# INTERIM GUIDELINE:
# Planning for a Possible U.S. Influenza Vaccine Shortage, 2005-06 Season

*August 4, 2005*

## BACKGROUND

This guideline was developed to assist state and other immunization programs in planning for and dealing with an influenza vaccine shortage during the 2005–06 influenza vaccine supply, should such a shortage occur. The 2004–05 influenza season raised awareness of the need for planning on federal, state, and local levels for the many ramifications arising from a possible vaccine shortage, even if a shortage is not immediately imminent. It became evident that certain infrastructure and communication systems and activities developed in response to the 2004-05 vaccine shortage would be beneficial if maintained on an ongoing basis and that these systems could be adapted to other adverse situations as well.

The 2004-05 influenza vaccine shortage strengthened collaboration and cooperation between national, state and local public health entities, public and private providers, manufacturers and distributors, and other stakeholder and partner groups involved in influenza vaccine. The lessons learned and successful activities during the 2004–05 influenza season provide a valuable foundation to plan for a future shortage situation. Information regarding these activities should be reviewed, updated, and included in preparedness planning for a future shortage. Likewise, the partnerships and coalitions that were operational during the 2004-05 influenza season should be regrouped and charged with preparedness planning for the 2005-06 influenza season. Preparedness activities should include various scenarios such as delays in the timeline for distribution, various absolute supplies of trivalent influenza vaccine (TIV) supply (severe shortage, moderate shortage and normal supply) [see Appendix 1: FluVaccine Scenarios], and reallocation of vaccine within and among jurisdictions.

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## THE 2005–06 INFLUENZA SEASON

As of early August 2005, estimates of the trivalent influenza vaccine (TIV) supply for the 2005-06 season ranged from 60 to 88 million doses produced by up to 3 manufacturers and include 10 million doses to be produced after November (see Table 1: Status of Influenza Vaccine Manufacturers for 2005-06). Most of the TIV supply (50-78 million doses) will be distributed from September through November. The anticipated minimum supply of TIV (60 million doses) is approximately equal to the total amount of TIV distributed during the 2004-05 influenza season (57 million doses), a season characterized by a mid-season vaccine shortage and distribution problems. There also remains the possibility of additional “late season” TIV production of modest amounts. In addition, at least 3 million doses of live attenuated influenza vaccine (LAIV) will be produced. LAIV should be considered for vaccination of healthy persons aged 5-49 years, including health-care personnel and other persons in close contact with groups at high risk for influenza-related complications and those desiring protection against influenza. During periods when inactivated vaccine is in short supply, use of LAIV is encouraged when feasible for eligible persons (including health-care personnel) because use of LAIV by these persons may increase availability of inactivated vaccine for persons in high-risk groups. Possible advantages of LAIV include its potential to induce a broad mucosal and systemic immune response, its ease of administration, and an improving acceptability of an intranasal rather than intramuscular route of administration.

TIV shortages or delays in vaccine delivery have caused disruptions in 4 of the 5 previous influenza seasons for reasons related to either production or regulation. In the event of a vaccine shortage during 2005–06, CDC will work with vaccine companies and planners at state and local levels to strive for population-based proportional distribution of TIV among states. It is important to note that traditionally, 85% to 90% of influenza vaccines are administered by the private sector, e.g., medical providers, long-term care facilities, hospitals, health maintenance organizations (HMOs), and corporate vaccinators. Finally, use of an Investigational New Drug (IND) application through FDA would be considered only if fewer than 50 million doses of TIV are available. In this scenario, unlicensed vaccine to be used as an IND would be purchased from the vaccine market when the shortage occurs. Considerations also are being given to using licensed vaccine in ways to increase the number of doses, such as administering half doses to selected populations, a strategy which would also require IND protocols.

