H1N1 Pediatrics Update and Overview of CDC's Child Care Guidance

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Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode until the question and answer session of today's conference. At that time you may press star 1 on your touchtone phone to ask a question. I would like to inform all parties that this call is being recorded. And if you have any objections please disconnect at this time.

I would now like to turn the call over to Ms. Alycia Downs. Thank you Ma'am, you may begin.

Alycia Downs: Hello and welcome to today's COCA conference call, H1N1 Pediatric Update and Overview of CDCs Child Care Guidance. We are very excited to have Beth Stevenson and Dr. Lisa Barrios, both from the Centers for Disease Control and Prevention, speak with us today.

We also have some CDC subject matter experts from vaccine and antivirals on the phone to help answer questions during the question and answer session. So we have Dr. Suchita Lorick, and Dr. Philip Peters on the line as well.

We're using PowerPoint presentation for this call that you should be able to access from our Web site. If you not already downloaded the presentation, please go to emergency.cdc.gov/coca. Again that's emergency.cdc.gov/C-O-

C-A. Click on Conference Call Information Summaries and Slide Sets; the PowerPoint can be found under the call in number and passcode.

After this activity the participants will be able to; describe the latest information related to H1N1 and pediatrics; discuss interim guidance on helping childcare and early childhood programs respond to influenza during the 2009-2010 influenza season; and identify potential issues, as well as suggestions for additional resources that may be of benefit to healthcare providers.

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CDC, our planners and our presenters wish to disclose they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. This presentation does not involve the unlabeled use of a product, or product under investigational use. There is no commercial support.

I will now turn the call over to Ms. Stevenson, who will not be using a PowerPoint presentation. You will begin to use that when Dr. Barrios begins her segment of this session. Beth?

Beth Stevenson: Thank you Alycia. What I wanted to do is just take a few minutes for people that have been on previous COCA calls -- or people new to calls -- to give you a bit of an update about flu, and what's happening with the latest information. And all of this information is online at various places on the CDC Web site.

First wanted to let you know what kinds of information we're sharing with the public and with patients, especially parents of children. We are certainly letting them know symptoms of flu, and being very clear about the symptoms around fever, cough, sore throat, runny or stuffy nose, body aches, headaches, chills, fatigue, and sometimes diarrhea and vomiting.

In addition, we are underscoring that while most people with 2009 H1N1 have had mild illness and have not needed medical care or antiviral drugs; and that the same is actually true of seasonal flu. However, we're also emphasizing that some people are far more likely to get flu complications and we're attempting to set a tone and assist people, connect with their healthcare provider about whether they need to be examined if they get flu symptoms this season.

So we're attempting to sort of set a stage for people to think in those terms around H1N1. Specifically, people that are more likely to get flu complications, as many of you all know are; children younger than 5.

But especially children younger than two years old; people 65 and older; pregnant women; people who have cancer or blood disorders -- including sickle cell disease; chronic lung disease -- including asthma or chronic obstructive pulmonary disease; diabetes; heart disease; kidney disorders; liver disorders; neurological disorders -- including disorders around the nervous system, brain or spinal cord; and neuromuscular disorders -- such as muscular dystrophy and multiple sclerosis; and weakened immune systems.

We also are letting people know that it certainly is possible for healthy people to develop severe illness from the flu, and so again, are referring anyone who's concerned to their healthcare providers. And so that you know, those are some of our key messages we're sending out.

And we are also starting to put up information related to making decisions about calling the doctor as well as emergency warning signs such as; fast breathing or trouble breathing; bluish skin color and not drinking enough fluids; or not waking up; or being - or interacting if a child might normally do; being irritable when the - because the child does not want to be held; flu-like symptoms; improved situations that happens and then it returns to the fever and worse cough; and a fever with a rash.

So we're attempting to sort of create an understanding of influenza and H1N1 in that context. And so anything that people can do to help us and assist with those types of messages.

In terms of the kind of information we have related to flu over the most recent information, flu activity remains elevated in the U.S. with more than half, really about 27 states, reporting widespread influenza activity.

We are still recommending a three-step approach to fighting the flu; vaccination is at the top of our list -- and I know we have Suchita here, who might be able to answer questions later about the vaccination program, I'll share a few quick highlights of what's been happening over this past week; also, everyday preventive actions including covering coughs, and frequent hand-washing, and staying home when sick; and the correct use of antiviral drugs if physicians recommend them. So we're putting it in that context.

However, it's also important for us all to remember that activity - influenza like illness activity in the U.S. is very unusually high for this time of year. We are seeing certainly more flu than we would normally see at this point in the year.

The proportion of deaths that are attributed to pneumonia and influenza had been low and within the bounds of what is expected, in some ways at this time of the year, but that's deaths. However, 60 pediatric deaths related to 2009 H1N1 have been reported to CDC since April, 2009 -- including 11 deaths reported in the last couple of weeks. So, those are a concern and they're being tracked individually and carefully.

