Connecticut Department of Public Health

IAP ON TIME

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Seasonal Influenza

Seasonal Flu

Recommendations for Prevention and Control of Seasonal Influenza with Vaccines**,** Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2009 were published on July 31, 2009**.** A full copy of these recommendations can be found at: http://www.cdc.gov/mmwr/PDF/rr/rr5808.pdf The recommendations provide guidance on when to begin vaccination with seasonal influenza vaccine. Providers of the seasonal influenza vaccination should begin to vaccinate as soon as they receive their influenza vaccine supply.

The 2009 recommendations include three principal changes or updates:

- Annual vaccination of all children aged 6 months --18 years should begin as soon as the 2009-2010 influenza vaccine is available.
- Annual vaccination of all children aged 6 months -- 4 years (59 months) and older children with conditions that place them at increased risk for complications from influenza should continue to be a primary focus of vaccination efforts as providers and programs transition to routinely vaccinating all children.
- The 2009-2010 trivalent vaccine virus strains are A/Brisbane/59/2007 (H1N1)-like, A/Brisbane/10/2007 (H3N2)-like, and B/Brisbane 60/2008-like antigens.

Most seasonal influenza A (H1N1) virus strains tested from the United States and other countries are now resistant to oseltamivir. Recommendations for influenza diagnosis and antiviral use will be published later in 2009. CDC issued interim recommendations for antiviral treatment and chemoprophylaxis of influenza in December 2008, and these should be consulted for guidance pending recommendations from the ACIP.

The recommendations for who should be vaccinated with the 2009-2010 seasonal influenza vaccine include:

- persons aged ≥50 years;
- women pregnant during the influenza season;
- persons who have chronic medical conditions;
- persons who have immunosuppression;
- residents of long-term care facilities;
- health-care personnel with direct patient care;
- household contacts and caregivers of children aged <6 months;
- household contacts and caregivers of persons with medical conditions that put them at higher risk for severe complications from influenza; and
- all children aged 6 months through 18 years.

Table 1 on the next page includes the licensed influenza vaccines for 2009-2010, age indications for the vaccine, and the thimerosal content of each vaccine preparation.

Inside This Issue:

Prevent the Spread of Flu

- Wash your hands often with soap and water or hand sanitizers, especially after coughing or sneezing.
- Cough into your sleeve or cover your mouth and nose with a tissue.
- Clean surfaces people touch a lot (telephones, doorknobs etc.) with a disinfectant or sanitizer cloths regularly.
- Avoid people who are sick unless you need to care for them.
- Stay home from work or school if you have a fever and cough or sore throat.

Connecticut Department of Public Health

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Commissioner J. Robert Galvin, MD, MPH, MBA

Reprinted from the report, "Prevention and Control of Seasonal Influenza with Vaccines --- Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2009, **MMWR July 31, 2009 / Vol. 58 / No. RR--8 / Pg. 1 - 52**

TABLE 1. Approved influenza vaccines for different age groups --- United States, 2009-2010 season

Vaccine	Trade name	Manufacturer	Presentation	Mercury content (mcg Hg/0.5 mL dose)	Age group	No. of doses	Route
TIV*	Fluzone	Sanofi Pasteur	0.25mL prefilled syringe 0.5 mL prefilled syringe 0.5 mL vial 5.0 mL multidose vial	0 0 0 25	6--35 mos ≥36 mos ≥36 mos ≥6 mos	1 or 2† 1 or 2 1 or 2 1 or 2	Intramuscular§ Intramuscular Intramuscular Intramuscular
TIV	Fluvirin	Novartis Vaccine	5.0 mL multidose vial 0.5 mL prefilled syringe	**25** **<1.0**	≥4 yrs	1 or 2	Intramuscular
TIV	Fluarix	GlaxoSmithKline	0.5 mL prefilled syringe	**0**	≥18 yrs	1	Intramuscular
TIV	FluLaval	GlaxoSmithKline	5.0 mL multidose vial	25	≥18 yrs	1	Intramuscular
TIV	Afluria	CSL Biotherapies	0.5 mL prefilled syringe 5.0 mL multidose vial	0 25	≥18 yrs	1	Intramuscular
LAIV¶	FluMist**	MedImmune	0.2 mL sprayer	0	2--49 yrs	1 or 2††	Intranasal