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## PREPAREDNESS PLAN FOR TRIVALENT INFLUENZA VACCINE (TIV) SHORTAGES

The following plan lists the desired objectives to be achieved nationally and at state and local levels in dealing with a TIV shortage and activities designed to enable programs to reach those goals. The primary goal is to achieve high immunization among all high-risk and priority groups. Specific objectives were developed from experiences with previous shortages and are considered essential to achieving equitable vaccine distribution and appropriate coverage. States and local jurisdictions may not have the resources to implement all of the suggested activities. However, they may achieve an effective response to a vaccine shortage situation by using parts of this guideline and activities identified at state and local levels as most useful for their constituents.

***Goal:*** Achieve vaccine coverage rates among high-risk and priority groups that are at least equal to rates achieved during influenza seasons in which the TIV vaccine supply is normal (defined as > 75 million doses).

***Objectives:***

- Establish infrastructure to develop and implement preparedness plan.
- Establish partnerships and collaborations.
- Communicate timely, accurate, consistent, and appropriate messages to partners and stakeholders.
- Estimate the size of high-risk/priority groups at state, local, and provider levels.
- Achieve timely and equitable ordering and distribution of TIV.
- Establish systems for timely vaccine redistribution and patient referrals to help ensure coverage of high-risk and priority groups.
- Develop a communication and education plan about influenza and influenza vaccine for provider and public audiences that includes strategies for
  - informing provider and public audiences of high-risk/priority groups and the rationale for vaccination prioritization; and
  - encouraging when feasible the use of LAIV for healthy persons aged 5–49 years who are not pregnant.

***Activities*** are directed at specific objectives. These activities were designed as guidance to federal, state, and local immunization program planning and may be modified to fit individual circumstances. They also may be useful during periods of normal vaccine supply and in preparedness planning for pandemic influenza.

## FEDERAL ACTIVITIES

- Define prioritization criteria, the rationale for these criteria, and priority groups for receiving TIV. (ACIP and CDC)
- Develop tiered system for ranking priority groups for receipt of TIV in the event of a TIV shortage. (ACIP and CDC)
- Track availability of TIV, determine if a TIV shortage exists, and inform states, partners, and news media about the results of this tracking. (CDC)
- Recommend tiered system for vaccination of priority groups as needed, based on the severity of a TIV shortage.* (ACIP and CDC)
- Determine if, what and when revisions in tier recommendations are necessary based on changes in TIV supply and inform state/local jurisdictions.* (ACIP and CDC)
- Collaborate with manufacturers/distributors to establish a secure data network (SDN) where jurisdictions can obtain distribution information, e.g., providers, prebooked doses, doses shipped, outstanding doses.* (CDC)
- Encourage the use of LAIV in healthy people aged 5-49 years. (CDC and ACIP)
- Work with manufacturers/distributors to ensure the equitable distribution of TIV among states for priority groups and avoid "spot" shortages.* (CDC)
- Act as central broker for redistribution of TIV supplies between jurisdictions.* (CDC)
- Determine need for and negotiate with manufacturers for (a) TIV stockpile, (b) additional "late season" TIV, and/or (c) the purchase of unlicensed TIV vaccine on the vaccine market as an IND if the need exists.* (CDC)
- Develop and implement a single, credible, nonduplicative system for communicating influenza-related information and updates to state/local health departments, partners and media. (CDC)
- Develop and disseminate influenza-related health alerts, media messages, and educational materials. (CDC).
- Develop and maintain influenza hotline, Web site, satellite broadcasts, net conferences, and DVDs for health providers. (CDC)

**Activities to be done if a shortage is anticipated or occurs. Extent of activities will depend on severity of shortage.*

## STATE AND LOCAL ACTIVITIES

***Objective: Establish infrastructure to develop and implement preparedness plan***

***Rationale:*** A functioning Executive Committee or Incident Command Structure (ICS) provides the technical, management, and organizational expertise and responsibility for planning, policy decisions and implementation of activities.

