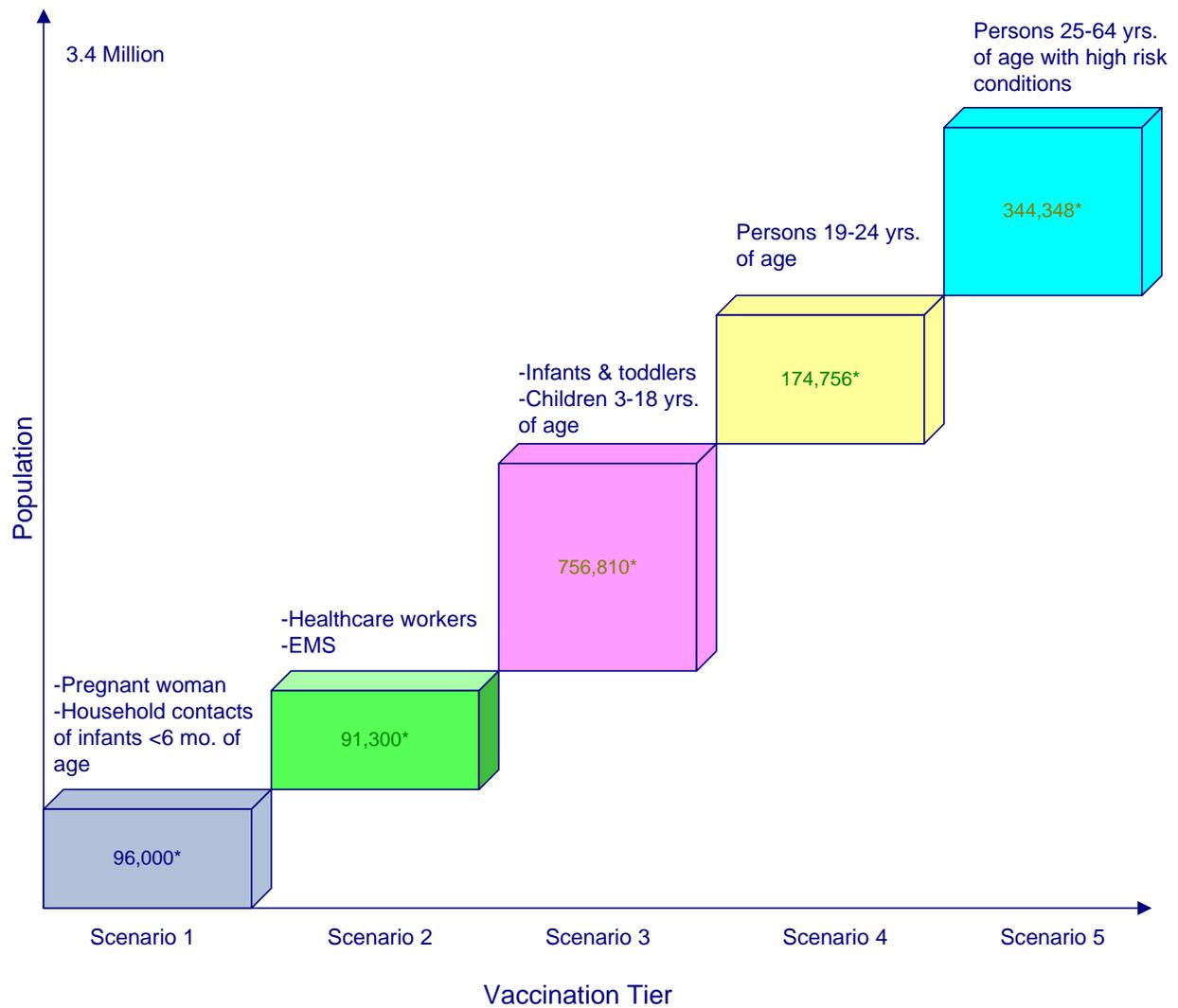
\*\*\* Local Practitioners could work together to regionalize vaccination sites. Several practitioners would use offices to vaccinate multiple practitioners' patients

**B. Figure 1: Priority Populations for Vaccination Based on Limited Supply According to CDC ACIP Sub-Group Planning Scenarios.**



\*Population group estimates

**C. Figure 2: Priority Populations for Vaccination Based on Adequate Supply According to CDC ACIP Sub-Group Planning Scenarios.\***



\*Population group estimates

\*When vaccine availability is sufficient at the local level to routinely vaccinate initial target populations, in consultation with State and local health departments, vaccination against H1N1 is recommended for all healthy adults 25-64 yrs of age.

\*Vaccination is recommended for persons 65 years or older once the demand for vaccination of younger age groups is met.

**D. Figure 3: CT Department of Public Health H1N1 Vaccine Delivery Schematic**

