

Subject: ASCA's Novel Influenza A (H1N1) Virus Update

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Dear Members and Emergency Planners:

This edition contains much information on H1N1. In this issue:

- **2009-2010 Influenza Season Week 43 ending October 31, 2009**
- **CDC Reports 22 H1N1 cases in U.S. since April and at Least 4,000 Americans Dead**
- **H1N1 exposes weak leave policies**
- **H1N1 vaccine - Should inmates move up in line?**
- **CDC Health Alert Network (HAN) Info Service Message: Key Issues for Clinicians Concerning Antiviral Treatments for 2009 H1N1**
- **NIC to Sponsor a Webinar on H1N1 in Criminal Justice Settings December 9th!**
- **Maryland Prison Inmates, Staff to Receive H1N1 Vaccinations**

Resources Repeated from prior updates to help you prepare for the potential resurgence of the H1N1 virus:

- **ASCA's Draft H1N1 Checklist - See attached**
- **BJA Information on Public Health Emergencies**
- **The National Institute of Corrections (NIC) Resources**

Visit the NEWS tab of the ASCA Website for more information on Pandemic and previous H1N1 updates (asca.net):

Members – please note that the Correctional Pandemic Plans have been moved. Pandemic Plans are now in the Members section on a subsection called "Pandemic Plans."

If you have staff members that you would like to receive ASCA emails and newsletters about Pandemic Planning or H1N1 Alerts, just email their names and email addresses to Rmay@asca.net.

Executive Office

WEEKLY NEWS & UPDATES

2009-2010 Influenza Season Week 43 ending October 31, 2009

During week 43 (October 25-31, 2009), influenza activity remained elevated in the U.S.

- 5,258 (37.2%) specimens tested by U.S. World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories and reported to CDC/Influenza Division were positive for influenza.
- Over 99% of all subtyped influenza A viruses being reported to CDC were 2009 influenza A (H1N1) viruses.
- The proportion of deaths attributed to pneumonia and influenza (P&I) was above the epidemic threshold.
- Eighteen influenza-associated pediatric deaths were reported. Fifteen of these deaths were associated with 2009 influenza A (H1N1) virus infection and three were associated with an influenza A virus for which the subtype was undetermined.
- The proportion of outpatient visits for influenza-like illness (ILI) was above the national baseline. All 10 regions reported ILI above region-specific baseline levels.
- Forty-eight states reported geographically widespread influenza activity, two states reported regional influenza activity, the District of Columbia reported local influenza activity; Puerto Rico and Guam reported

sporadic influenza activity, and the U.S. Virgin Islands did not report.

CDC Reports 22 H1N1 cases in U.S. between April and October, 2009 and at Least 4,000 Americans Dead

Federal health officials now say that 4,000 or more Americans likely have died from swine flu — about four times the estimate they've been using. The new, higher figure was first reported by The New York Times. It includes deaths caused by complications related to swine flu, including pneumonia and bacterial infections. Until now, the Centers for Disease Control and Prevention had conservatively put the U.S. swine flu death count at more than 1,000. Officials said this week they're working on an even more accurate calculation.

Estimating the number of individual flu cases in the United States is very challenging because many people with flu don't seek medical care and only a small number of those that do seek care are tested. More people who are hospitalized or die of flu-related causes are tested and reported, but under-reporting of hospitalizations and deaths occurs as well. For this reason CDC monitors influenza activity levels and trends and virus characteristics through a nationwide surveillance system and uses statistical modeling to estimate the burden of flu illness (including hospitalizations and deaths) in the United States.

