Department of Health and Human Services

Nevada State Health Division

H1N1 Program Overview

The Mission of the Health Division is to Promote and Protect the Wellbeing of Nevadans and Visitors to our State by Preventing Disease, Injury and Disability

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Executive Summary

1. Background H1N1 in Nevada:
   a. On April 17th 2009 the Centers for Disease Control and Prevention (CDC) determined that two cases of febrile illness occurring in two children who resided in adjacent counties in Southern California were caused by an infection with Swine Flu or Novel H1N1 virus. This virus had not been previously reported in the United States or elsewhere. Also, neither child had contact with pigs and the source of their infection remains unknown. During the following weeks, influenza activity continued to increase in the United States. Today, Swine Flu (Novel H1N1) activity is widespread in 48 states and is the dominant strain.
   b. On June 11, 2009, the World Health Organization (WHO) declared that a global pandemic of H1N1 flu was underway by raising the worldwide pandemic alert level to Phase 6. The pandemic phase 6 is characterized by human-to-human spread of the virus into at least two countries in one WHO region as well as one other country in a different WHO region. Phase 6 also designates the time to finalize the organization, communication, and implementation of planned mitigation measures.
   c. In a concentrated effort to protect the health of Nevada residents and visitors the Nevada State Health Division's (NSHD) Public Health Preparedness program put into motion an Incident Action Plan. The goals of this plan are to mitigate the impacts of H1N1, and respond to the impacts of H1N1 through the CDC's guidance.
      This Nevada plan involves the three local health authorities, NSHD Frontier and Rural health program, Division of Emergency Management and public and private healthcare providers.
   d. On August 20th 2009, the NSHD launched its new flu website, flu.nv.gov. The website was developed to provide a unified, up to date, factual information source for Nevada residents, visitors, businesses, schools, doctors and healthcare providers.
   e. Since August 20th, NSHD has also launched an H1N1 flu vaccine locator, weekly flow charts and algorithms depicting H1N1 information have been developed as well as educational and informational presentations over radio and TV. Also, open and closed points of dispensing have been conducted throughout the state. These will all be described later in the presentation.
   f. Genetically, the virus has not changed. It's still closely matched with vaccine. We have not seen mutations that would suggest that it would become more deadly. This is a younger people's flu. In a usual flu season, 90% of the deaths are among people over the age of 65. In H1N1, 90% of the deaths are in people

under the age of 65. Up until now, there have been 114 laboratory confirmed deaths among children nationwide. More than two-thirds of those have been children with underlying conditions.

g. H1N1 vaccine supply is increasing steadily. There's not enough for all providers or people who would want it. And this is very frustrating. Last week, we had 16.1 million doses available. As of today, we have 26.6 million doses available for shipment. That's an increase of 10.5 million doses. The gap between supply and demand is closing but very slowly.

2. Incident Command Structure (ICS):
   a. On October 2nd 2009, the Incident Action Plan was revised and updated to reflect the ever-changing H1N1 situation. The NSHD PHP team went into the Incident Command System mode of operation. Incident Command Structure (ICS) is an organizational model used throughout the United States and is compliant and aligned with the National Incident Management System (NIMS). The ICS structure defines lines of communication and authority, coordinates and structures planning amongst agencies, and defines clear goals and activities to achieve the designated H1N1 mission.
   b. The mission of the NSHD H1N1 ICS is to mitigate the impact of H1N1 within Nevada for the duration of this pandemic. To protect Nevada's citizens and visitors by collaborating with federal, State, local, tribal, and private sector partners.
   c. The goals of the NSHD H1N1 ICS is to
      i. Decrease the transmission of H1N1 within Nevada
      ii. To bolster medical surge capacity within Nevada
      iii. To maintain epidemiological surveillance of the H1N1 virus within Nevada
      iv. To facilitate a comprehensive Public Information and Communication plan specific to the H1N1 response within Nevada.
      v. SEE diagram on page 14 for the ICS organizational chart
3. Antivirals and Personnel Protective Equipment (PPE):

ANTIVIRALS

   a. While CDC recommends flu vaccine as the first and most important step in preventing flu, antiviral drugs are a second line of defense against the flu. There are two antiviral drugs recommended by CDC this season. The brand names for these are Tamiflu® and Relenza.
   b. Antiviral drugs are prescription medicines in the form of pills, liquid or an inhaled powder that fight against the flu in your body. Recently, an Intravenous (IV) antiviral, peramivir has been authorized for use by the US Food and Drug Administration (FDA), subject to the Emergency Use Authorization (EUA) terms

and conditions. IV peramivir may be appropriate for certain hospitalized and critically ill patients only with suspected or confirmed 2009 H1N1 influenza, such as patients not responding to either an oral or inhaled antiviral therapy and patients without a dependable oral or inhaled route of drug delivery (e.g. patients unable or unlikely to absorb Tamiflu due to bowel problems or absorption problems).