Almost all of the influenza viruses identified so far are 2009 H1N1 Influenza A viruses. These viruses remain similar to the virus chosen for the vaccine, and so that's valuable to know. And they also remain susceptible to the antiviral drugs oseltamivir and zanamivir with rare exception. So the resistance - the antiviral drug resistance is not high.

Wanted to talk to you briefly and let you know that the Department of Health and Human Services has approved deployment of about 300,000 bottles of Tamiflu oral suspension from the strategic national stockpile to all states. And that's based on population for youth and pediatric populations to ensure a greater availability of supply. And there are also some other pieces to that that Dr. Peters may be able to respond to later in the call.

All states who request suspension are expected to receive the material very soon -- within the week. So we are looking for ways to increase the ability for people to treat with the antiviral drugs.

In terms of vaccine, states and cities began placing their orders for the 2009 H1N1 vaccine on September 30. And there was a kind of decision made within the Vaccine Task Force, we could choose between waiting to distribute vaccine until we had large quantities ready to ship, or distribute rather limited quantities of vaccine sooner.

And while it makes it difficult, we chose the latter, knowing that it might make a few challenges, but also knowing that it would allow us to start protecting people as early as possible. So we are gearing up for the kinds of questions and concerns people may be having with - because we're shipping it before we have those large quantities available.

We - however, the vaccine amounts for states to order at the moment is all the nasal spray vaccine, and people who can receive those vaccines are healthy non-pregnant people between the ages of 2 and 49. And we're - you should be looking to the providers of that vaccine but doing targeted vaccination efforts with the vaccine that is available.

This vaccine program is going to be massive. And it's a challenging undertaking. And it's being counted at a time when state and local health departments have experienced budget cuts, and so there will likely be bumps. We're expecting those, and we have emails and phone numbers available to assist in whatever we can. We're optimistic that we can achieve our goals of making the 2009 H1N1 vaccine available to all those who need it and want it.

Children younger than ten years, you know and - should receive two doses of 2009 H1N1 flu vaccine. This is slightly different from CDCs recommendations for seasonal influenza vaccination which states that children younger than 9 who are being vaccinated for influenza for the first time need to receive two doses. Infants younger than 6 months of age are too young to get the 2009 H1N1 and the seasonal flu vaccines. And so that's an important thing to consider, especially in the childcare setting and - which is the topic of this call.

You can certainly go in and note some of the guiding principles around recommendation for how to vaccinate to people as many as possible and as

quickly as possible. There are lists of recommendations from the Advisory Committee in Immunization Practices related to the target groups for vaccination, to start with.

The identification of five initial target groups for vaccination was sort of set up back in August. And it estimated about 159 million persons are on that kind of initial recommendation list including; pregnant women; people who live with or provide care for infants under six months of age -- because they can't be vaccinated; healthcare and emergency medical services personnel; children and young adults aged 6 months through 24 years; and people who are aged 25 through 64, but have medical conditions that put them at higher risk for influenza complications -- as we talked about earlier.

We certainly expect the H1N1 influenza vaccine to have a very similar safety profile of seasonal flu vaccines, which do have a very good safety track record. And CDC expects that any serious side effects following vaccination with H1N1 influenza vaccine would be very, very rare.

And that is an attempt to give you a bit of an update. There is more information online, and quite a lot of it, if you're interested in exploring further. And we also have people who can answer questions later in the call. And I will turn this now over, because childcare, and that age group that is served by childcare, is so very, very critical; wanted to provide an opportunity to describe the childcare guidance to you. And look forward to the ways that clinicians especially can help support the initiatives to keep these young children safe.

Lisa Barrios: Thanks Beth. And we are going to use slides now, if people would like to follow along. We're going to start, I just wanted to be able to tell you a bit about the guidance that we released almost a month ago now, I guess, about

childhood - early childhood programs and childcare and how we can help them respond to influenza during this flu season.

Switch to the next slide there. Okay, so let's go to the next one then. So the First Slide that talks about the purpose and the goals; let's start by talking about why we did this. We did guidance out in the spring, and this document was developed to provide updated guidance for reducing the spread of influenza among children and staff in early childhood settings during this flu year.

And this guidance, as with our other guidance documents for schools and businesses and institutions of higher education, we really have two goals that we're trying to balance in everything that we're deciding to do. The first one is, of course, to decrease the spread of flu, in this case among children and childcare providers. But our Second goal is also to minimize the destruction of day-to-day social, educational, and economic activities.

The kinds of strategies that we recommend are things that are a little - can be a little bit more complex to do, even though in many ways they're common sense, as compared to getting a vaccine. And so they can have a lot of serious social, educational, economic impact on society. And we want to make sure that what we do is really in balance between trying to decrease the spread and minimize the disruption.

Go to the next slide and we'll talk about the components of what’s in the guidance document. The document includes recommended actions to take now, this flu season. And it also includes suggested strategies for communities to consider adding if the severity of influenza is found to be increasing.

The document includes a checklist for making decisions about which strategies to do and how to do them. And it's also accompanied by some supplemental materials. So the guidance document itself is about six pages or so.

