



RECOMMENDATIONS AND LESSONS LEARNED FROM THE 2004-05 FLU SEASON

AIM represents the program managers of the 64 state, territorial and urban area immunization programs that receive direct funding grants from the National Immunization Program to improve and assure high immunization coverage rates in the population. These immunization programs reside within their respective state or local public health agencies.

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Communication

1. The Centers for Disease Control and Prevention (CDC) should develop a fast-track approval process for written guidance and announcements.
2. Updates and policy decisions should be communicated immediately through a single, consistent message to all partners.
3. Regular conference calls between federal, state and local public health partners should remain an essential component of vaccine shortage response. Listen-only capacity should be available to all state and local public health agencies.

One of the biggest challenges during the supply shortage was communication. Immunization programs received messages from a number of different sources. Distributors, manufacturers, providers and other partners also received messages from different sources. It was challenging for the constituencies to work together and work with the public in a rapidly changing supply and information environment.

Eighteen program managers (over half of respondents) listed CDC as their primary source of information on the vaccine shortage and management of limited amounts of vaccine, 14 listed the Association of State and Territorial Health Officials (ASTHO) and 12 listed the Association of Immunization Managers (AIM). Associations can play a role of sharing information with their respective memberships, but messages must be consistent and originate from one source: the CDC.

Role of Public Health

4. The role of public health in vaccine purchase and distribution should be discussed and more clearly defined by federal, state and local public health agencies for a variety of supply scenarios. In times of short supply, public health intervention provides assurance that limited vaccine supply is delivered to those most in need.
5. Funds should be set aside at the federal level for emergency purchase of vaccine by public health agencies in times of supply or disease crisis. Funds should not be taken from immunization or other existing programs. At the same time, cost should not be a barrier to state and local public health agencies acquiring vaccine to distribute to the highest risk.
6. Consideration should be given to accessing federal preparedness funds for emergency purchase of vaccines.

Program managers expressed a high degree of satisfaction with the decision to route the distribution of limited amounts of vaccine through state and local public health agencies. Control and awareness of available vaccine doses allowed public health agencies to assure that vaccine was distributed to those most at risk for disease complication and most in need of vaccine. In times of vaccine supply shortage, public health interventions and supply management are needed.

Adult Immunization Infrastructure

7. Investment to support routine adult immunization activity should be increased through the Section 317 immunization grant program. Routine adult immunization activities and dedicated staff would increase annual influenza immunization coverage rates as well as build better capacity to work with private providers and high risk populations in times of shortage.
8. Agreements should be made with manufacturers and distributors to annually share pre-booking, ordering and shipping data with public health agencies in a secure information environment.
9. Immunization program managers should have access to data and information regarding location and amount of vaccine distributed in their area.

The ability to identify the amount and location of vaccine in a community is critical to assuring delivery to high risk persons. However, most programs do not have the capacity to contact and assure response from the growing and changing number of providers in their localities. Programs largely succeeded in surveying private providers and moving vaccine amongst providers to assure consistent distribution during the recent crisis; however, these activities required considerable time and were a tremendous strain on resources. More than half of program managers responding to the survey reported that

75% to 100% of staff time was devoted to the flu vaccine shortage in October, November, and December. Routine immunization activities were delayed, VFC provider evaluations were deferred, school and daycare audits were delayed, and outreach and clinic activities were canceled.

Data on vaccine orders and shipments provided on the secure data network was extremely helpful to program managers as they worked to map out areas of vaccine availability and need. This represented a breakthrough in partnership with pharmaceutical companies, but the data was not specific enough to be optimally helpful. Future data should include provider specific information on pre-booking, ordering, and delivery before and during the flu season. This would allow public health to provide a more effective safety net in seasons with adequate supply and a more effective distribution plan in times of supply shortage.

Policies to Address Supply Crises

10. CDC should develop a decision-making structure to improve the timeliness of federal decisions related to vaccine distribution in times of shortage.
11. Alternatives for use of VFC vaccine in non-VFC populations should be explored and procedures for transfer of vaccine in supply shortage situations should be simplified. All attempts should be made to maintain persons in their medical homes.
12. Criteria should be developed for the purchase of flu vaccine not licensed in the United States based on vaccine supply, disease incidence, and the timing of the vaccine availability – recognizing that demand for the vaccine, even in supply shortage years, drops precipitously after the Christmas and New Year holidays.

Program managers were fairly satisfied with the efforts of CDC to engage state and local public health in the decision-making process. However, low satisfaction was reported for the ability of CDC to respond to changes quickly.

Program managers expressed high satisfaction with the decision to allow the transfer of Vaccines for Children (VFC) vaccine to non-VFC populations, but low satisfaction with the timing of the decision and process for transferring the vaccine. Program managers also expressed low satisfaction with the timing and decision to purchase international vaccine to be administered under Investigational New Drug (IND) procedures. Flexibility to use vaccine where it is needed should come earlier in the season and must be a simple procedure. Similarly, vaccine from international sources should be received before January, and procedures for administration should be simplified.