

Comments on the Draft Pandemic Influenza Plan from the Virginia Department of Health:

October 25, 2004

Thank you for providing such an informative draft pandemic influenza plan for the nation. The plan contains a great deal of important information that will help public health officials and medical care providers understand what to expect in the event of a pandemic, guide state and local planning efforts, and move us closer to being better prepared to respond appropriately if such a large scale public health crisis occurs. The Virginia Department of Health has some comments to offer about clarifications that would enhance the plan and additional subject matter that would be beneficial. Our suggestions are presented below by subject matter category.

Prioritization. It is very important to have national leadership in ranking the priority groups and defining sub-priorities within each group to ensure some consistency across the country regarding who may receive vaccine and antivirals in a time of extremely limited supply. The vaccination goals listed in the annex help identify broad priority groups, but not everyone in those groups will have access to vaccine. Thus, more specific definitions of priorities are needed. Similarly, antiviral priorities are listed in the healthcare system annex but need further definition. For example, the definition of front-line health care workers should be standardized. This priority ranking needs to occur in the inter-pandemic years and not wait until Phase I of the pandemic. Of course, it may need to be modified in Phase I depending on the epidemiology of the epidemic.

Along with specific priority group definition, we need the rationale for each priority group to be developed in advance so communication messages can be clear and consistent and delivered in a timely manner if a pandemic were to occur. Public education will be so critical to the success of any disease control campaign. Messages are needed about what people who are not in the priority groups can do during a time of crisis. It is important for these messages to be crafted in inter-pandemic years to ensure a standardized message comes out nationally during a time of need. The public information annex also mentions conducting assessments of provider and public information needs; tools to standardize the methods used for these assessments are needed. Perhaps an entire portfolio of communication materials surrounding pandemic influenza preparedness and response may be created.

Laboratory. It is imperative that the national pandemic influenza preparedness and response plan address laboratory capacity. Laboratory results are critical for influenza surveillance and for public health decisions during an influenza epidemic or pandemic concerning isolation, quarantine, prioritization of vaccination when vaccine supplies are limited, and appropriate use of antiviral agents. Therefore, an annex devoted to laboratory preparedness should be added to the national plan.

The laboratory capacity annex of the pandemic influenza preparedness and response plan should address all relevant laboratory issues, including the following: (1) sufficient laboratory capability for inter-pandemic surveillance, including influenza culture to assure adequate tracking of virus strains; (2) development and deployment of

rapid influenza virus detection and subtyping methods within the state public health laboratories, to enable rapid detection of Influenza A and its H subtype; (3) laboratory surge capacity for a nationwide pandemic; (4) provision for surge capacity in the supply of laboratory reagents for influenza detection and subtyping. Laboratory reagents have become a limiting factor even in years of moderately increased demand for laboratory testing (e.g., in the 2003-2004 season, several laboratories had to limit their laboratory testing for influenza because sufficient laboratory reagents could not be obtained). Planning for laboratory reagent supply is essential because laboratory reagent supplies could rapidly become one of the first and most critical elements to limit appropriate public health response to pandemic influenza.

Data Systems. The need for data systems is mentioned throughout the plan. It would be helpful if the plan could contain more information about suggested data elements and if the Centers for Disease Control and Prevention could develop some databases in advance so consistent data collection would be assured. Examples of databases mentioned include tracking who received the vaccine, who needs a second dose of vaccine, adverse reactions, antiviral use, drug resistance, vaccine supply, medical and material supplies and their allocation, beds available vs. patients waiting, monitoring the quality of care in non-traditional settings, priority group status and demographics of vaccine recipients, vaccination status of people making medical visits or being hospitalized, compliance with antiviral therapy recommendations, compliance with containment measures, etc. Clearly, a lot of data needs have been identified. The development of tools to meet these needs would aid public health capacity to respond and document critical information .