There's also a longer technical report which you can access also on the cdc.gov or the flu.gov Web site. The technical report provides some more information for those who want it, about why some of these strategies are recommended; some of the caveats that go along with them, some of the instructions for doing them, in a little more detail.

And then there's also a communications toolkit to accompany the guidance. And that provides questions and answers, it provides fact sheets for childcare providers or health departments or others to use in talking about the guidance and what they're going to do. And it also includes some templates for emails and letters to be sent home describing what programs are doing.

So our next slide talks about the background. And I don't want to spend a lot of time here, because I think you all have some familiarity with childcare. I just think that it's important to get across, sort of two main points. One is that we're talking about a large number of children; more than 9 million children under age 5 who were in childcare for some portion - some significant portion of their week.

And not only a lot of different caregivers in childcare programs, but a lot of different types of childcare programs we've got ranging from corporate, multi-center, multi-state organizations to home based childcare programs that might only have a couple of children in them.

Another important part of this - of the background is that - and I think Beth said this already couple of times, and I'll just add to it again, obviously it's important to us. But infants who are under 6 months of age are really a particularly vulnerable population because they cannot receive either the seasonal or the H1N1 flu vaccine. And that's a population that tends to be in early childhood programs. And so we need to think about the other things that we can do to try to decrease their risk of getting the flu.

Next slide. There's a lot of things we can do. There's also a lot of challenges. And you know, the - some of the unique challenges in talking about childcare is we've got a highly vulnerable population; not only do we have the under 6 month olds who can't get vaccines, we've got the under 2 year olds who are showing up as much higher in terms of their risk of complications and hospitalizations. And - but everybody in this population under 5 is in a high risk group.

We've got a group of kids who are in close interpersonal contact. They're sharing toys, they're sharing other objects. They're just mouthing each other. There's lots of sharing going on and there's a really limited ability for -- especially the younger children -- to understand or to really practice good respiratory etiquette and hand hygiene. So it makes a wonderful setting for transmitting all sorts of infectious diseases.

It's important to keep in mind that because of all of that -- and really this is true for any setting -- no policy, no strategies or recommendations that we can come up with are going to completely prevent the transmission of infectious disease. And so we - our goal is to do as many different things as we can do, but keep in mind that we're - it's never going to be perfect.

In particular, no policy is going to keep out everyone who is potentially infectious from these settings. You can be contagious before you have symptoms, you can be contagious without ever having a fever. You can have - be contagious long after a fever. It's very difficult to ever set any kind of a policy or rule that will keep anyone who's potentially infectious out.

Okay. Can you go to the next slide please. We're going to be continually looking at the influenza, both the virus itself, it's spread and severity of the disease. We all know that influenza is a very unpredictable virus. It can change at any moment. It can spread to some groups and not to others. It can be - you know, we can see an increase in severity or it can remain the same.

And so CDC and our partners domestically and internationally are continually monitoring the severity in the spread of the disease and looking for changes. And we will provide periodic updates of these assessments. And based on these assessments we may recommend additional strategies if we feel that they're needed.

But at this point decisions should really be made at a local level, and they should be made collaboratively between, in this case, childcare providers and their local or state health departments, their other local state officials that have a role in childcare provision, with their communities, with their parents and families and staff to determine what are the best actions to take locally.

The next slide talks about planning. And you know, most childcare programs, most communities, do have some sort of plan in place. I just wanted to make sure that we always remember, because when we get into emergency mode, sometimes we forget to look back at the plans that we did have. This is the time to stop and examine and consider whether or not revisions are needed to existing plans and procedures.

In particular - a particular example that doesn’t seem to - seems to be coming out more and more is for people to develop contingency planning for staffing when people are going to need to be out because they are ill or they are taking care of their own children or other family members. It's important to think about what kind of staffing plans are necessary to have in place.

It's important to update contact information for staff as well as families. And to share these plans; to share them with local healthcare providers, to share them with local health officials, with parents and with staff so that everyone who's involved knows what the plan actually is.

Sick leave policies in particular are of - are a particular concern, because many places do not have sick leave policies that will really allow people to stay home for a - for full (unintelligible) time that they need to recover from a flu-like illness. So we'd like to see people reviewing and potentially revising sick leave policies before they need that.

And I wanted to make sure I had in here, for this audience in particular, that we are making a pretty clear statement that people not require - both at schools and childcare, not require a doctor's note either to prove that you've been ill or that someone's been ill or to get permission to return to the setting.

We're very concerned about the burden on clinicians of having people coming in for something like a doctor's note. And so we've been talking to all of these various settings about really not requiring that when it may take a considerable amount of time and energy from their community clinicians to put that together.

And then of course educating children, families and staff is something you can be doing before the flu is in your community, while it's in your community and after the current wave goes through, because we know it'll be back next year, if not before.

Let's turn to the next slide and talk about some of the specific recommendations. So (unintelligible) with the guidance list, some recommended strategies to use now and then it also has some strategies that can be added if influenza severity increases. The short list is up on the slide right now, and then we can go through this in a little bit more detail.

