APR 26 2012

MEMORANDUM OF AGREEMENT
On
Policy for Influenza Immunization of Civilian Health Care Personnel (HCP) Who Provide Direct Patient Care or HCP Who Routinely Work in Military Treatment Facility (MTF) Common Areas

REFERENCES:

1) Assistant Secretary of Defense for Health Affairs Memorandum, HA Policy 08-005, dated 4 April 2008.
2) Air Force 2011-2012 Influenza Immunization Program Guidance, dated 25 July 2011.
3) Air Force Joint Instruction 48-110, Immunizations and Chemoprophylaxis, dated 29 September 2006.
4) 29 CFR 1605, Guidelines on Discrimination Because of Religion.

1. The American Federation of Government Employees (AFGE) Council 214 and Air Force Materiel Command (AFMC), hereafter referred to as the Union and Management, hereby enter into this Memorandum of Agreement (MOA) regarding subject policy as it applies to bargaining unit employees covered by the Master Labor Agreement (MLA) between the parties.

2. HA Policy 08-005 (Attachment 1) directs all civilian health care personnel who provide direct patient care in Department of Defense MTFs to be immunized against seasonal influenza infection each year as a condition of employment, unless there is a documented medical or religious reason not to be immunized. This policy will therefore be implemented consistent with the provisions outlined below.

3. Air Force 2011-12 Influenza Immunization Program Guidance (Attachment 2) further defines civilian HCP who provide direct patient care to include workers whose daily activities include contact with patients or involve work in common areas or clinic/hospital rooms where patients are likely to be present (e.g. clerical staff, food service personnel, and cleaning or janitorial staff). A listing of job series covered by this MOA is at Attachment 3. HCP personnel in these job series are covered only if they have routine contact or work in common areas with patients.

4. Medical and religious/spiritual exemptions will be handled in accordance with AFJI 48-110, and as further defined by this MOA. Religious/spiritual is defined as moral and ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views.

    a. Civilian HCP with a medical contraindication to the seasonal influenza vaccine will provide a signed note from their healthcare provider to the MTF Employee Health point of contact. The note will identify the underlying health condition

and the duration of the exemption (up to 365 days for a condition that is expected to resolve or permanent).

b. Civilian HCP will submit a signed religious/spiritual exemption request to their supervisor. The request should include details as to the source of the individual's religious/spiritual objection to the seasonal influenza vaccine. Such requests will be processed in accordance with 29 CFR 1605. The MTF Commander serves as the final approval and revocation authority for such immunization exemptions.

5. Civilian HCP without an exemption, who refuse to take the immunization will be handled on a case by case basis and may also be subject to measures to prevent the spread of the virus to include, wearing a face mask, relocation and/or changes in work assignments or work schedules. Management and the Union mutually embrace the goal of minimizing the spread of influenza in MTFs. To meet the need, flu shots will be made available to all HCPs on a priority basis. Employees may also choose between injectable and intranasal influenza vaccines as medically appropriate and available. Employees, who wish, may choose to get inoculated through private sources at their own expense and will provide required documentation of the same to the MTF Employee Health point of contact within 3 business days.

6. Further, in an effort to mitigate any seasonal flu outbreaks, employees will notify their supervisor as soon as possible if flu symptoms develop.

7. All remedies available under the MLA or 5 U.S.C. 71 will remain available to the parties if concerns cannot be cooperatively resolved.

FOR MANAGEMENT

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Colonel, USAF, DC
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FOR THE UNION

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Attachments:
1. Assistant Secretary of Defense for Health Affairs Memorandum, HA Policy 08-005, dated 4 April 2008.