***Activities:***

- Reactivate or form an Executive or Incident Command group with overall responsibility for preparedness planning, intervention, management and effective communication.
- Designate persons or departments responsible for individual components of the plan and response activities.
- Ensure familiarity with jurisdiction's response to 2004–05 vaccine shortage, including best practices, resources needed, and problems encountered.
- Determine preparedness components and implementation activities.
- Establish secure and effective communications within the ICS and with partners and collaborators.
- Determine the legal foundation for emergency infrastructure and its activities.
- Estimate impact on state and local levels at varying levels of TIV availability (e.g., 30-54 million, 55-74 million, 75+ million).
- Determine personnel and other resource needs.
- Establish timelines for preparedness planning and exercising plans, and, in the event of an outbreak, for implementing response activities.
- Conduct planning exercises and evaluate and update plan as needed.

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***Objective: Establish partnerships and collaborations***

***Rationale:*** The success of the 2004-05 responses to the TIV shortage can be traced to the development of strong and responsive partnerships and collaborations among federal, state and local public health and other agencies, hospitals and health-care providers, professional associations, and vaccine producers and distributors.

***Activities:***

- Identify and contact national, state and local public health, healthcare providers, their associations, producers and distributors, and stakeholders and partners from 2004-05 season.
- Review and document 2004-05 partnership responsibilities and actions: successes, best practices, problems, timelines, activity leaders, data sources, and resources.
- Seek additional partners (e.g., associations of long-term care [LTC] facilities, HMOs, and corporate/community vaccinators) and include them in the planning process.
- Obtain agreement from partners regarding the need to prepare for the possibility of another shortage year.
- Update partners on the current year's expectations for TIV and LAIV supplies, timelines, priority groups, and rationale for instituting TIV prioritization.
- Discuss various shortage scenarios, response activities, resource needs, and preparedness timelines.

- Establish lead persons or organizations for each planning component and its associated activities.
- Ensure that providers and partners are updated and included in any revisions as national and state vaccine plans evolve during the 2005-06 season.

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***Objective: Communicate timely, accurate, consistent, and appropriate messages to partners and stakeholders.***

***Rationale:*** During influenza vaccine shortages, effective communication between partners and stakeholders is critical to a coordinated, successful public health response.

***Activities:***

- Evaluate partner and stakeholder 2005-05 communication strategies and processes with state and local health departments and identify best practices and problems.
- Develop and test system for timely, consistent and non-redundant dissemination of urgent and information messages from CDC and state public health to local public health, healthcare providers and stakeholders  Plans should include points of contact and distribution chains to reduce redundancy and potential "information overload."
- Update partner lists and designated contacts; provide partners with updated lists of state and local agency contacts.
- Encourage partners to update and maintain constituent lists and their systems for contacting and being contacted by their constituents.
- Assure partners serving priority groups that needed vaccine and other influenza-related information will be disseminated in a timely manner.
- Develop with public health and health care provider associations an agreed upon system for keeping providers informed.
- Keep federal agency partners updated with current state and local contact information.
- In the event of a TIV shortage, establish or renew contacts with vaccine producers and distributors concerning vaccine providers and their location within the jurisdiction.
- Consider alternative communication channels (e.g., e-mail, telephone conference calls, secure websites) and determine those most appropriate to the message and the audience on the basis of usability, completeness, security, and reliability.

***Sources for Up-to-Date Provider Communication List***

- Health-care licensing agencies
- General/internal/pediatric/specialty (e.g., pulmonary, diabetes) provider associations
- Public health clinics providing routine vaccine preventive services and/or influenza and pneumococcal vaccine to priority clients and accepting referrals for vaccination
- Hospital associations, health maintenance organizations
- Community health center associations
- Long-term care associations
- Nonprofit providers (e.g., Visiting Nurses Association)
- For-profit corporate/community vaccinators
- Producer/distributor provider lists
- State and local public health agencies managing terrorism preparedness
- State Quality Improvement organizations

***Objective: Estimate the size of high-risk/priority groups at state, local, and provider levels.***

***Rationale:*** If a TIV shortage occurs, ACIP and CDC will recommend institution of prioritization of groups to receive TIV. The priority groups designated during the 2004-05 influenza season were considered to be of equal importance for receipt of TIV. To help vaccine providers develop contingency plans for the 2005-06 influenza season in the event of a TIV shortfall, ACIP and CDC further detailed priority groups for TIV vaccination and ranked them in three tiers on the basis of influenza-associated mortality and hospitalization. The priority groups, their tier ranks and the circumstances that would lead to prioritization are found at (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5430a4.htm). Announcement of a need for prioritization will be made promptly upon receipt of information indicating a potential disruption to the vaccine supply, if necessary. Estimating the size of priority groups nationally and at state/local levels is an essential step to determine the amount of TIV necessary to cover the persons in each priority group.