But basically we're talking about getting vaccinated, as our first line. Always is the top thing we can do to protect people from the flu, staying home when sick, and all sorts of other things that we can do to try to separate well and sick individuals. We've also got a number of strategies that are more focused on sort of the basics of infection control including hand hygiene, and respiratory etiquette, and routine type types of cleaning of settings.

Early treatment, and particularly talking about antivirals and I'll come back to that in a minute. And then we'll talk - let's talk a little bit more about closing childcare programs as the sort of closure option is one of the ones that rises to people's minds frequently. And we want to make sure we have a chance to address that.

You can go to the next slide. This slide lists the strategies that are recommended for adding if influenza increases. And these are things that are definitely more difficult to do; more costly perhaps. And really don't necessarily have as much evidence of effectiveness in a community setting. But we felt it was important to put out the possibilities for a layered approach

that makes sense to try to do whatever we can to reduce the transmission of influenza in the community. And I'll come back to these in a minute too.

So let's move on to getting vaccinated. I'm not going to spend any time here, I think because I think Beth has already laid out the basics. But our guidance does - even though the focus of the guidance is on community measures and not about vaccines and not about antivirals per se, we did feel it's important when we're talking about ways to reduce the spread of influenza that we also make it very clear to people that vaccination is the first and foremost thing to do both for seasonal and for H1N1.

And Beth already listed out - I think you already stated all the targeted...

Beth Stevenson: Yes.

Lisa Barrios: ...groups for the initial doses of flu vaccine that are rolling out now for H1N1. So you've got that listed here on the Web site and many other places. So I'm not going to go through that list now. But just so you know that we've put that out there in the guidance for childcare providers.

And we're encouraging childcare providers themselves to get vaccinated, especially those folks who are caring for children under 6 months of age. But also to play a role in encouraging their family members to get themselves vaccinated.

Let's move to Staying Home When Sick. Seems simple; sort of our primary recommendation when it comes to community measures is that if you are sick, stay home. We put a lot of time and energy into getting this message across. The basics of it are to remain at home until at least 24 hours after your fever has gone, after you no longer need fever-reducing medications to keep the

fever down. In the spring we found that this was about three to five days in most cases. And people who are staying home should avoid contact with others during this time period.

As I've said already, you can shed virus before the fever, more than 24 hours after, you can shed without a fever, and you can shed while you're using antivirals. So this is not a perfect solution; this will not keep out everybody.

But we're - but our intent was not to keep out everyone who is potentially contagious. It is in line with standard kinds of practice around the time that people have had respiratory illnesses should stay home. And given the severity of this virus, we went with the same type of recommendation.

We've also stated though in the childcare guidance that some programs or localities may elect to have longer periods of time. For example, if you have a program with a lot of children under 6 months of age, or you have a program for medically fragile children where the vast majority of children in the program are at really high risk, then you might want to think about -- in conjunction with your health officials -- potentially setting a longer period of exclusion before people can come back.

Go to the next slide. So that's sort of the keeping people - asking people to stay home. The other thing we can recommend that people can do is to conduct daily health checks to look for people who come in ill or actually become ill during the day, and have recommended that childcare providers; observe their children and their staff; talk with parents and children when they come in in the morning, find out about any signs or symptoms of illness, find out if they've recently been to a medical visit for something flu-like; and to look for any sorts of changes in behavior and signs and symptoms that they can see themselves.

They can also do the same sort of thing throughout the day by identifying children and other staff people who might be ill. And so some simple, simple sorts of screening, basically by taking a temperature and just inquiring about the symptoms in order to really sort of help - again, anything we can do to separate well from sick folks that can help us reduce the risk for transmission.

Speaking of separating, let's go to the next slide. So the next slide talks about the - the - the - the recommendations about how to separate people who are ill in the childcare setting. And it's important to promptly separate children or staff who become ill from others until they can be sent home. With the goal being to get them sent home as quickly as possible, both for the children and the staff.

Ill children should be moved to a separate space, some place that's comfortable for them to be while they're waiting. And someplace that is going to be continuously supervised. Folks who work in childcare know that we really cannot be taking a sick child and sticking them someplace without adult supervision.

We can't ask this of children, at this age particularly, but staff members who develop a flu-like illness while they're at work should wear a surgical mask when they're in close contact with others until they are able to leave their work setting. It's a lot harder to get that - to do that with children under 5. But we can ask staff to do that. And the staff who provide care for ill people should be using appropriate personal protective equipment as well, you know, for example a surgical mask for themselves.

Next slide. The next slide talks about hand hygiene and respiratory etiquette. This is very consistent across all of our guidance documents. We're talking

about the basics of; washing hands frequently with soap and water, when that's not possible, using an alcohol based hand rub; keeping hands away from your nose mouth and eyes; covering noses and mouths with a tissue when coughing or sneezing, or using your shirt sleeve or elbow if a tissue is not available.