When the 2009 H1N1 flu outbreak began in April 2009, CDC began reporting the number of laboratory-confirmed cases, hospitalizations and deaths associated with 2009 H1N1 flu in the United States that were reported by states to CDC. These initial case counts, and subsequent ongoing laboratory-confirmed reports of hospitalizations and deaths, are thought to represent a significant undercount of the actual number of 2009 H1N1 flu cases in the United States. A paper in *Emerging Infectious Diseases* authored by CDC staff entitled "Estimates of the Prevalence of Pandemic (H1N1) 2009, United States, April–July 2009" reported on a

study to estimate the prevalence of 2009 H1N1 based on the number of laboratory-confirmed cases reported to CDC. Correcting for under-ascertainment, the study found that every case of 2009 H1N1 reported from April – July represented an estimated 79 total cases, and every hospitalized case reported may have represented an average of 2.7 total hospitalized people. Since that time, CDC has been working to develop a way to estimate, in an ongoing way, the impact of the 2009 H1N1 pandemic on the U.S. in terms of 2009 H1N1 cases, hospitalizations and deaths.

For more information, go to: http://www.cdc.gov/h1n1flu/estimates_2009_h1n1.htm

H1N1 Exposes Weak Leave Policies

Bill calls for paid time off Some firms adjusting rules as flu spreads
By V. Dion Haynes and Ylan Q. Mui, Washington Post

When Great Falls resident Carolyn Cuppernull's 10-year-old daughter came down with swine flu, she didn't have to take time off work to stay home with her.

Cuppernull is senior marketing manager of the Washington office of the law firm Akerman Senterfitt. Under the group's former policy, she would have had to use paid leave to stay home if she or a relative got sick. But the firm recently updated its rules to allow employees to stay home with full pay -- without using leave time -- for H1N1-related absences.

"I have a laptop and a BlackBerry," Cuppernull said. "I was able to attend a meeting telephonically and participate in online training with hardly a blip."

In Washington and across the country, the arrival of the flu season has prompted companies of all sizes to weigh how to accommodate sick workers while keeping the business running. President Obama has declared the swine flu situation a national emergency, and federal agencies recommend that businesses remain flexible and let sick workers stay home.

Congress has also weighed in with a proposal that would mandate employers to offer paid sick leave. Under a bill introduced last week by members of the House Education and Labor Committee, employers with 15 or more workers would be required to provide five paid sick days per year for workers sent home with contagious conditions such as the swine flu.

Sick workers

"Sick workers advised to stay home by their employers shouldn't have to choose between their livelihood and their coworkers' or customer's health," [Rep. George Miller](#) (D-Calif.), chairman of the education and labor panel, said in a statement. The National Small Business Association, which has not taken a position on the legislation, has in the past criticized similar proposals as harmful for business owners.

"The more restrictive the government is in how businesses can develop their benefits programs, the less flexible business owners can be," said Molly Brogan, a spokeswoman for the small-business group. "If it's paid sick leave, you're paying somebody who's not going to be there and you have to pay somebody to replace them. That has the potential to affect the bottom line for a lot of small businesses."

Mike Aitken, director of government affairs for the Society for Human Resource Management, said that although the legislation attempts to protect employees, the wording of it could do the opposite. The bill is triggered by employers who send their sick workers home. Aitken said he was concerned that employers might get out of providing the sick days simply by forcing workers to stay on the job.

"The way the bill is crafted, one questions whether they will be able to achieve" protections for workers, Aitken said. "We think other approaches should be used."

According to a survey by the group released last week, most human resource managers said they plan to use their current sick-leave policies to accommodate swine flu absences. About 20 percent of firms require a medical statement to clear an employee to return to work.

The Department of Homeland Security has urged employers to establish contingency plans so that they could continue operating if an outbreak of the H1N1 influenza occurs among their workers. The federal government has strongly recommended that businesses force employees with the flu to stay home and that they adopt flexible sick-day policies allowing staff to work from home if a family member becomes infected.

John A. Boardman, executive secretary and treasurer of Unite Here Local 25, the union representing 5,000 Washington-area hotel workers, said his members have numerous options if they need to take time off to care for themselves or a sick relative. He said they could use sick days, vacation or short- and long-term disability time.

'Safety net'

"When you have a safety net, you can continue to get income while you're out, and that's helpful," Boardman said.