Updated Recommendations for Use of *Haemophilus influenzae* Type b (Hib) Vaccine: New Supply Developments

As many of you may know, beginning July 1st the *Haemophilus influenzae* Type b (Hib) booster dose was reinstated for children aged 12–15 months. Although supply is sufficient to reinstate the booster dose and begin catch-up vaccination, supply is not yet ample enough to support a mass notification process to contact all children with deferred Hib booster doses. Older children for whom the booster dose was deferred should receive their Hib booster dose at the next routinely scheduled visit or medical encounter.

The reinstatement of the Hib booster dose was initially made possible due to an increasing supply of the combination vaccine DTaP-IPV/Hib (Pentacel). Pentacel can be administered to any child 6 months through 4 years of age for whom DTaP, IPV and Hib are indicated. Supply of the monovalent Hib vaccine (ActHib) has remained nearly stable. To reinstate the booster dose and maximize the number of children protected from Hib, it has been necessary for most practices to incorporate DTaP-IPV/Hib.

However, providers should soon have an alternate monovalent Hib vaccine for their pediatric patients. In August, FDA licensed Hiberix as a Hib booster dose for children aged 15 months–4 years. Hiberix is manufactured by GlaxoSmithKline. **We are anticipating Hiberix will be available for order from the Department of Public Health Immunization Program to Vaccines for Children providers beginning in October.**

The FDA approved Hiberix under the agency's accelerated approval pathway to help ensure that there is an adequate Hib vaccine supply during necessary catch-up vaccinations. Hiberix is used in nearly 100 countries. The FDA based its conclusion that Hiberix is safe and effective for use as a booster dose in certain children in the United States on data from seven clinical studies conducted in Europe, Latin America and Canada that involved more than 1,000 children. As part of the approval, the manufacturer, GlaxoSmithKline, will conduct a post-market study in the United States to evaluate the safety and immunogenicity of primary and booster vaccination with Hiberix compared to a Hib vaccine already licensed in the United States. The study is intended to confirm the clinical benefit of booster immunization with Hiberix in accordance with the accelerated approval regulations, and to provide additional data on Hiberix for young infants.

In addition to the currently available Hib-containing vaccines, Merck anticipates bringing their monovalent Hib vaccine (PedvaxHib) back to the market in limited amounts by the end of this calendar year, with full supply beginning in the first quarter of 2010. For additional information on the Hib vaccine shortage and reinstatement of the booster dose, visit http://www.cdc.gov/vaccines/vpd-vac/hib/default.htm and scroll down to *Vaccine Recommendations on Hib*.

Make adolescents a priority — *if you see one, immunize one!*

Pediatric offices are great at providing preventive healthcare for babies! But sometimes when babies get a little older, they can fall under the radar screen. As you know, teens need preventive health care too and specifically, they need immunizations. An ideal time to see teens is at 11 or 12 years of age. Immunizations have been proven to provide important benefits to teens, especially as they grow into adults. Lowering disease rates among teens also assists in lowering the chances of those diseases being spread to those most at risk: the elderly, children and infants. Protection for one means protection for all.

What should providers do?

Routinely get into the habit of checking / administering immunizations at "each and every visit" (well, acne, asthma check, uncomplicated sick etc…). Data show that the majority of teens (**83%**) are in your office every year, but only **16%** of them are getting a needed shot.[1,2] Also if they are in the office for a required shot for school, be sure to give them ALL of the vaccines recommended by the AAP and ACIP.

Use "Reminder or Recall" to target adolescents. When your patients turn 11 years old, send them a reminder that a check up is due. Recommendations change and new vaccines are being introduced every year. Being proactive ensures that your whole population is receiving optimal medical care.