And of course the added bonus here is that you're talking about children who have emerging self-care skills in addition to the staff and the older children. And so a lot of these things are - must be assisted in this age group. You can't just sort of ask people to do, you've really got to not only provide the supplies, but really help kids wash their hands properly as well as teach them about respiratory etiquette. So routine cleaning.

A lot of places, in schools in particular, have taken cleaning to a level that is probably not necessary when dealing with influenza virus. And so our recommendations include the strategy of regularly and frequently cleaning items and areas that are likely to have frequent contact with hands - face, hands, mouths and bodily fluids of young children.

But this is something that is basically just sort of the routine cleaning process. You can use the cleaning agents that are normally used in these settings. And there's no need to do things like closing down the building and fumigating, you can just use sort of standard cleaning and disinfecting procedures that are appropriate that are regulated in many places, in many states for a childcare setting.

The next slide talks about early treatment for high-risk students and staff. And again, antivirals and treatment are slightly outside of community measures for prevention, but so critical that we have included it here. That the childcare providers can encourage their parents and staff to talk with their healthcare

providers, first of all to determine if they're - they or the members of their family are at high risk for flu complications.

Beth read off a - the long list of conditions that can place someone at higher risk. Not everybody really understands that they might be in one of those high-risk groups. So it's important for people to know before they become ill if they might be in one of those high-risk groups.

And then the childcare provider can also encourage staff, or parents of their high-risk children who do become ill to call their healthcare provider as soon as possible to determine if they need antiviral treatment. We've said call, and if you're looking at the slides it's underlined, because we're really encouraging people not to rush into their doctor's offices, but to actually call and discuss whether or not this is something that they need to do first.

Given that antiviral, when used within the first two days after becoming ill (unintelligible) have a significant impact on the severity of complications, we'd really like to encourage people to be talking to their healthcare provider about antiviral treatment early. And childcare providers who know that their - the child is out, or a staff person is out can play a really important (unintelligible) encouraging people to do that.

The last strategy in the currently recommended list is for selective early childhood program closures. If flu transmission is high in a community, and that community or the childcare program perhaps, has the goal of decreasing the spread of flu among children less than five years of age, they might want to consider selectively closing early childhood programs. We are not recommending this overall at this time period, but it's something that might be considered at the local level. And it's something that should be decided in partnership with public health officials.

And again, really working on a balance of the risks of keeping children in these programs, with the social and economic disruptions of - that are going to result if you close these programs and the parents who work and don't have any place to put their children for childcare for some period of time. Again this might be something that's more important or more critical for programs that have large percentages of children who are at extremely high-risk and medically fragile children to consider.

So on the next slide we start talking about - a little bit about the strategies to consider adding for increased severity. And I'm not going to go into each of these in detail since we - we're not talking about recommending these right now. But just to give you a heads up of what might be possibilities for communities to consider adding.

The First is to permit high-risk staff to stay home when flu's widespread in the community and if it's a much more severe flu virus, that's something we might - communities might want to think about is letting people who are at high risk not be in a setting like this where there are a lot of children potentially passing a virus back and forth.

Something that's particularly difficult to do in most cases, but increasing the social distance between children. There are things we can do like decreasing the number of kids in the classroom, that can increase the space between children. And that's something that very much needs to be decided on a - using a lot of creativity at the local level.

The Third option, again which we are not recommending now, but is basically a voluntary quarantine recommendation to encourage children who have ill household members to stay home. So that would be for a short period of time,

perhaps five days, to try to keep the transmission from leaving that household. We could also talk about extending the time that ill people stay home so that it covers much more of that potentially contagious period; so not all, but something more.

And then the Final one is early childhood program closures. And I have two more slides to talk about that in a little bit more detail. There are essentially two different ways that you can talk about - or two different reasons you can talk about closing - temporarily closing early childhood programs.

The First is really reactive. We're seeing a lot of this now, particularly around schools. But basically when normal functioning just cannot be maintained any longer; you've got a lot of staff out, you've got a lot of kids out, and you just can't keep functioning, it might make sense to just ride out that wave at home and to close down the program for probably about a week to get through that.

The Second reason is really a pre-emptive closure. And this is something that we might recommend in order to decrease the spread of flu. This is something that needs to be done early if we really want to have an impact. And again, we would not be talking about this without an increased severity in the illness that we're seeing.

The length of the closure is really going to vary - would really vary depending on the reason and the illness severity. And just wanted to also point out that it is not really necessary to do any kind of additional disinfection of the property while closed for either of these reasons.

Given that it isn't - it is a possibility that some communities may want to look at, it's important now actually to encourage parents to develop alternative childcare plans; to think about what they would do if their program was closed

for a week or two weeks or longer, in order to maintain their jobs and provide care for their children. Not something that most of us spend a lot of time thinking about. So it's something that childcare programs and healthcare providers can really talk to parents about now.

And then, communities overall, in particular I'm thinking health departments, education agencies, others, can really be planning now for how they would address the possible secondary effects of closing childcare programs.

That we're talking even critical infrastructure; whether or not you have enough firefighters and police or you know folks are able to staff the hospitals if they don't have access to their childcare programs, potential impacts on parent's job security and income, as well as the sustainability of childcare programs and other things that need to be considered.