Surveillance. Surveillance challenges are presented in the annex, providing a good list of reasons why it is very difficult to count all cases of influenza. In the surveillance annex, very reasonable approaches to influenza surveillance are outlined by pandemic phase. However, if a pandemic occurs, the expectation will be that we can count all cases, hospitalizations, and deaths and provide those data daily. States need national guidance and recommendations about flu surveillance that is above and beyond what is normally done, rather than statements that states should develop strategies for monitoring deaths and hospitalizations. Public health leaders need to determine how we are going to handle the expectation of the public for daily counts, which are so difficult to determine for influenza. The communication and education annex mentions the need to collect data daily, including morbidity and mortality figures, geographic location of cases, number of persons affected, number hospitalized. The healthcare annex mentions ongoing monitoring of hospitalizations and deaths and monitoring nosocomial influenza infection. Surveillance for adverse events is also mentioned in the plan, although it is unlikely that resources would be available to conduct interviews at specific intervals after vaccination. These concepts are not addressed in the surveillance annex and clearer surveillance goals are needed. Additionally, states need national recommendations regarding the applicability for influenza of the use of emergency department or discharge data currently being used for syndromic surveillance for bioterrorism detection. Statements about the expected number of hospitalizations should be updated to reflect the data presented in the September 15, 2004 edition of the *Journal of the American Medical Association*.

Epidemiologic Studies. The plan mentions epidemiologic studies that would be recommended during a pandemic. These include monitoring for antiviral resistance and vaccine effectiveness and evaluating the effectiveness of interventions and impact on communities and the health care system. Guidelines for study methodologies and data collection tools for these types of studies would be helpful.

Antiviral distribution. The draft plan presents the use of antivirals as a critical component to the control of disease. The need for definitions of priority groups to receive these products has already been mentioned above. Additional information is needed about antivirals, some of which are mentioned but may deserve greater emphasis. Neuraminidase inhibitors are so difficult to make and not likely to be available in sufficient quantities. Yet they are a cornerstone of the planned method of control. More detailed estimates of the demand for antivirals if used for treatment and if used for both treatment and prophylaxis are needed. Those estimates could then be linked with estimates of available supply and permit more specific planning for what populations should receive them given the anticipated supply and demand. It needs to be very clear that the use of antivirals for prophylaxis should be limited to certain populations because it will drain the supply so quickly.

Some points that were made in the plan that need further emphasis are 1) that antiviral prophylaxis should not be used with live-virus vaccination; 2) how people should be asked to document that they are in a priority group; 3) how vaccines and antivirals will be distributed, including a plan for public and private sector distribution. We believe distribution plans need to be standardized. Information sheets should be developed and disseminated in advance, covering topics such as contraindications, drug interactions, and adverse events.

Fatality Management. The plan does not address any plans for management of mass casualties. This is an important component that deserves more attention and planning.

Disease control strategies/infection control. 1) More specific recommendations should be provided regarding methods of environmental decontamination, including cleaning procedures for common items (horizontal surfaces, floors, toys) as well as acceptable disinfectants to use. 2) The definition of a contact to include those working within 6 feet of a suspected case may be problematic to implement, especially if those contacts are asked to stay home for 7 days. 3) The communication and education annex mentions “intense contact tracing”. This may be impractical to do during a large-scale event. Guidelines are needed on how much contact tracing is recommended. Further enhancement of isolation and quarantine plans is also indicated. 4) Consideration should be given to including terminology and guidelines to communicate a healthcare worker’s ability to remain at or return to work (as in the Canadian Pandemic Influenza Plan), such as Fit for Work, Unfit for Work, and Fit for Work with Restrictions. 5) The healthcare system annex was a particularly strong component of the draft plan. A point made therein, however, raises concern regarding disease control. That is the recommendation to consider expediting patient discharge into a skilled nursing facility, which would increase the risk of institutional outbreaks among high risk populations. 6) Hospital

partners in Virginia have voiced a desire for more clarity about expectations and legal authority if isolation of infected individuals is needed.

Roles and Coordination. In the core plan, in section 3 on pandemic influenza response, more information about the roles and degree of coordination between the Departments of Health and Human Services (HHS) and Homeland Security is needed as well as the method of coordinating federal roles with those of state and local responders. A further indication of coordination would be demonstrated if the web sites for National Center for Infectious Diseases and the National Vaccine Program Office and cdc.gov/flu could be consolidated into an overall HHS flu site with a common link from each.

I have great appreciation for the magnitude of the effort that went into creating the draft national plan for pandemic influenza. The information provided is invaluable. I appreciate the opportunity to comment on the plan and look forward to continued work at all levels of government to assure public health preparedness for pandemic influenza. Thank you for the profound guidance you have provided thus far.

Sincerely,

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