As in 2004–2005, states may make some adjustments to the national priority group schema to reflect features unique to the state. Priority group size estimates should be determined at federal, state, local, and provider levels.

***Activities:***

- Review ACIP and CDC priority groups and TIV prioritization schema in the context of state and local conditions; consider the need for state/local modifications.
- Ensure public health and healthcare providers, partners and stakeholder, the public and the media receive and understand the ACIP and CDC information on priority groups, tiering, (if its introduction is deemed necessary), TIV shortage triggers, and the rationale for prioritization.
- Ensure healthcare providers, partners and stakeholders, the public and media are made aware of any changes in the TIV supply and prioritization recomendations.
- Review methods used in 2004-05 to determine best practices used to estimate TIV priority group needs.
- Estimate TIV priority group needs at the state and local levels and the geographic distribution of clients and providers.
- Request that providers estimate their priority group sizes and TIV needs.
- Develop methods to monitor and enforce implementation of preferential TIV vaccination of priority groups.
- Obtain legal consultation regarding prioritization and its implementation.
- On the basis of TIV availability, decide whether and when to support public and private mass vaccination clinics.

***Sources of Information to Estimate Priority Groups***

- Census, birth certificate data, age groups (6–23 months, 2–64 years, 65 years and older), and geographic density: demographic data and trends
- Medicaid, Medicare, national and state-based health and cause of mortality data, insurance data, and published literature: health status data and trends
- Medical and life insurance sources by national and state/local jurisdictions: actuarial-ages and types of conditions:
- Local and national long-term care facility associations
- Local and national healthcare worker associations and licensing boards
- Vaccine manufacturers and distributors
- Providers and provider associations

***Objective: Achieve timely and equitable ordering and distribution of TIV***

***Rationale:*** Timely ordering of vaccine—based on estimates of both the high-risk/priority groups and the total clientele served—will help ensure that providers can vaccinate persons in priority groups and will facilitate an equitable distribution process (see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5412a4.htm ). If a TIV shortage occurs, manufacturers/distributors will likely deliver as large a portion of the prebooked priority group order as the supply permits. The non-priority part of the order will be delayed until priority groups have been offered vaccine. Sanofi-Pasteur completed prebooking for the private sector without prior Sanofi-Pasteur contracts in late May, 2005 but continues to pre-book orders for other sectors, including public health. In addition, some distributors have also pre-booked their entire anticipated supply of inactivated vaccine but may be accepting orders on a waiting list. Other distributors may be accepting orders for TIV likely to be produced by one or more additional manufacturers

If a TIV shortage occurs or appears inevitable, CDC will attempt to prevent substantial inequalities in distribution by working with vaccine manufacturers and distributors and the states to establish an improved secure data network (SDN). The SDN would identify nationally and by state which providers have prebooked TIV and from which manufacturer/distributor, where these providers are located, amount of vaccine for priority groups and the total amount ordered, and how much vaccine was actually shipped to providers and when.

***Activities:***

- Encourage providers to include priority group(s) and total TIV needs in their orders.
- Encourage valid TIV estimations and timely ordering; discourage double-booking.
- Determine TIV amounts providers have prebooked and with whom.
- In the event of a significant TIV shortage collaborate with CDC using the SDN to link with manufacturers and distributors and obtain information on TIV prebooked, ordered, shipped and outstanding and to where and whom.
- Ensure public health and healthcare providers are aware that in a shortage situation priority group orders will be filled first.
- Document provider problems with TIV prebooking or receipt of orders.