So the next slide. We've included, I think I said earlier, some materials in the guidance about decision making. Just a couple of key points that I wanted to bring out now; the First is that it's really important to think about using multiple strategies together. None of these are going to be perfectly effective by themselves, and they get stronger when you use them together.

It's also important to do whatever you can early. And to target groups that are at higher risk whenever possible. We'd like to see decisions made based on local information as well as what we're talking about in terms of severity and spread at the national level, and for decisions to be made collaboratively. And those decisions really do need to balance individual benefits as well as the common good.

You need to be thinking about whether or not your purpose is to try to reduce community transmission overall of flu, or try to reduce the spread within the

childcare program, or to protect people at highest risk. And it's important to plan early and to reduce adverse consequences or nothing you do is likely to work if the adverse consequences are too large.

There are many different groups who can play a role both as decision makers and as stakeholders, depending on the community and depending on the setting. And it's important to ask yourself whether or not everybody who needs to be involved is involved in making these decisions.

There's also roles, if you turn to the next slide, that variates of these groups can provide in - or can fill in providing certain kinds of information that is necessary to make decisions on. State and local health officials have important information which they can hopefully share with other decision makers about the extent and severity of flu-like illness in their community.

But early childhood programs also have information that they might be able to put together and share with their state and local decision makers about what's happening in their programs, what's the impact on their programs of the flu. So for example, looking at their absenteeism, that might be information they can share with their local and state decision makers to help everyone get the best handle on the right strategies to use.

Next slide. Two other questions to think about in terms of making decisions; the First would be sort of the feasibility of things, "Does the state or community have the resources to implement the strategies being considered?" The basic things need to think about in terms of whether or not the strategies are appropriate for the community.

And then also whether or not the community is going to accept the strategies and actually implement them as you'd like or whether or not the challenges to

implementing the strategies might become too much for them to be effective. These are the kinds of things that are included in the decision making guidance.

And you know, I think the last slide of mine is sort of the Web site, because I know that this is a whirlwind tour through the guidance. Again, you can get the guidance document, the technical report and the communication toolkit in English, in Spanish and I think also in one or two other languages, on www.flu.gov, and also on the www.cdc.gov/h1n1flu Web site.

And I will turn it back over to Alycia for questions.

Alycia Downs: All right, thank you. We can go ahead and open up the line for the question and answer session. And just as a reminder, we do have subject matter experts on antivirals and H1N1 vaccine with us here today.

Coordinator: Thank you. We'll now begin the question and answer session. If you would like to ask a question please press star 1, un-mute your phone, and record your name clearly when prompted. I will require your name to introduce your question. If you need to withdraw your question, press star 2.

Again, to ask a question please press star 1 and record your name. It will take a few moments for the questions to register, please stand by. Thank you, our first question comes. Go ahead, your line is open.

Question: Yes, my question has to do with the prescribing information regarding the vaccines that are going to be used. Are - is that information available regarding - because some of - it's very much the concern of many people regarding the incidence of adverse effects, et cetera, so I wanted to know if the prescribing information was available?

Suchita Lorick: Thanks for your question. Just to clarify, did you mean the FDA package insert?

Question cont'd: Yes I did.

Suchita Lorick: Yeah, those are available on the FDA Web site. And I don't have a direct link for you, but if you go to the FDA Web site, they should be readily available for all the four licensed H1N1 vaccines.

Question cont'd: Thank you.

Suchita Lorick: Sure.

Coordinator: Thank you, the next question. Go ahead, your line is open.

Question: Hi. I have a question about the wording of the recommendations about cleaning. The wording in the document talks only about cleaning - like routine cleaning, it doesn't talk about disinfection. And you did mention in your verbal presentation that many states have requirements about cleaning and disinfecting. But just using the word cleaning makes it sound like cleaning up body fluids is adequate just using soap and water, rather than using the regular cleaning and sanitizing or disinfecting process that many...

((Crosstalk))

Lisa Barrios: ...it's just a - it's a complex issue. And you're right, there are lots of permutations and there are lots of different state regulations and requirements for various different settings -- schools and childcare and others. We're going to try to put out some more information and tools that can help people really

sort of break that down for - to really help understand the difference between cleaning and disinfecting and sanitizing and what is appropriate and what is not.

Question cont'd: Great, and may I ask another question? Just about the recommendation for checking temperatures in children who appear to be ill; I'm just wondering do you have a recommendation on how to check temperatures?

Lisa Barrios: The guidance has a link to a document on conducting the sort of daily checks. That provides very detailed sort of a checklist description on the process for those doing those daily health checks. I can't tell you the link right off the top of my head, but it's in the guidance of the technical report in that section.

Question cont'd: Okay, actually I did read through that. I don't remember seeing anything about physically how to check temperatures. We've gotten that question because I am actually a pediatrician and know how difficult it is sometimes to get an accurate temperature on a young child; rectal temperatures aren't allowed, the ear temperatures are very unreliable as are probably the skin temperatures.