Wal-Mart, which employs about 1.4 million people in the United States, came under fire from labor groups last week for its sick-leave policy. Full-time workers accrue an average of six sick-leave days per year but are only allowed to use the time after the first day off because of illness. The first day can be covered with a personal or vacation day, or employees will not receive pay. Temporary and part-time workers do not receive sick time but do get personal and vacation days.

In addition, Wal-Mart begins reprimanding workers after four absences of up to three days each over the course of six months. Six absences can lead to termination.

"The policy is really draconian," said Charles Kernaghan, director of the National Labor Committee, which last week published a report detailing the practice. "You drag yourself to work sick, especially during the swine flu pandemic. This should be a concern."

Last week, Wal-Mart issued a clarification of its policy to its more than 3,000 stores across the country, stating that no one will be fired for contracting swine flu or caring for a family member with the illness.

"Clearly, there's been a misunderstanding about what our policy is," said Gisel Ruiz, a senior vice president of Wal-Mart's U.S. stores. "Wal-Mart is encouraging our associates who may be ill to stay home and get well. That's in everyone's best interests."

The company said missed work days because of swine flu will not count as an absence. However, workers will receive pay only if they have accrued sick leave or personal or vacation days.

According to Gary Laugharn, principal at human resources consulting firm Hewitt Associates, about 20 percent of national retailers require employees to have been sick for up to a week before leave benefits kick in. He said many of the companies he works with have tried to combat the H1N1 virus by providing plenty of hand sanitizer in the stores and encouraging sick workers not to come in.

But for the roughly 50 million workers who do not receive sick time, the options are more stark: work or don't get paid.

Leah Daniels, who sells pots, pans and other cookware from her Capitol Hill store called Hill's Kitchen, said her one full-time and three part-time workers do not receive sick days and would simply have to miss a day of pay if they were to take time off to recover from the flu. "I don't have a contingency plan," Daniels said. "There is no way for someone to work from home."

H1N1 vaccine - Should inmates move up in line?

States are providing the H1N1 vaccine to high-risk groups, and in some cases that includes parts of the prison populations.

By Tracey D. Samuelson | Contributor to The Christian Science Monitor
from the November 7, 2009 edition

Should those in prison and jails across the country receive priority status for

getting the H1N1 vaccine?

With vaccines in short supply, it's become a difficult issue for public health departments and correctional facilities across the country.

Earlier this week, the White House had to rebut erroneous reports that the vaccine had been given to detainees at the Guantánamo prison camp in Cuba.

"There is no vaccine in Guantánamo and there's no vaccine on the way to Guantánamo," said White House spokesman Robert Gibbs at a press briefing.

But a cohesive national strategy seems lacking. Local departments of public health are deferring to federal Centers for Disease Control and Prevention (CDC) guidelines for establishing high-priority groups. According to the CDC, vaccination planning is a state issue.

The nation's top public health agency issues recommendations, but "states are in charge of vaccinations," says CDC spokesman Tom Skinner.

Though the CDC has acknowledged that certain settings – including prisons, schools, day care centers, and universities, among others – may increase the risk of contracting the H1N1 virus, they do not give vaccine priority to those groups.

Instead, they limit priority to those with individual risk factors, including pregnant women, those who care for young children, individuals younger than 24, healthcare workers, or people with certain underlying health conditions.

"Certain settings may increase the risk of infections, but we haven't prioritized vaccinations for those settings," says Mr. Skinner. "Our recommendations are based on population risk factors."

Many states, including Massachusetts and Ohio, have decided to prioritize those at high risk in the general population over those in prison.

In Texas, the Department of State Health Services says it will vaccinate all high-risk individuals at the same time, regardless of whether or not they're incarcerated. But while they have begun vaccinating the high-risk general population, they have not done the same for high-risk inmates.

"It's all a question of vaccine availability," said John Jacob, a spokesperson with the Massachusetts Department of Public Health in an e-mail. "As soon as significant enough quantities have arrived in the state and have begun to be distributed to high-risk groups in the general population such as adults 25-64 with underlying conditions, some vaccine will begin to be distributed to those same high-risk populations within prisons."