c. Nevada has antiviral mediation available from shipments received from the CDC's Strategic National Stockpile. These shipments are made available when pharmacies supply are exhausted or when patients are unable to afford antivirals. As of October 28th 2009 Nevada has 229,951 courses remaining on hand. Pediatric liquid has been the most limited. In the Nevada stockpile we have 2662 courses of pediatric liquid Tamiflu. On October 1, the CDC released 300,000 courses from the strategic national stockpile. This week an additional 234,000 courses of liquid Tamiflu were released to states. Nevada will receive 103 cases which has an additional 1854 courses from this release. In total we have 4516 doses of Pediatric liquid Tamiflu. We are able to make liquid Tamiflu from adult capsules, and pharmacies should be able to provide these services.
d. To date: (see page 15) we have used 55 courses of Tamiflu liquid requested from our stockpile. Much of all Tamiflu is still available at our state pharmacies.
e. The NSHD has added to our website, flu.nv.gov, an Antiviral Request Form for physicians, healthcare clinics, hospitals, pharmacies and other facilities that provide healthcare (not individuals), to request antiviral medication for dispensing purposes.
f. It's very important that antiviral drugs be used early to treat flu in people who are very sick (for example people who are in the hospital) and people who are sick with flu that have a greater chance of getting serious flu related complications. Most healthy people with flu, however, do not need to be treated with antiviral drugs.
g. Due to the widespread nature of this virus, the CDC expressed concern that there was the possibility of running out of antiviral medication if used inappropriately. In early October, the NSHD developed a technical bulletin to stress that antiviral medications should be prioritized for persons with severe illness or those at higher risk for flu complications. (see page 18)

PERSONAL PROTECTIVE EQUIPMENT (PPE):

i. Definition: Specialized clothing or equipment worn by employees for protection against health and safety hazards. These include Gloves, Gowns/aprons, Masks, respirators, Goggles and Face shields.
ii. In areas with confirmed human cases of 2009 influenza A (H1N1) virus infection, the risk for infection can be reduced through a combination of

actions. No single action will provide complete protection, but an approach combining the following steps can help decrease the likelihood of transmission. These recommended actions are:

- Wash hands frequently with soap and water. If soap and water are not available, use an alcohol-based hand rub.
- Cover your mouth and nose with a tissue when coughing or sneezing.
- Avoid touching your eyes, nose and mouth.
- People who are sick with an influenza-like illness (ILI) (fever plus at least cough or sore throat and possibly other symptoms like runny nose, body aches, headaches, chills, fatigue, vomiting and diarrhea) should stay home and keep away from others as much as possible, including avoiding travel, for at least 24 hours after fever is gone except to get medical care or for other necessities. (Fever should be gone without the use of fever-reducing medicine).
- Avoid close contact (i.e. being within about 6 feet) with persons with ILI.

iii. In some circumstances these measures are inadequate and surgical masks or specialized masks called N95s are necessary. The CDC has put out specific guidance for these circumstances.

iv. Nevada has shipments of personal protective equipment that we have received from the CDC's Strategic National Stockpile. (see page 15 for exact amounts to ie. To date-aprox 646,460 N95s and 163,000 surgical masks)

v. Healthcare providers can request PPE through their local health departments PHP program with a form available on our website flu.nv.gov.

4. Testing and Surveillance:

TESTING

a. In response to the demand for H1N1 influenza testing the Nevada State Public Health Lab began a 24/7 schedule.
b. From April 26th-October 28th the NSPHL has tested 5,795 samples. 2323 cases confirmed, probable-60(minimal specimen).
c. There is a rapid test for Influenza A that is very inaccurate, producing false negative results, and a specific confirmatory test that is a PCR test (polymerase chain reaction).
d. To slow the use of reagents and prevent shortage or running out of supply an algorithm was developed to ensure both proper testing and proper indication for testing. (page 22-23)
e. This season CDC recommends that influenza diagnostic testing be prioritized for 1) hospitalized patients with suspected influenza; 2) patients for whom a diagnosis of influenza will inform decisions regarding clinical care, infection control, or management of close contacts; and 3) patients who died of an acute illness in which influenza was suspected. Most patients with a clinical illness consistent with uncomplicated influenza who reside in an area where influenza

viruses are circulating do not require diagnostic influenza testing for clinical management.