Tdap • Proposed to be a requirement for school year 2010/2011 for 7th graders • The Department of Public Health (DPH) provides the vaccine for all children regardless of insurance status	**Varicella** • 2nd dose proposed to be a requirement for school year 2010/2011 for all 7th graders • The Department of Public Health (DPH) provides the vaccine for all children regardless of insurance status
HPV • Recommended for girls only ages 9-26 years of age • The Department of Public Health (DPH) provides the vaccine for girls 9 --18 years of age who are VFC-eligible	**MMR** • 2nd dose proposed to be a requirement for school year 2010/2011 for all 7th graders • The Department of Public Health (DPH) provides the vaccine for all children regardless of insurance status
Meningococcal • Proposed to be a requirement for school year 2010/2011 for 7th graders • Required for all college students living in on-campus housing • The Department of Public Health (DPH) provides the vaccine for all children regardless of insurance status	**Hep B** • Recommended if not given in early childhood • The Department of Public Health (DPH) provides the vaccine for all children regardless of insurance status
Flu • Recommended for teens every year • The Department of Public Health (DPH) provides the vaccine for children 6 months -- 18 years of age who are VFC-eligible	**Hep A** • Recommended if not given in early childhood • The Department of Public Health (DPH) provides the vaccine only for VFC-eligible children

[1] Sanofi Pasteur Inc., Data on file (Adolescent Missed Vaccination Opportunities Overview), January 30, 2008. MKT15175

[2] CDC's National Center for Health Statistics, 2004 National Health Interview Survey

ACIP Update

The following provisional recommendations were made by the Advisory Committee on Immunization Practices (ACIP) at their June 24-26, 2009 meeting. These recommendations are provisional until they are reviewed by the director of CDC and published in the MMWR which typically takes about six months. However, the substance of the final recommendations will not differ from the provisional recommendations.

General Recommendations: A clarification was made to the General Recommendations regarding combination vaccines, maintaining a general preference for combination vaccine products, but stating specific criteria by which a provider might choose the single-component products. Important considerations include provider assessment, patient preference, and potential for adverse events.

Rabies Vaccine: The committee voted to reduce the number of doses recommended for post-exposure prophylaxis for human rabies prevention from five to four. The schedule for administration of the doses is days 0, 3, 7, and 14.

Polio Vaccine: The minimum interval between dose 3 and dose 4 of polio-containing vaccines was changed from 4 weeks to 6 months.

Measles-Mumps-Rubella Vaccine: Modifications were made to the criteria for acceptable evidence of immunity to measles, mumps, and rubella for healthcare providers. Documentation of physician-diagnosed disease (previously considered evidence of measles and mumps immunity) is no longer an acceptable criterion. Birth before 1957 is still evidence of immunity, but facilities should consider vaccinating health-care providers born before 1957 who have no other criterion for immunity with two doses of MMR vaccine. In an outbreak, two doses of vaccine are specifically recommended for health-care providers born before 1957.

Meningococcal Vaccine: A recommendation was made for revaccination using meningococcal conjugate vaccine for persons who remain at high risk for meningococcal disease after their first vaccination (with either the polysaccharide or the conjugate meningococcal vaccine). These include persons with persistent complement component deficiencies, persons with anatomic or functional asplenia, persons infected with HIV, microbiologists who are routinely exposed to *Neisseria meningitidis,* and frequent travelers to or people living in areas with high rates of meningococcal disease, such as the African meningitis belt. For children 2 through 6 years of age the dose should be given at an interval of 3 years, for persons older than 6 years, at an interval of 5 years.