***Objective: Establish systems for timely vaccine redistribution and patient referrals to help ensure coverage of priority groups***

***Rationale:*** The experience of 2004–05 demonstrated that systems established by state and local jurisdictions to enable TIV reallocations between providers, local jurisdictions and states did much to ensure that persons in priority groups were vaccinated and waste was minimized. These systems helped providers to find TIV supplies and to identify providers who needed TIV. In addition, a system whereby patients can be referred to providers who have TIV supplies will help ensure equitable and adequate coverage.

***Activities:***

- Encourage all providers, public and private, to administer influenza vaccinations.
- Review and modify 2004-05 reallocation and referral systems for best practices and problems.
- Establish a redistribution system within state and local jurisdictions and with neighboring states that can be made operational if TIV shortages occur.
- Solicit the help of local health departments and other partners to expedite vaccine exchanges at the local level and when TIV exchanges need to be made over greater distances.
- Encourage clinics and provider offices to designate a contact person with authority to make redistribution decisions.
- Determine and mediate and practical issues for payment and liability for redistributed TIV.
- Provide all providers, partners, the public and media details on the redistribution system.
- Solicit local health departments to arrange a telephone exchange and/or internet site to expedite patient referrals (e.g., providers who have inadequate TIV supplies could refer priority-group patients to providers who have TIV) and inform providers, partners, the public and media.

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***Objective: Develop a communication and education plan about influenza and influenza vaccine for provider, stakeholder, and public audiences that includes strategies for***

- ***informing audiences of high-risk/priority groups and the rationale for vaccination prioritization; and***
- ***encouraging when feasible the use of LAIV for healthy persons aged 5–49 years who will not be pregnant.***

***Rationale:*** Providers, other stakeholders, and the public need to be educated about influenza vaccine priority groups including their prioritization for receiving TIV during vaccine shortages, the rationale and conditions for enacting prioritization, and effective interventions that would increase vaccination coverage.

***Activities:***

- Review state/local, CDC, and other partner 2004-05 efforts to produce and disseminate information and education materials. Note best practices and problems.
- Solicit partners to determine their education needs, responsibility and ability to disseminate information to their own constituents.
- Determine types of educational materials and methods of dissemination to be used (e.g., media events, TV/radio/other news media, seminars, mailings, newsletters, conferences, e-mails, “hotlines”, web sites).
- Provide providers and partners with state-specific information and CDC and other agency web linkages and education sources on effective interventions such as standing orders, reminder/recall and provider reminders.

- Encourage provider associations to disseminate pertinent information such as vaccine effectiveness, cost effectiveness, disease morbidity, mortality, and priority groups and the rational for prioritization.
- Educate priority groups including healthcare personnel to have annual influenza vaccinations.
- Encourage providers and the public to accept LAIV use, when feasible, for healthy persons aged 5-49 years who are not pregnant.
- Solicit private organizations such as HMOs, pharmacies and corporations to co-sponsor the development and dissemination of vaccine and disease fact sheets to their constituents.
- Identify and train credible, trusted spokespersons to the media; maintain updated media contact lists.
- Work with state and local media to develop state fact-based materials on influenza and influenza vaccine for use by newspapers, popular magazines, TV, radio, and talk shows.
- Develop and promote an "expert speaker" network to provide talks to and discussions with professional, social, and other public groups on priority groups and TIV prioritization and other influenza disease and vaccine issues.
- Build or support websites for disseminating influenza disease and vaccine materials and provide web links for materials produced by CDC and other partners and agencies.
- Establish an "Influenza Outreach" hotline for the general public. Provide hotline staff with up-to-date information on where immunizations can be obtained.