Though high-risk inmates will be prioritized over some in the general prison population, in Massachusetts, as in Texas, they will not receive the vaccine at the same time as their non-incarcerated peers.

For example, the state "will be getting vaccine to pregnant women who are incarcerated as soon as we have been able to vaccinate a significant percentage of pregnant women overall" writes Mr. Jacob.

The idea that high-risk people inside prisons would be treated differently from those outside is "invidious and discriminatory," says Nancy Stoller, coordinator of the American Public Health Association's jail and prison health group.

Incarcerated individuals are at a higher risk for H1N1 than the general population, Ms. Stoller says, and therefore should receive vaccination priority.

Inmates' higher risk is largely due to the close proximity in which they are confined. They also tend to be more susceptible to H1N1 because of their age (the average jail population is under 30), and also because they tend to come from poorer backgrounds and therefore are less likely to have received regular medical attention.

"Not only do they have a higher risk of getting the flu, but they're more likely

to have a more serious case," says Stoller.

Ohio has developed a tiered priority system within its correctional facilities once vaccination becomes available. The first wave of vaccinations will include pregnant women, those who have given birth while incarcerated, healthcare staff, 10 percent of the general staff, juveniles, and inmates with compromised immune systems. A second tier will provide for the rest of the prison staff and inmates.

But Ohio hasn't yet distributed any vaccinations for that first, high-risk tier. So despite having distributed 984,700 vaccinations thus far, Ohio has yet to vaccinate the 66 pregnant women currently in its prison system, or its healthcare staff.

Neither the Ohio Department of Rehabilitation and Correction nor the Ohio Department of Health had any estimates on when vaccination might begin, due to its limited supply.

"Sometimes, there's a lot of pressure on health departments to think of the health needs of prisoners as less important than the health needs of people outside," says Stoller.

But there's a concern that without vaccinations, correctional facilities may experience H1N1 epidemics. With the flow of visitors, staff, and inmates through prisons, that could put the general population at risk.

"Prisons are not sealed institutions," says Stoller. "Whatever happens in prisons will leak out."

**CDC Health Alert Network (HAN) Info Service
Message: Key Issues for Clinicians
Concerning Antiviral Treatments for 2009 H1N1**

Situation: Although use of influenza antiviral drugs in the United States has increased during the 2009-2010 flu season, not all people recommended for antiviral treatment are getting treated. Listed below are important facts to consider when deciding whether a patient needs to be treated with antiviral medication. It is critical to remember that it is not too late to treat, even if symptoms began more than 48 hours ago. Although antiviral treatment is most effective when begun within 48 hours of influenza illness onset, studies have shown that hospitalized patients still benefit when treatment with oseltamivir is started more than 48 hours after illness onset. Outpatients, particularly those with risk factors for severe illness who are not improving, might also benefit from treatment initiated more than 48 hours after illness onset.

Recommendations for Clinicians: Many 2009 H1N1 patients can benefit from antiviral treatment, and all hospitalized patients with suspected or confirmed 2009 H1N1 should receive antiviral treatment with a neuraminidase inhibitor – either oseltamivir or zanamivir – as early as possible after illness onset. Moderately ill patients, especially those with risk factors for severe illness, and those who appear to be getting worse, can also benefit from treatment with neuraminidase inhibitors. A full listing of risk factors for severe influenza is available at: <http://www.cdc.gov/h1n1flu/highrisk.htm>.

Although antiviral medications are recommended for treatment of 2009 H1N1 in patients with risk factors for severe disease, some people without risk factors may also benefit from antivirals. To date, 40% of children and 20% of adults hospitalized with complications of 2009 H1N1 did not have risk factors. Clinical judgment is always an essential part of treatment decisions.