Japanese Encephalitis Vaccine: The ACIP voted to include the recently licensed Japanese encephalitis virus (JEV) vaccine, Ixiaro®, in the list of recommended vaccines for U.S. travelers. Clarifications were also made to the existing recommendations for the use of Japanese encephalitis vaccine. The vaccine is recommended for travelers who will spend 1 month or more in an endemic-disease area during the JEV transmission season, or for short-term travelers if they have an increased risk of JEV exposure. The vaccine is not recommended for short-term travelers whose visit will be restricted to urban areas or times outside of a well-defined JEV transmission season.

Measles-Mumps-Rubella-Varicella Vaccine: Additional language was added to the recommendation for MMRV vaccine regarding combination vaccines versus separate injections of equivalent component vaccines. Combination vaccines are preferred, but considerations should include provider assessment, patient preference, and the potential for adverse events. In addition, a personal or family history of seizures was included as a precaution for MMRV vaccine use.

For more information please visit CDC's website http://www.cdc.gov/vaccines/pubs/ACIP-list.htm

Connecticut Gets Nearly $3 Million in Stimulus Funds to Support Immunizations

The Connecticut Immunization Program has received over $2.1 million worth of rotavirus vaccine and nearly $1 million to develop and implement a web-based immunization registry and tracking system thanks to funding from the American Recovery and Reinvestment Act (ARRA).

Rotavirus is a leading cause of severe acute gastroenteritis in infants and children. Before licensure of the rotavirus vaccine, an estimated 2.7 million infections occurred in the U.S. each year resulting in approximately 55-70,000 hospitalizations among children under age five. Worldwide rotavirus is responsible for the death of over 600,000 children annually.

The Immunization Program has been supplying rotavirus vaccine for VFC-eligible patients since July 2006. The additional vaccine has allowed us to expand state-supplied rotavirus vaccine to all children regardless of insurance status beginning in September 2009. The vaccine being provided is Rotarix ® which is a two dose series. The first dose should be administered no earlier than 6 weeks of age and the last dose no later than 8 months of age with at least 4 weeks between doses. Rotavirus vaccine must be kept refrigerated between 35 and 46 degrees Fahrenheit.

For a current list of all Connecticut Immunization Program vaccines eligibility information criteria, please go to: http://www.ct.gov/dph/lib/dph/infectious_diseases/immunization/pdf/2009_vaccine_eligibility_criteria-september_09.pdf

The funding for the immunization registry will allow us to replace our outdated DOS-based registry with a web-based registry and tracking system. Immunization registries are an important tool for increasing and sustaining high immunization coverage by consolidating vaccination records of children from multiple providers, generating reminder and recall vaccination notices, and providing official vaccination forms and vaccination coverage assessments. The registry will be developed and tested during 2010 with deployment scheduled for early 2011.

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Betty Murphy
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Andrea Rosario
860-423-4534

Other areas
Debora Alvarenga
860-509-7241

Connecticut Immunization Registry and Tracking System (CIRTS)

Immunization Status on 2nd Birthday of Children Enrolled in CIRTS

Date of Birth: January 1, 2006 – December 31, 2006

Connecticut - Statewide Rates

Schedule Used – By Age 2	Not up-to-date in CIRTS	Up-to-date in CIRTS #	%	Total Number in CIRTS Registry
HEDIS – Medicaid	1,344	6,425	**83%**	7,769
Doses Only – 4:3:1:3:3:1:4	11,804	23,196	**66%**	35,000
Doses Only – 4:3:1:2:3:1:4	6,806	28,194	**81%**	35,000
OK – 4:3:1:2:3:1	6,190	28,810	**82%**	35,000
OK – 4:3:1:2:3:1:2-4	6,732	28,268	**81%**	35,000

2006 Birth Cohort in CIRTS:

The 35,000 children represent 87% of the 40,260 births recorded in Connecticut for 2006

17,720 children or 44% of the 40,260 births are also enrolled in Medicaid

4,290 children or 11% of the 40,260 births refused registry enrollment

SCHEDULES USED – BY AGE TWO:

HEDIS – Medicaid (Specifications Combo 3.0) = 4 DTaP - any shot prior to 42 days after birth not counted, 3 Polio - any shot prior to 42 days after birth not counted, 1 MMR, *2 Hib - any shot prior to 42 days after birth not counted, 3 Hep B, 1 Varicella given on or after first birthday or Varicella disease, and 4 PCV. Children must have been enrolled continuously in the same Medicaid Plan for twelve months prior to their second birthday.