We used to always do axillary and then add a degree. But if you're really concerned about 100 degrees exactly, it's kind of difficult to get a real accurate temperature reading that way. So I just was wondering if you had any specific recommendations.

Lisa Barrios: No. We do use the word orally, but recognizing that people will be taking the temperature in a variety of different ways.

Question cont'd: All right, thank you.

Suchita Lorick: Hi, this is Suchita Lorick again. I just wanted to follow up on that first question about vaccine safety. I wanted to make sure that folks are aware; on the CDC Web site we have many documents related to vaccine safety and the plans for vaccine safety monitoring. So those can definitely assist you in trying to get that message across to your patients or other partners that you need.

Coordinator: Thank you, the next question. Go ahead, your line is open.

Question: Hi. I'm a pediatrician also. In the presentation that you gave, you talked about the vaccine priorities and the slide and what you said are a little bit discordant, because I agree with what you said which is that child care personnel should be among the priority group for the vaccine, but that is not - they are not listed unless they are caring for children less than 6 months of age.

However, because of the frequency of transmission of infection between childcare and the community and among childcare personnel and their families and across childcare in general, it seems sensible to me that they would be considered those who are between 25 and 64 years of age, should - and in childcare, should be considered a priority. But can you clarify if you slip that in, childcare personnel should be encouraged. Did you intend to widen them - widen the priority groups to include all childcare personnel?

Suchita Lorick: Hi, this is Suchita Lorick again. The ACIP, the Advisory Committee on Immunization Practices, when they reviewed the EpiData for influenza, for H1N1, they did come up with these five target groups. And you're right, daycare providers for children younger than 6 months were among the target groups, but they did not specify all daycare providers for older kids in there. So unless the daycare provider is 24 or less, they wouldn't be in one of the target groups.

But we expect that, you know, there'll be plenty of vaccine for people who want it. So I think we can get all those folks covered once vaccine is available.

And really these target groups are just to help folks make decisions but, you know, if a facility or if a provider and patient - if let's say a older daycare provider shows up in a doctor's office and says, "I'd like to get a vaccine," but they don't fit any of the target groups, I think you know, individually the provider and patient can come to a decision based on where we are in the vaccination season.

And I think if the provider feels that, you know, this person may not come back to the office and it's a missed opportunity, then we would certainly hope that the vaccine would be given. But you're right, it's not specifically there in the target groups.

Question cont'd: Yeah, and really it's not a very sensible way of going about, you know, trying to get vaccine out to this group anyway. It would be much more sensible to try to take vaccine out to the childcare provider site and try to catch those people who are there, most of whom are really going to be in the priority group, either because of their medical risks or because of their ages, including the kids who are 6 months through 24 years, to try to chase them all to their medical homes is going to be...

((Crosstalk))

Suchita Lorick: Right, no. I didn't mean to imply that, but there are actually states, locals, other communities that do plan to target daycare providers and daycare facilities in the manner that you just described.

((Crosstalk))

Suchita Lorick: So varied from place to place, but there are some plans for people to do that.

Question cont'd: Which would be super. And please do clean up the information sanitizing, I was delighted to hear you mention that you were going to do that. When you use disinfecting, which implies a higher level of intent than sanitizing, people begin to think that they have to do something far more rigorous than what we've advised them to do in the past. So I appreciate your plan to clean that up because I (unintelligible) somewhat of a pun out of it.

Beth Stevenson: Yes, absolutely. Create some clarity with that. That's an...

Question cont'd: Thank you.

Beth Stevenson: ...important thing. Thank you.

Alycia Downs: Do we have any other questions? Stacy?

Coordinator: I apologize. One moment please. Okay, I apologize. Your line is open.

Question: Hello can you hear me? Great. A good follow-up to a question on cleaning; I get a lot of questions from schools about the use of hand sanitizers, specifically their concern about kids putting it in their mouth, which is much more of an issue I guess with little kids. How do you address that? And are there some specific hand sanitizers that you recommend over others?

Beth Stevenson: I don't know if Lisa's on the phone; we had a person walk out who's on a mobile phone, but I can answer that. And in general the hand washing issue - the primary message is to - is really for use of soap and water and to sort of do

regular hand cleaning in that way. That's kind of the emphasis point within the guidance.

And we know a lot of people talk in terms of hand sanitizers. We do not have recommendations of hand sanitizers, I know that we talk about alcohol base, but we recognize there are some issues. So our primary though in terms of - it's actually a fairly complex subject, and a lot of research being done in terms of sanitizing hands and different kinds of ways and reasons for that.

But the primary emphasis we've been trying to place is on, you know, just hand washing with soap and water. Hand sanitizers, we talk about alcohol base, but we also recognize that, you know, people may use others. We tend to try to place the emphasis - until more data emerges, we can't recommend one type over another exactly. We'd rather, sort of emphasize the soap and water which we know has some efficacy.

Question cont'd: Thank you.

Coordinator: Thank you, the next question. Go ahead, your line is open.