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**Table 1. STATUS OF INFLUENZA VACCINE MANUFACTURERS FOR 2005-06**

*Last updated: August 4, 2005*

| *Manufacturer* | *Vaccine Type* | *Mfg Status* | *Doses in 2005* | *Notes* | *Formulations* |
|---|---|---|---|---|---|
| Sanofi Pasteur | TIV | Licensed | 50M | The 50 million dose projection includes 6-8 million doses of thimerosal-free single dose syringes.<br>An additional 10 million doses can be if late season demand through the end of the year warrants this (includes 3.5 million doses for CDC stockpile/ strategic reserve.<br>Pre-booking has closed for the multi-dose vial formulation and 0.5 mL single-dose syringe formulation. The 0.25 mL single dose syringe formulation is still available for pre-booking. | 10-dose multi-dose vials with preservative indicated for ages 6 months and above.<br>0.5 mL single-dose syringes (thimerosal-free) indicated for ages 3 years and above.<br>0.25 mL single-dose syringes indicated for ages 6-23 months. |
| MedImmune | LAIV | Licensed | 3M | Product is still available for pre-booking. | Live virus nasal vaccine indicated for healthy persons age 5-49 years. |
| Chiron | TIV | Cannot currently sell vaccine in the U.S. market. | 18M to 26M | UK license reinstated.<br>FDA cGMP inspection completed late July.<br>Pre-booking has been vigorous. | 10-dose multi-dose vials with preservative indicated for ages 4 years and above.<br>0.5 mL single-dose syringes (preservative-free, trace thimerosal) indicated for ages 4 years and above may be available for CDC stockpile/strategic reserve pending cGMP inspection. |
| GSK | TIV | BLA submitted | 8M | Accelerated approval pathway process is being used to license GSK this year.<br>License application for those 18 years of age and older.<br>Prebooking with distributors is occurring pending FDA license approval. | 0.5 mL single-dose syringes (preservative-free, trace thimerosal) indicated for ages 18 years and above. |

## Appendix 1: FLU VACCINE SCENARIOS *(August 4, 2005)*
## Federal and State/Local Activities Guideline at Varying TIV Supply Levels

| | | ***TIV Doses** (in millions)* | | |
|---|---|---|---|---|
| *approximate amounts >* | | ***<30-54*** | ***55-74*** | ***75+*** |
| ***FEDERAL ACTIVITIES*** | *relative amount >* | ***½ '04-'05*** | ***= '04-'05*** | ***'normal'*** |
| Define prioritization criteria, the rationale and TIV priority groups | | Yes | | N/A |
| Develop tiered system for ranking priority groups for preferential receipt of TIV in the event of a TIV shortage | | Yes | | N/A |
| Track TIV availability, determine if a TIV shortage exists, inform states, partners, and media | | Yes | | N/A |
| Recommend use of tiered system for vaccination of priority groups based on TIV shortage severity, as needed | | Yes | | N/A |
| Determine if, what and when revisions in tier recommendations are necessary based on changes in TIV supply and inform state/ local jurisdictions | | Yes | | N/A |
| Collaborate with manufacturers/distributors on SDN to provide state/local info: providers, prebooked doses, doses shipped, outstanding doses | | Yes | | Optional |
| Work with TIV manufacturers/distributors to ensure equitable state distribution for priority groups and avoid 'spot' shortages | | Yes | | Optional |
| Act as central broker for redistribution of TIV between jurisdictions | | Yes | | No |
| Determine need for and, negotiate and purchase if the need exists: | TIV stockpile | Yes | | |
| | 'Late season' TIV | Yes | Probably | No |
| | IND TIV supply from the vaccine market | Yes (at <50m) | No | No |
| Encourage the use of LAIV in healthy people aged 5-49 years | | Yes | | |
| Broker with states the use of a single, credible, non duplicative system for communicating information and updates to state/local HDs, partners and media | | Yes | | |
| Develop and disseminate health alerts, media messages and educational materials | | Yes | | |
| Develop hotlines, Web site, satellite broadcasts, net conferences and DVDs for health providers | | Yes | | |