SURVEILLANCE: H1N1 surveillance the following activities are underway:

a. Weekly tracking of confirmed cases, death and ILI (influenza like illness) rates. To date there are 2323 confirmed cases and 21 deaths. These are also divided by counties. (see page 86)The Nevada ILI rate is 8.4% with the nationwide rate at 8.0 %.
b. Regular monitoring of OTC healthcare products usage in Nevada and nationwide using the National Retail Data Monitor system to identify disease outbreaks as early as possible.
c. Daily monitoring of EpiCenter activity. Data from ERs, Hospitals and urgent care facilities.
d. Regular bulletins from State Epidemiologist on testing, reporting and surveillance.
(county by county trends, OTC data, reporting criteria all provided on pages 24-26)

5. Vaccine:
   a. H1N1 overall Immunization program goals:
      i. Decrease transmission by distributing vaccine efficiently and quickly while meeting the CDC target groups.
      ii. Provide superior and responsive customer service.
      iii. Provide consistent, informative, accurate and rapid communications to all stakeholders. Use innovative and traditional forms of media.
      iv. Use lessons learned in VFC model to respond to this public health emergency.
      v. Effectively track doses administered to ensure H1N1 performance based targets are met and identify problem areas in vaccine administration rapidly.
   b. Vaccine in the initial stages must conform to the target groups established by the CDC
      i. Pregnant women
      ii. Healthcare workers and emergency medical services workers
      iii. People 6 months through 24 years
      iv. People who care for infants under 6 months of age
      v. People 24 years through 64 years of age with chronic medical conditions (ie. Diabetes, neurologic disorders, rheumatologic disorders)
   c. Vaccine dosing and facts:
      i. Mist-Ages 2yrs-49 yrs: only with normal immune systems- two Mists (seasonal and H1N1 must be spaced by 28 days) Mist and shot can be given simultaneously or spaced. Two doses for ages 9 and under spaced one month apart. No pregnant women.
      ii. Shots-6 months -36 months :(2)-.25cc doses spaced 28 days apart
      37 months-9 years: (2) -.50cc doses spaced 28 days apart.
      10 years to all adult: (1)-.50 cc dose
      iii. Egg allergies contraindication

d. H1N1 vaccine allocation:
    i. State by state allocation based on 2008 census with Nevada's Pro-rata at 0.8425% of the nation's population.
    ii. 5 manufacturers providing the nations H1N1 vaccine and mist.
    iii. Weekly allocations estimate the amount of vaccine being allocated and the specific presentations available. (shot,mist)
    iv. Weekly allocations have been 20-40% less than anticipated
    v. 1.4 Million doses H1N1 vaccine is expected to be allocated to Nevada through January 8,2010.
    vi. Vaccine shipped directly to providers in allocations of 100 and more. With county health departments doing further distribution.
    vii. McKessan to ship all vaccine through mechanisms established with VFC program.
    viii. The Immunization program will determine order distribution with input from each Local Health authority for their counties.
    ix. The Immunization program is also shipping directly to providers that desire less than 100 doses.
e. Public Health Vaccination Clinics:
    i. The three local health authorities, Washoe County Health District, Southern Nevada Health District and Carson City Health and Human Services and Frontier and Rural program have plans for mass dispensing clinics (Points of Distribution or PODs). However to date, the nation including Nevada has not received estimated allocations. This is reportedly due to the manufacturing delays. This has left the state with insufficient vaccine numbers to utilize POD plans for mass vaccination. In lieu of mass vaccination each jurisdiction continues to have day to day clinics and school outreach clinics to meet target populations. As vaccine numbers increase the POD plans will occur.
    ii. There is no charge for vaccine at Public Health Clinics.
f. Vaccination by Private Sector vaccinators:
    i. The CDC has allocated 1202 ship to sites for public and private providers.
    ii. As of October 27,2009- Nevada has 537 completely enrolled H1N1 providers.
    iii. Immunization program has provisions to order and ship direct to private providers who have decreased capacity to store and immunize target population.
    iv. Weekly provider teleconferences with over 100 participants to answer all questions. All call notes posted to Flu.nv.gov
    v. Providers are fully enrolled and educated on appropriate vaccine storage and use. NSHD field staff visit each clinic to provide education and determine adequate vaccine storage capabilities.
    vi. Webinars are provided on all education points ie. Storage, handling, administration.
    vii. Private providers can charge and administration fee only –aprox 21 dollars
g. Coordination with other partners:

i. Flu.nv.gov
ii. All Nevada tribes have pre-registered to be H1N1 providers
iii. A FLU-FINDER component has been added to the flu.nv.gov website. This will locate all public immunization clinics and pharmacy clinics. Private providers are not listed to prevent excessive calls or misdirection of patients.

h. Coordination of vaccine distribution:
   i. The Immunization program coordinates with each health jurisdiction prior to allocation of vaccine.
   ii. An H1N1 Vaccine Distribution Algorithm was developed based on multiple topics including
      1. Allotment
      2. Ability to reach target population
      3. Capacity for storage
      4. Population

      (page 51-52 for algorithm)
   iii. To date 143,900 doses of vaccine have been distributed to the public and private sector.
   iv. Vaccines ship in 100 dose allotments and will be accompanied by needles, syringes, alcohol swabs and vaccination cards.