When treatment of persons with suspected 2009 H1N1 influenza is indicated, it should be started empirically. If a decision is made to test for influenza, treatment should not be delayed while waiting for laboratory confirmation. The earlier antiviral treatment is given, the more effective it is for the patient. Also, rapid influenza tests often can give false negative results. If you suspect flu and feel antiviral treatment is warranted, treat even if the results of a rapid test are negative. Obtaining more accurate

testing results can take more than one day, so treatment should not be delayed while waiting for these test results. For more information on influenza testing, please see: http://www.cdc.gov/h1n1flu/guidance/diagnostic_tests.htm.

Although commercially produced pediatric oseltamivir suspension is in short supply, there are ample supplies of children's oseltamivir capsules, which can be mixed with syrup at home. In addition, pharmacies can compound adult oseltamivir capsules into a suspension for treatment of ill infants and children. Additional information on compounding can be found at: <http://www.cdc.gov/H1N1flu/pharmacist/>.

For More Information: Updated Interim Recommendations for the Use of Antiviral Medications in the Treatment and Prevention of Influenza for the 2009-2010 Season: <http://www.cdc.gov/H1N1flu/recommendations.htm>

NIC to Sponsor a Webinar on H1N1 in Criminal Justice Settings - December 9th from 12:00 – 3:00 PM eastern time

Speakers will include:

Newton E. Kendig, M.D.
Assistant Director of Health Services & Medical Director
Federal Bureau of Prisons

Lester N. Wright, MD, MPH
Deputy Commissioner/Chief Medical Officer
New York State Department of Correctional Services

A representative from the CDC

ASCA will distribute a webinar flier next week. Mark your calendars.

Maryland Prison Inmates, Staff to Receive H1N1 Vaccinations - November 12, 2009

The Maryland Department of Public Safety and Correctional Services will administer a first round of H1N1 vaccinations to high-risk inmates and staff, according to department spokesman Mark Vernarelli. The shots will be given by Correctional Medical Services staff based on predetermined priority groups consistent with the guidelines provided by the Centers for Disease Control, according to Vernarelli.

High-priority individuals include those who are pregnant, those who are younger than 24 years old with underlying health conditions, and those between the ages of 25 and 64 who might have health complications that make them higher risk than others. About 600 doses of the vaccine will be offered to staff members who are permanently assigned to infirmaries or to medical transportation units. The spokesman said the department must meet constitutional obligations to provide health care that meets “community standards of care” to inmates, and this includes administering seasonal and H1N1 flu vaccinations.

“This is not something we’re going to be giving to 23,000 inmates,” Vernarelli said. The federal government provided the vaccinations at no cost, he said. The department petitioned for correctional officers to be considered “first responders and emergency personnel” and, therefore, be given higher priority for vaccinations, but the status was declined based on Centers for Disease Control guidelines and the limited number of shots available, Vernarelli said.

2009 H1N1 Influenza Vaccine Supply Status

November 12, 2009, 3:00 PM ET

Doses Allocated as of 11/11/09*	41,297,100
Doses Ordered as of 11/11/09	36,983,500
Doses Shipped as of 11/11/09**	35,445,700

*Doses allocated to project areas for ordering are those that are at the distribution depots and ready for project areas to order. Vaccine is allocated to each project area in proportion to its population (pro rata).

**There is a lag time between allocation, ordering, and shipment of doses as project areas place orders and those orders are processed and shipped.

For Planners: Vaccine Allocation and Distribution Q&A <http://www.cdc.gov/H1N1flu/vaccination/statelocal/centralized_distribution_qa.htm>

RESOURCES

ASCA Draft and Modified Pandemic Planning Checklist

With funding from BJA, ASCA has also been developing a Corrections Checklist for Pandemic Planning to assist corrections administrators to assess whether their Continuity of Operations Plans (COOPs) are sufficient to handle a pandemic emergency. Given the rapid spread of the recent outbreak of the so-called H1N1 virus, we thought it would be important to release to you a Summary of the Checklist items that you could use now to mitigate the effects of the impending H1N1 Influenza emergency. The attached modified and shortened Draft Summary Checklist is **not** meant to cover every matter that will need to be addressed if a flu epidemic occurs, or if it transforms into a full-blown pandemic. Rather, it is meant to serve as a way to assess your current medical emergency plans to ensure that they are ready should the H1N1 virus begin to have a major impact on your staff, their families, the prisoners in your charge, and ultimately the ability of your institutions to operate as they should. See the attached ASCA Pandemic

Planning Checklist.