## FLU VACCINE SCENARIOS *(continued)*
## Federal and State/Local Activities Guideline at Varying TIV Supply Levels

| | ***TIV Doses*** *(in millions)* | | |
|---|---|---|---|
| *approximate amounts >* | ***<30-54*** | ***55-74*** | ***75+*** |
| ***STATE/LOCAL ACTIVITIES*** *relative amount >* | ***½ '04-'05*** | ***= '04-'05*** | ***'normal'*** |
| ***Infrastructure and Responsibility*** | | | |
| Reactivate/form Executive or Incident Command overall responsibility preparedness plan, interventions, management and effective communication | Yes | | |
| Designate persons/departments responsible for individual component planning and responses | Yes | | |
| Review 2004-05 vaccine shortage responses: best practices, resource needs, problems | Yes | | |
| Determine preparedness components and implementation activities | Yes | | |
| Establish secure and effective communications within ICS and with partners and collaborators | Yes | | |
| Determine legal foundation for infrastructure and its activities | Yes | | |
| Estimate impact on state/local levels at the estimated TIV supply levels | Yes | | |
| Determine personnel and other resource needs | Yes | | |
| Establish timelines for planning, exercising and implementing responses | Yes | | Optional |
| Exercise, evaluate and update plan as needed | Yes | | Optional |
| ***Partnering and Collaboration*** | | | |
| Identify/contact national, state and local public health and healthcare providers, their associations, producers and distributors, stakeholders and partners from 2004-05 | Yes | | |
| Review 2004-05 partnership responsibilities, successes, best practices, problems, timelines, activity leaders, data sources, and resources | Yes | | |
| Seek and include additional partners in planning | Yes | | |
| Obtain partners' ageement on need for and input on planning for possibility of a shortage | Yes | | Optional |
| Update partners/health providers on expected TIV and LAIV supplies, timelines, priority groups and the rationale for prioritization | Yes | | |
| Discuss and plan for various shortage scenarios, activities needs and timelines | Yes | | N/A |
| Establish leaders/organizations responsible for individual component planning and activities | Yes | | |
| Ensure provider/partner have updates and input as vaccine plan evolves during 2005-06 season | Yes | | |

## FLU VACCINE SCENARIOS *(continued)*
## Federal and State/Local Activities Guideline at Varying TIV Supply Levels

| | ***TIV Doses*** *(in millions)* | | |
|---|---|---|---|
| *approximate amounts >* | ***<30-54*** | ***55-74*** | ***75+*** |
| ***STATE/LOCAL ACTIVITIES*** *(cont.)* *relative amount >* | ***½ '04-'05*** | ***= '04-'05*** | ***'normal'*** |
| ***Communications Among Partners*** | | | |
| Evaluate 2004-05 partner communication strategies and processes and identify best practices and problems | Yes | | |
| Develop and test system for timely, consistent and non-redundant dissemination of CDC and state messages to local public health, healthcare providers, and partners and stakeholders | Yes | | |
| Update partners' list and designated contacts; give partners updated state/local HD contacts list | Yes | | |
| Encourage partners to develop systems for updating and contacting constituent lists | Yes | | |
| Assure partners serving priority groups of timely dissemination of vaccine and influenza info | Yes | | Optional |
| Develop with provider associations a system for keeping providers fully aware of vaccine issues | Yes | | Optional |
| Keep federal partners up-to-date on state/local contact information | Yes | | Optional |
| Establish/renew contact with manufacturers and distributors re: who/where vaccine providers are | Yes | | N/A |
| Consider alternative communication channels (e.g., e-mail, conference calls, websites) including security, reliability, audience appropriateness | Yes | | |
| ***Priority Groups, Prioritization, TIV Estimates*** | | | |
| Review CDC/ACIP TIV prioritization schema; consider the need for state/local modifications | Yes | | |
| Ensure public health and healthcare providers, partners and stakeholders, the public and media understand priority groups, tiering, TIV shortage triggers, the rationale for prioritization | Yes | | |
| Ensure healthcare providers, partners, the public, and media are made aware of any changes in TIV supply and prioritization recommendations | Yes | | |
| Review 2004-5 state/local, and provider methods, best practices/problems in TIV estimating needs | Yes | | |
| Estimate state TIV priority group sizes and geographic distribution of clients and providers | Yes | | Optional |
| Have providers estimate TIV for priority groups | Yes | | Optional |
| Develop and use methods to monitor and enforce TIV prioritization | Yes | | N/A |
| Obtain legal consultation concerning TIV prioritization and its enforcement | Yes | | No |
| Consider whether/when/where to support public/private mass vaccination clinics | No | Optional | Yes |