i. Dose tracking and administration tracking:
   i. WebIZ the state registry will be used
   ii. All doses will be recorded in WebIZ-clinics are encouraged to use the system but if unable all vaccines will be documented on paper form and can be entered by state WebIZ staff. Once per week providers are asked to aggregate their data for entry.
   iii. Staff will generate weekly data in order to meet aggregate CDC reporting requirements.
   iv. All H1N1 providers will provide weekly updates on target populations that received the H1N1 vaccine.
   v. Nevada Immunization program has hired many temporary data entry staff to assist with all data entry.
   vi. As of October 24, 2009 132,321 doses have been distributed to our state and 62,900 are being shipped this week for a total of 195,221 doses. Of these, 49,054 doses have been administered to date with more occurring each day.
   vii. We have developed a tracking system to monitor administration weekly. This data will be used to determine where dose re-allocation needs to occur.

j. Safety Monitoring:
   i. The Vaccine Adverse Event Reporting System (VAERS) will be the primary means of reporting adverse reactions to vaccine.
   ii. Vaccine cards issued by the CDC provided
   iii. Increased education on adverse events to providers provided.

k. Legal:
   i. Information re: PREP act included to all providers.(page 79)

6. Community Mitigation:
    a. Definition: Non-pharmaceutical ways to control disease spread and infection.
    b. Examples of Community Mitigation:
        i. Infection control and hygiene
        ii. Social distancing-ie. Cancelling large public gatherings, changing gathering schedules
        iii. Community education
        iv. Isolation and quarantine-stay home when ill
        v. School dismissals
    c. Example of Nevada State Health Division Community Mitigation actions:
        i. Establishing school dismissal procedures (pg 58-62)
        ii. Participation in Nevada State Education Summit
        iii. Presentations to school Superintendants
        iv. Nevada Department of Personnel Pandemic Flu Planning Committee participation
        v. Communication Toolkit for Schools (Grades K-12)
        vi. Communication Toolkit for Businesses and Employers (Page 63-665)
7. Communication:
    a. The Nevada Ste Health Divisions Public Information Officer (PIO) has been the lead at the state level working on H1N1 flu communication activities.
    b. The local health jurisdiction PIOs have been included from the beginning.
    c. Examples of Statewide communication activities:
        i. Contract with Nevada Broadcasters Association (NBA)
            1. Radio scripts currently airing statewide in English and Spanish (examples pg 67-70)
        ii. Full Page advertisement in the Washoe County Parents Magazine
        iii. Contract with Nevada Press Association-when completed will provide adds in 16 newspapers statewide.
        iv. Numerous media interviews
        v. Website dedicated to H1N1-flu.nv.gov with health information listserv
        vi. H1N1 flu vaccine locator
        vii. Weekly Briefing (page 86-90) – provided to a wide variety of partners and stakeholders
        viii. PIO conference calls with all health jurisdiction PIOs
        ix. Immunization program partner and provider conference calls
        x. Participation in CDC media briefings
        xi. Updates to Bilingual hotline provided by Rocky Mountain Poison Control
8. President Obama signs Emergency Declaration for H1N1 (Page 74-78)
    a. On October 24, 2009 President Obama signed a proclamation declaring the 2009 H1N1 influenza pandemic a National Emergency to facilitate our ability to respond to the pandemic-**if warranted-**the waiver of certain statutory Federal requirements for medical treatment facilities.
    b. This is a pre-emptive measure that would allow HHS the ability to waive legal requirements that could limit the ability of the nation's health care facility to respond to surge of patients with Novel H1N1 influenza virus.

c. Examples:
    i. Hospitals request to set up an alternative screening location for patients away from the hospitals main campus.
    ii. Hospitals request to transfer patients from ERs and inpatient wards between hospitals
    iii. Critical Access Hospitals requesting waiver which requires a 25-bed limit and average patient stays less than 96 hours.
    iv. Skilled nursing facilities increasing the number of certified beds
d. Development of Alternate Care Plans:
    i. The state has begun to develop Alternate Care plans and policy for when surge capacity is exceeded.
    ii. Mission Statement: Participating statewide key stakeholders and public, private and tribal partners will collaborate to develop a statewide ACS plan by the end of calendar year 2012 to meet the medical surge needs of Nevada's citizens and visitors by using shared modular design with interoperability.
    iii. Definition: An Alternate Care Site(s) are pre-selected sites or an alternative location for temporary use for delivery of healthcare services when healthcare capacities are exceeded.
    iv. Future Plans: Next meeting is scheduled for December 10, 2009 to be held in Las Vegas, the specific site is yet to be determined.

Weekly Summary concludes this document- we can send this document to you on a weekly basis with an email address. Please let us know if you would like to receive this weekly document.

QUESTIONS??