This is the standard used by commercial and Medicaid Managed Care insurance plans.

Doses Only – 4:3:1:3:3:1:4 = 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella, 4 PCV *(Doses Only = intervals and validity not counted)*

Doses Only – 4:3:1:2:3:1:4 = 4 DTaP, 3 Polio, 1 MMR, *2 Hib, 3 Hep B, 1 Varicella, 4 PCV *(Doses Only = intervals and validity not counted)*

OK – 4:3:1:2:3:1 = 4 DTaP , 3 Polio, 1 MMR given on or after first birthday, *2 or more Hib, 3 Hep B with one given on after 24 weeks of age, 1 Varicella given on or after first birthday or Varicella disease

OK – 4: 3:1:2:3:1:2-4 = 4 DTaP, 3 Polio, 1 MMR given on or after first birthday, *2 or more Hib, 3 Hep B with one given on or after 24 weeks of age, 1Varicella given on or after first birthday or Varicella disease, 2 to 4 PCV age appropriately given with one given on or after first birthday

Please note the 2-dose Hib schedules reflect the Hib supply shortage and the February 2008 deferment of the Hib booster dose.

Congratulations to the Following Practices for Achieving a ≥ 90 - 94% Immunization Rate on CIRTS Enrolled Children Born in 2006

Avon Pediatrics
Dr. Sherry Banack
Berlin Pediatric Associates
Center for Advanced Pediatrics/Darien
Center for Pediatric Medicine/Danbury
Child & Adolescent Health/Waterbury
Child Care Associates/Danbury
Children's Medical Group/Bloomfield
Community Health Center/Norwalk
Dr. Michael Curi
Day/Kimball Pediatric Center
Doctors' Pediatric/Wilton
East Hartford Community Health Care
Ellington Pediatrics
Dr. Mary Eslick
Fairfield Pediatrics
Family Medical Center/East Hartford
Dr. Leonard Forner
Fote & Schwab MD's
Gold Star Pediatrics
Guilford Pediatrics
Hartford Area Pediatrics
Drs. Hemenway & Guerra
Dr. Kenneth Inchalik
Kid's Station Pediatrics
Dr. Uwe Koepke
Dr. Michael S. Levine
Litchfield County Pediatrics
Litchfield Hills Pediatrics
Main Street Pediatrics
Dr. Joel Markowski
Meriden Pediatric Associates
Middlesex Pediatrics
Naugatuck Pediatrics
New Britain Pediatric Group
New London Family Practice
Newtown Center Pediatrics
Norwich Pediatrics/Colchester
Optimus Health Care/Bridgeport
Dr. Robert Parnes
Pediatric & Adolescent Health Care/Ansonia
Pediatric & Medical Associates/Cheshire
Pediatric Associates/New London
Pedi-Care Associates/Stratford
Pediatric Health Center/Danbury Hospital
Pediatric Health Care Associates/Stratford
Pediatric Medicine/Wallingford
Dr. Mark Peterson
Plainville Pediatric Center/Day Kimball
Prakash Pediatrics
Putnam Medical Associates
Ridgefield Pediatric Associates
Dr. Harold Shapiro
Shoreline Pediatrics/Madison
Smart Start Pediatrics
Somerset Family Health Care
South Windsor Pediatrics
Southbury Pediatrics
Drs. Spiesel, Butler, Davis
St Raphael's Family Medical Health Care Center
Stamford Pediatrics/Darien
Stamford Pediatrics/Stamford
Dr. Teresa Szajda
Tolland County Pediatric & Adolescent Medicine
Torrington-Winsted Pediatric Associates
United Community & Family Services
Vernon Pediatrics
Warren Pediatrics
West Hartford Pediatrics
Whitney Pediatrics & Adolescent Medicine
Wildwood Pediatrics/Essex
Wildwood Pediatrics/Old Saybrook
Willows Pediatric Group
Windham Primary Care
Windsor Family Medicine