Question: Yes, my question is if a patient has tested positive for, you know, the H1N1, if they should still receive the vaccine?

Suchita Lorick: That's a great question. So the current recommendation from the CDC is that unless the patient was tested using a RTPCR test, that's the only definitive test that can tell us if they had H1N1, then they should go ahead and get vaccinated.

Because there's a lot of office space tests that people use that have different sensitivities. So we can't always be sure and there's, you know, seasonal virus

- seasonal influenza could be floating around. So I think the safest thing to do is, unless it was confirmed by RTPCR, then the patient should be recommended to get a vaccine.

Question cont'd: Okay, thank you.

Coordinator: Thank you, the next question. Go ahead, your line is open.

Question: My question is again around safety for children receiving the vaccine, and is there a more simple response for parents who are afraid it's not safe? You know, other than sending them to all of the drug literature?

Suchita Lorick: I think the simple response that you could try is that this H1N1 vaccine is being produced in the same manner that seasonal vaccines are produced. And you know, hopefully these are parents that might have gotten seasonal vaccines in the past and you can try to rely on that.

But these H1N1 vaccines are being produced the same way, and there's a lot of safety monitoring going on. So if there's anything that's notice there's people at, you know, CDC, HHS and several other partners who're working on monitoring safety, and we expect that the side effect profile would be the same as the seasonal vaccines. But that's something that you can try.

Question cont'd: (Unintelligible). Thank you.

Coordinator: Thank you, and the next question - excuse me. Go ahead, your line is open.

((Crosstalk))

Coordinator: Yes, we can hear you.

Question: I - could we just do a little more in depth about safety for children. We've had questions from parents who have read that there has not been any clinical trials on young children, and so therefore that's right where their question goes. Is there any way to address that?

Suchita Lorick: And actually, as you probably know, there are clinical trials that have been done, and are sort of finishing up, on kids. And there have been no red flags that have been noticed. That (unintelligible) profile looks to be the same as seasonal vaccines. And I'm probably guessing that NIH will probably release some of those data shortly, once the trials are completed and the data are looked at, so that pediatricians and other providers can use those data for those parents that would like to see some of that.

Question cont'd: Okay, thank you very much.

Coordinator: Thank you, our next question. Go ahead, your line is open.

Question: Hi. My question is; is the vaccine, the H1N1 a live virus?

Woman: So there's two different kinds of H1N1 vaccine just like seasonal H - seasonal influenza vaccines. There's one that's live attenuated; that means it's a weakened virus, so there's - that's the LAIV, that's what you might see it as. And then there's the inactivated, which is the shot in the arm. So just like seasonal, there is the live one that goes in the nose, and then a shot that goes in the arm for H1N1.

Question cont'd: Oh, thank you.

Coordinator: Thank you, the next question. Go ahead, your line is open.

Question: Yes, hi. And this ties right into the live virus question; I work in healthcare, work on a pediatric and work on NICU. And as well as you can refer to daycare, is those that are under 6 months of age, especially in our (unintelligible) we as healthcare providers are not instructed or are allowed to have anyone that's had the mist come into our unit for seven days after.

So, any of our healthcare workers cannot get the mist. But you're recommending the mist, is that something okay for - if you're caring for those under 6 months of age, for the providers in these daycare centers?

Suchita Lorick: For the daycare centers, yes, that's definitely okay. The LAIV, the mist, is contra-indicated, or not - sorry, not contra-indicated, but it is not recommended for people who are close contacts or healthcare workers who work with severely immunocompromised patients, so like your bone marrow transplant patients, and that's the only group that that would apply to. So in the daycare setting, that should be fine.

Question cont'd: Okay. I just have concern with it being, you know, (unintelligible) and the 6 month olds had not protection (unintelligible). Those who work in centers that care for compromised children at these centers, so that was - I know in our NICU at our hospital we are not allowing anyone to come in that has been, within the last seven days.

Suchita Lorick: Right, and actually, in the, you know, official guidance that ACIP puts out, NICUs are not mentioned, but you know...

Question cont'd: Right.

Suchita Lorick: ...that's something we can try to clarify and put up on our Web site if that's a concern elsewhere. But the only group, like I said, is the severely immunocompromised person.

Question cont'd: Thank you.

Alycia Downs: Well I would like to thank our presenters for providing our listeners with this information. I'd also like to thank our participants for joining us today. In case you didn't get the chance to ask your question, please send an email to coca@cdc.gov -- that email address is coca@cdc.gov, C-O-C-A@cdc.gov -- and we will do our best to get a response back to you.

The recording of this call, and the transcript, will be posted to the COCA Web site at emergency.cdc.gov/coca -- again that's emergency.cdc.gov/coca -- within the next week.

You have one year to obtain continuing education for this call. All continuing education credits and contact hours for COCA conference calls are issued online through the CDC training and continuing education online system.

Thanks again for all of our presenters for sharing this information with us. And I hope everyone has a wonderful day.

Coordinator: And that does conclude today's conference. Thank you for participating. You may disconnect at this time.

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