State H1N1 Flu Information Site with Links

This site has links to; State H1N1 Flu Websites, State Press Releases, Fact Sheets, Health Alerts. Guidance to Schools, Guidance to Health Care Providers and Testing Guidelines. Go to: http://www.astho.org/templates/display_pub.php?pub_id=3797&admin=1

BJA Information on Public Health Emergencies

The Bureau of Justice Assistance (BJA) recognizes that public health emergencies, whether an epidemic or pandemic influenza, biological terrorist attack, or natural disaster with public health implications can threaten America's justice system and place the rule of law at risk. BJA has undertaken a broad-scope initiative to identify the critical planning and response objectives for local justice systems and to identify lessons learned and promising approaches in preparing the justice system for such emergencies. The goal of BJA's initiative is to ensure that the rule of law is upheld during any public health crisis, whether natural or manmade. This initiative's design parallels the major components of the justice system: law enforcement, courts, corrections, and communities. To view the latest issue of Justice Today with links to a variety of additional resources, go to: <http://bj.ncjrs.org/justicetoday/newsletter.html>

The National Institute of Corrections (NIC) Online Resources

- Pandemic Flu Planning Checklist for Corrections Facilities, CDC, 2007
- H1N1 Flu Website, Centers for Disease Control and Prevention

- Pandemic Flu Website, U.S. Dept. of Health & Human Services
- Pandemic Alert, Association of State Corrections Administrators, April 26, 2009
- Swine Flu News Bulletin, American Correctional Association, April 29, 2009
- Flu and HIV Blog, AIDS.gov
- American Correctional Health Services Association Webpage
- Federal Bureau of Prisons Pandemic Influenza Plans, 2008
- Module 1: Surveillance and Infection Control
- Module 2: Antiviral Medications and Vaccines
- Module 3: Health Care Delivery
- Module 4: Care of Deceased

To access the information, go to <http://www.nicic.gov/SwineFlu>. (NIC will update this page frequently)

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CORRECTIONS CHECKLIST FOR H1N1 FLU VIRUS PREPAREDNESS

May 1, 2009

In anticipation of the possibility that the Avian Flu would transform from a bird-to-human into a human-to-human contagion and cause an uncontrollable pandemic in our communities and in prison systems, ASCA, with funding from the Bureau of Justice Assistance, has been assembling expertise and guidance from medical, emergency response, corrections and other justice agencies to develop guidance for state prison operators about how to respond to an outbreak of pandemic influenza. The ASCA Pandemic Newsletter, together with frequent communiqués and updates you have been receiving from ASCA and the BJA Pandemic Consortium, have been a part of this effort.

ASCA has also been developing a Corrections Checklist for Pandemic Planning to assist corrections administrators to assess whether their Continuity of Operations Plans (COOPs) are sufficient to handle a pandemic emergency. This Checklist is based on an examination of pandemic emergency plans that have been developed and adopted by state corrections agencies, along with the advice of health experts and officials. The Checklist is in draft form and still under review.

Given the rapid spread of the recent outbreak of the so-called "swine flu" (here, and more correctly called the H1N1 Influenza virus) in the United States, and the elevation of the World Health Organization alert to Level 5 (an epidemic just short of a pandemic emergency), we at ASCA thought it would be important to release to you a summary of the Checklist items that you could use now to assess the adequacy of your medical emergency plans to mitigate the effects of the impending H1N1 Influenza emergency, should it reach your agency, and prepare for the very real possibility of this medical emergency developing into a pandemic.

The following Checklist clearly cannot cover every matter that will need to be addressed if a flu epidemic occurs, or if it transforms into a full-blown pandemic. Rather, it is meant to serve as a way to assess your current medical emergency plans to ensure that they are ready should the H1N1 virus begin to have a major impact on your staff, their