Congratulations to the Following Practices for Achieving a ≥ 95 - 100% Immunization Rate on CIRTS Enrolled Children Born in 2006

Baker Pediatrics
Dr. Dennis Bekeny
Branford Pediatric & Allergy/Branford
Branford Pediatric & Allergy/Clinton
Branford/North Branford Pediatrics/Branford
Branford/North Branford Pediatrics/North Branford
Drs. Bush, Speigelman, Pemberton, Robert
Dr. Gerald Calnen
Center for Pediatric Medicine/New Fairfield
Central Pediatrics
Children's Medical Associates
Children's Medical Group/Hamden
Children's Medical Group/Rocky Hill
Community Health Center/Middletown
CT Valley Pediatric Center
East Avenue Pediatrics
East Haven Pediatrics
East Shore Pediatrics
Flanders Pediatrics
Dr. Sari K. Friedman
Dr. Diane Fountas
Dr. Laurentiu Galan
Dr. Stuart Gardner
Dr. Sobhy Ghabrial
Greenwich Hospital Ambulatory Pediatrics
Hamden Pediatrics
Hill Health Center/West Haven
Dr. Richard J. Lavoie
Mansfield Family Practice
New Haven Pediatrics/Southbury
Newington Pediatrics
Optimus Health Care/Pediatric Clinic/Stamford
Pediatric & Adolescent Medicine/Cheshire
Pediatric & Adolescent Medicine/Middletown
Pediatric & Adolescent Medicine/Orange
Pediatric & Adolescent Medicine/Wallingford
Pediatric Associates/Branford
Pediatric Associates/Bristol
Pediatric Associates/Marlborough
Pediatric Associates/Western Connecticut
Pediatric Health Care Associates/Fairfield
Pediatric Health Care Associates/Huntington/Shelton
Pediatrics Plus
Pedicorp/Windsor
Personal Care Pediatrics
Dr. Foster I. Phillips
Pioneer Valley Pediatrics
Primed Pediatrics/Stratford
Primed Pediatrics/Trumbull
Dr. Vandana Sacheti
Dr. Fred E. Santoro
Dr. Gerald L. Schwartz
Dr. Lester Schwartz
Dr. Sedat Shaban
Shoreline Pediatrics/Clinton
Staywell Pedi-Private
St Luke's Family Medicine
Sutay & Stewart Pediatrics
Dr. Robert Toscano
Unionville Pediatric Group
Wallingford Family Practice
Westone Pediatrics
Yale Health Plan Pediatrics
Dr. Barbara Ziogas

Recognition based on the following schedule administered on or before the children's 2nd birthday
OK – 4,3,1,2,3,1,2-4:

4 DTaP
3 Polio
1 MMR given on or after first birthday
*2 or more Hib
3 Hep B with one given on or after 24 weeks of age
1 Varicella given on or after first birthday and/or Varicella disease
2 to 4 PCV age appropriately given with one given on or after first birthday
(Based on practices with ≥ 20 CIRTS enrolled children born in 2006.)

**Please note the 2-dose Hib schedule reflects the Hib supply shortage and February 2008 deferment of the Hib booster dose.*

H1N1 Flu

In June 2009, the Centers for Disease Control and Prevention (CDC) authorized the manufacturing of a vaccine for the prevention of H1N1 influenza disease. At that time, CDC cautioned that while manufacturing would begin, the decision to administer the vaccine had not been made. The administration decision would be made after the review of data on the disease incidence and severity in both the southern hemisphere and US over the summer months. While disease severity in the southern hemisphere was comparable to the US severity in the spring 2009, the overall incidence and predominance of the H1N1 strain during the southern hemisphere flu season (our 2009 summer) influenced the decision to proceed with planning and vaccine administration.