2. Air Force 2011-2012 Influenza Immunization Program Guidance, dated 25 July 2011.

3. List of Occupational Series/Positions Subject to Mandatory Influenza Vaccinations

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THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR - 4 2008

MEMORANDUM FOR GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)
DIRECTOR, JOINT STAFF

SUBJECT: Policy for Mandatory Seasonal Influenza Immunization for Civilian Health Care Personnel Who Provide Direct Patient Care in Department of Defense Military Treatment Facilities

Society expects health care personnel to "do no harm" to the patients they treat and serve. I expect no less, and ensuring patient safety in our health care facilities is a top priority for the Military Health System (MHS). Minimizing the transmission of infections between health care personnel and patients is a major part of this effort. Historically, the MHS has followed national recommendations to minimize such transmissions. In some instances, specific immunization or proof of immunity has been made a condition of employment (e.g., measles and rubella).

Each year, influenza infections are a problem for all of us, especially during the late fall and winter. The severity of the influenza season varies from year to year. It is not possible to predict the severity of an influenza season in advance, just as it is not possible to predict when an influenza pandemic will occur. The Centers for Disease Control and Prevention (CDC) reports that influenza is responsible for more than 200,000 excess hospitalizations and about 40,000 deaths each year in the United States. Many of these cases are preventable by immunization with the seasonal influenza vaccine.

Each year, the Advisory Committee on Immunization Practices (ACIP) and CDC recommend seasonal influenza immunization for health care personnel (HCP) as a priority (Morbidity and Mortality Weekly Report, Prevention and Control of Influenza, June 29, 2007, *www.cdc.gov/mmwr/weekcvol.html*). Recent surveys show that compliance with this recommendation for HCP is only about 40 percent nationwide. Influenza immunization benefits the individual worker at the same time it benefits our patients. In addition to reducing the risk of HCP-to-patient transmission of influenza, studies show that immunization also results in reduced infections and fewer lost days of work among HCP.

HA POLICY: 08-005

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In December 2005, the Armed Forces Epidemiological Board sent a letter to the Assistant Secretary of Defense (Health Affairs) advocating mandatory influenza vaccination of all Department of Defense (DoD) HCP directly involved in providing patient care in the MHS. Currently, all military HCP are required to be immunized against influenza annually as part of DoD's annual mandatory Active Duty influenza immunization policy. In previous years, influenza immunization was highly recommended (but not mandatory) for our civilian HCP, consistent with CDC, ACIP, and Healthcare Infection Control Practices Advisory Committee recommendations. This recommendation will continue for HCP who are not involved with direct patient care.

I direct every DoD military treatment facility (MTF) to require all civilian HCP who provide direct patient care in DoD MTFs be immunized against seasonal influenza infection each year as a condition of employment, unless there is a documented medical or religious reason not to be immunized. I am directing this to minimize the risk of influenza transmission within the military health care setting and maximize personal protection from infection. This policy will help to reduce potential outbreaks of influenza that could adversely affect military preparedness and medical care. It applies to all DoD MTF settings, regardless of age or gender of the health care provider, and includes Federal personnel, contract personnel consistent with the terms of their contracts, and volunteers. The MHS will provide influenza vaccines used for Federal employees and volunteers covered by this policy. HCP may choose between injectable and intranasal influenza vaccines as medically appropriate and available.

During the influenza season, all MTFs should institute heightened febrile illness surveillance of patients and HCPs. All HCP with febrile illnesses should not be allowed to work until afebrile and medically cleared. MTFs should enforce standard and droplet precautions for infected individuals and respiratory hygiene and cough etiquette by all.

Local bargaining obligations will need to be satisfied prior to full implementation of this policy. Therefore, local management must fulfill applicable labor relations obligations under the Federal Service Labor-Management Relations statute before implementing any changes to conditions of employment of bargaining unit employees represented by a union. Contact your servicing labor relations professional for additional guidance on these matters. This requirement should be included when establishing new civilian positions, awarding new contracts, and renegotiating existing collective bargaining agreements and contracts. Full implementation should be attained by the 2009-2010 influenza season. Until local bargaining obligations have been met, influenza immunization will continue to be highly recommended on a voluntary basis for HCP not covered under the mandatory immunization program. All MTFs should institute a comprehensive, aggressive HCP influenza immunization education program to achieve high immunization rates among HCP.