## FLU VACCINE SCENARIOS *(continued)*
## Federal and State/Local Activities Guideline at Varying TIV Supply Levels

| | ***TIV Doses*** *(in millions)* | | |
|---|---|---|---|
| *approximate amounts >* | ***<30-54*** | ***55-74*** | ***75+*** |
| ***STATE/LOCAL ACTIVITIES*** *(cont.)* *relative amount >* | ***½ '04-'05*** | ***= '04-'05*** | ***'normal'*** |
| ***Ordering and Distribution*** | | | |
| Encourage providers to include priority group(s) and total TIV needed in their practice ordering | Yes | | Optional |
| Encourage timely and valid TIV order estimates; discourage double-booking | Yes | | |
| In collaboration with CDC, manufacturers and distributors determine TIV amounts prebooked, ordered, shipped, and outstanding and to where/whom using secure data network (SDN) | Yes | | Optional |
| Ensure public health and healthcare providers are aware that in a shortage situation priority group orders will be filled first | Yes | | No |
| Document provider problems with TIV prebooking, receipt of orders, delays | Yes | | No |
| ***Vaccine Redistribution and Client Referral*** | | | |
| Encourage all providers, public and private, to administer influenza vaccinations | Yes | | |
| Review 2004-05 redistribution and referral practices for best practices and problems | Yes | | |
| Establish a TIV redistribution system within state and local jurisdictions and neighboring states | Yes | | Optional |
| Work with LHDs and other partners to enable and expedite local and more distant vaccine redistribution | Yes | | Optional |
| Encourage clinics/providers to designate contact responsible for handling redistribution activities | Yes | | Optional |
| Determine and mediate legal and practical issues for payment and liability for redistributed TIV | Yes | | |
| Provide all providers, partners, the public and media details on the redistribution system | Yes | | Optional |
| Solicit LPHs to set up a telephone/internet site for to expedite client referrals for vaccination; inform providers, public and media | Yes | | Optional |

## FLU VACCINE SCENARIOS *(continued)*
## Federal and State/Local Activities Guideline at Varying TIV Supply Levels

| | ***TIV Doses*** *(in millions)* | | |
|---|---|---|---|
| *approximate amounts >* | ***<30-54*** | ***55-74*** | ***75+*** |
| ***STATE/LOCAL ACTIVITIES*** *(cont.)* *relative amount >* | ***½ '04-'05*** | ***= '04-'05*** | ***'normal'*** |
| ***Education, Information, Communication*** | | | |
| Review information and education materials and activities, best practices and problems for 2004-05 | Yes | | |
| Solicit partner educational needs, responsibility and ability to disseminate info to constituents | Yes | | Optional |
| Decide on types of material and distribution (TV/radio/other news media, seminars, web site newsletters, conferences, e-mails, etc) | Yes | | Optional |
| Provide providers/partners info on effective vaccine interventions (standing orders, reminders) | Yes | | |
| Encourage partners provide constituents info on disease morbidity, vaccine effectiveness, priority groups and rationale for prioritization | Yes | | Optional |
| Educate priority groups including healthcare personnel to have an annual vaccination | Yes | | |
| Promote LAIV for healthy persons aged 5-49 year | Yes | | |
| Encourage HMOs, pharmacies, corporations and community organizations to sponsor vaccine and disease fact sheet development and dissemination | Yes | | |
| Identify/train credible, trusted spokepersons to the media; update media contact lists | Yes | | |
| Work with state/local media to develop fact-based material for TV, talk shows, newspapers, etc | Yes | | |
| Develop/promote 'expert speaker' network for talks/ discussion on disease and vaccine | Yes | | |
| Build/support websites to disseminate influenza materials and provide linkages to other websites, satellite broadcasts, and net conferences | Yes | | |
| Establish an Influenza 'hotline' for the public including up-to-date vaccination sites information | Yes | | Optional |