The H1N1 vaccine is being procured and purchased by the US government. The vaccine is being allocated across states proportional to population. Connecticut's population is 1.1344% of the US population, so we will get that percent of the total supply. At this time it is not anticipated that the H1N1 vaccine will be available for purchase by anyone on the private market.

The Department of Public Health (DPH) and its local health partners have been planning for the possibility of an influenza pandemic since 2002. With the emergence of the H1N1 virus in the spring and the subsequent declaration by the World Health Organization of a pandemic, the Department reviewed the Pandemic Flu Plan. In addition, the Department sought guidance from many health care providers, local health directors and health care associations in an effort to revise that plan so that distribution of the H1N1 vaccine could occur. Some highlights of the plan include:

Vaccine will be sent to state-designated receiving sites: mix of health departments and private settings. The overall intent is for this effort to be a public/private partnership.

Pre-registration of providers interested in administering H1N1 vaccine is being coordinated through the State Immunization Program. Pre-registration information is available at www.ct.gov/ctfluwatch/providers

H1N1 vaccine will be distributed first to those providers who identify the priority populations for H1N1 as their potential vaccinees. The CDC has published "Use of Influenza A (H1N1) 2009 Monovalent Vaccine Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2009 http://www.cdc.gov/mmwr/PDF/rr/rr5810.pdf

The initial group of people, approximately 160 Americans (1.85 million CT residents, 1.1344%) who should be vaccinated include:

- Pregnant women
- Household and caregiver contacts of children younger that 6 months of age
- Health care and emergency medical services personnel
- Children from 6 months through 18 years
- Persons aged 19-24 because we have seen many cases of novel H1N1 influenza in these healthy young adults and they often live, work, and study in close proximity, and they are a frequently mobile population
- Persons aged 25 through 64 years who have medical conditions associated with higher risk conditions

If the initial vaccine supply is less than the 160 million the CDC has a subset of the group listed above. This subset represents approximately 40 million Americans (463,000 CT residents):

- Pregnant women
- Household and caregiver contacts of children younger than 6 months of age
- Health care and emergency medical services personnel with direct medical contact with patients or infectious materials
- Children 6 months through 4 years old
- Children with chronic medical conditions under 19 years of age

The "public sector" participants in this effort are the local health authorities that have received Public Health Preparedness funds since 2002. The state is divided into 41 areas called Mass Vaccination Areas (MVAs) or sometimes referred to as Mass Dispensing Ares (MDAs). Each area is of equal population size. The MVAs will receive the information on who preregisters (private provider pre-registration) in their area. Each MVA will be responsible for then closing any gaps, for access to vaccine for priority populations not covered by private providers in their area. These MVAs will use their own resources and other identified vaccinator agencies to have resources available for the populations in their areas. Links to the Mass Vaccination Area contact information is available on the DPH website: www.ct.gov/ctfluwatch.com

The statewide effort to educate the public on H1N1 vaccination, as well as seasonal influenza vaccination is a coordinated effort between DPH, our local health authorities and our private health care providers.

The CDC anticipates that 5 manufacturers will have licensed H1N1 vaccine available. They anticipate that indications for the current influenza vaccines that each company manufactures will be the same H1N1 vaccine.

Three points should be emphasized:

The H1N1 vaccine is a licensed product. To the best of the current knowledge, no influenza vaccine with an adjuvant will be available in the US. If an influenza vaccine with an adjuvant did become available in the US, it would need to be administered under the investigational protocols.

The H1N1 vaccine is in reality a monovalent seasonal influenza vaccine, under the same manufacturing procedures as "usual" seasonal influenza vaccine. This 2009 H1N1 strain could not be included in the trivalent influenza vaccine for 2009-2010 because the 2009 H1N1 disease occurred AFTER production began for the seasonal influenza vaccine.

The effort to vaccinate the population, both priority groups and others, will require an extraordinary public and private partnership.