For HCP working under contract to any component of the DoD, influenza immunization may be provided by the MTF, according to terms of the contract. Otherwise, contractors will provide influenza immunization to their employees. The contractor is responsible for work-related illnesses, injuries, or disabilities under worker-compensation programs, supplemented by existing Secretarial designee authority as appropriate. Contracted health care personnel are eligible for influenza immunization provided by the MTF, if stated in the contract agreement.

Services will ensure that all immunizations or exemptions are documented in the worker's health record and recorded in the Service's immunization tracking system, as appropriate. In addition, Services will monitor the immunization coverage rate for HCP in their MTFs, and provide to my office an annual Service-wide consolidated report no later than May 1, 2008, beginning with the 2009-2010 influenza season.

My point of contact is Dr. Benedict Diniega. He may be reached by telephone at (703) 681–1703 or by e-mail at *Benedict.Diniega@ha.osd.mil.*

S. Ward Casscells, MD

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force
Deputy Director, TRICARE Management Activity
Joint Staff Surgeon
Director, Health Service, U.S. Marine Corps HQ
Director of Health and Safety, U.S. Coast Guard
Director, Civilian Personnel Management Service, OSD
Director, Military Vaccine Agency
Defense Supply Center Philadelphia (Attn: Chief, Pharmaceuticals)

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

JUL 25 2011

MEMORANDUM FOR ALMAJCOM/SG

FROM: HQ USAF/SG3
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Air Force 2011-2012 Influenza Immunization Program Guidance

This memo and attached guidance provide implementation instructions for the 2011-12 influenza immunization programs, supplementing AFJI 48-110, Immunizations and Chemoprophylaxis. A new section in the guidance addresses the new Tricare benefit and how it affects those in uniform.

Air Force medical staff will administer influenza vaccines to all military members in accordance with AFJI 48-110 and offer vaccines to eligible beneficiaries as appropriate. The success of this year's influenza program will require earliest possible administration of seasonal influenza vaccine as supplies become available. Do not hold onto vaccine with the intent to vaccinate only during a mass vaccination clinic. MTF staff must ensure vaccination of all mission critical military personnel and high-risk beneficiaries. Civilian health care personnel are required to receive influenza immunization annually. (per ASD(HA) memo, 4 Apr 08).

Immunization personnel and healthcare providers should review the most recent Advisory Committee on Immunization Practices (ACIP) recommendations for updates and changes. MTF leadership should work to improve vaccination coverage and remove barriers to influenza vaccination. While maintaining the high level of influenza vaccine coverage previously achieved for military members, medical staff and commanders should develop programs to target beneficiaries who are at increased risk for influenza-related complications.

My POC for this memorandum is Col Philip Gould, AFMSA/SG3PM, 1780 Air Force Pentagon, Washington, DC 20330-1780, (703) 588-6470, DSN 425-6470, or e-mail: philip.gould@pentagon.af.mil.

James D. Collier

JAMES D. COLLIER
Colonel, USAF, MC, CFS
Assistant Surgeon General, Health Care Operations
Office of the Surgeon General

Attachment:
Air Force 2011-2012 Influenza Immunization Program Guidance

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

Air Force 2011-2012 Influenza Immunization Program Guidance

1. Purpose

This message provides Air Force guidance for influenza vaccination programs. Request dissemination of this message to all military treatment facilities (MTFs), MTF/CCs, immunization point of service/clinics, public health offices, pharmacy services, medical logistic/supply sections, and primary care managers.

2. Influenza

a. Seasonal influenza epidemics occur annually in the United States. Estimates of influenza-related events include 95 million infections, 25 million physician visits, 200,000 hospitalizations, and on average, 36,000 deaths annually in the United States.
b. Influenza also contributes to cardiac events, premature births, and low birth weight infants.
c. Immunization is the key to seasonal influenza prevention. Influenza vaccine can reduce the risk of cardiac events in persons with cardiac risk factors, as well as the incidence of premature or low birth weight infants.
d. The Advisory Committee on Immunizations Practices has issued a **universal recommendation for influenza for all adults and children older than 6 months of age.** High risk groups should be targeted for immunization, but immunizing healthy persons is also recommended.

3. Current Seasonal Influenza Virus Vaccines and Their Availability

a. **Do not use leftover vaccines from last year's influenza immunization program for this year's program.** Many of the preventable vaccine administration errors came from using outdated vaccine.
b. Both the inactivated and live, attenuated vaccines prepared for the 2011-2012 season include an A/California/7/2009 (H1N1)–like virus, an A/Perth/16/2009 (H3N2)–like virus, and a B/Brisbane/60/2008-like virus (this formulation is unchanged from last year).
c. Influenza viruses for both Trivalent Inactivated Influenza Vaccine (TIV) and Live Attenuated Influenza Vaccine (LAIV) are grown in embyonated chicken eggs and might contain limited amounts of residual egg protein. Persons with a history of severe hypersensitivity to eggs, such as anaphylaxis, should not receive influenza vaccine. Mild allergic reactions are not a contraindication, and may be mitigated with premedication with allergy medications.

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d. Anticipated timelines for TIV and LAIV from Defense Logistics Agency – Troop Support (DLA-TS) (as of 12 July 2010) are:

Date (2010)	Percent Complete TIV (vials and 0.5ml prefilled)	Percent Complete LAIV (FluMist®)	Percent Complete Peds TIV
Aug 31	70% +	35%	
Sept 30	30%	25%	25%
Oct 31	--	30%	75%
Nov 30		10%	

While prefilled pediatric formulation will be slow to release based on the contract, if the patient is high risk, the vial formulation (which contains thimerosal) could be used. However, the prefilled vaccine was ordered specifically for children less than 36 months of age.

e. A new high-dose formulation of the seasonal influenza vaccine exists (FluZone High Dose), but has only a permissive recommendation (i.e. you can use it, but it is not recommended more than other vaccines) for adults over 65 years of age. **However, FluZone High Dose remains unavailable through the usual DSCP influenza vaccine purchase contracts. Direct vendor delivery (through the use of the Impact card) may be an option. The Tricare network benefit (section 4) does cover the High Dose formulation.**

f. As there are various influenza vaccine products available this season, it is imperative that utmost care and attention is devoted to providing correct immunizations based on age and medical conditions and that recording of immunizations given is accurate.

g. Air Force Medical Logistics (AFMLO) is responsible for ordering and distributing influenza vaccine for AFMS activities. AFMLO will notify units of the quantities ordered and the document numbers being used. Additional quantities required must be coordinated with AFMOA/SG3SLC, DSN: 343-4170, commercial (301) 619-4170. AFMLO website is: https://medlog.detrick.af.mil/index.cfm

4. Tricare Influenza Vaccine Benefit:

Tricare Prime is continuing its reimbursement program for influenza and pneumococcal vaccines only.

a. Active Duty Air Force and Air Reserve Component personnel on full-time military status located on an installation with an MTF. **To ensure conservation of resources and to ensure compliance with the requirement for uniformed personnel to be vaccinated against influenza, all Active Duty Air Force and Air Reserve Component personnel on full-time military status located on an installation with an MTF must receive their vaccines through the MTF.**

b. Air Force service members who are not located on an installation with an MTF (and are considered to be geographically separated based on local determination) or those members in part-time military status (ARC members) should follow local or MAJCOM policy for receiving their vaccination.

c. Documentation if influenza vaccine received outside an MTF. IAW the ASD(HA) memo for the 2011-2012 season, if service members receive their influenza vaccination through non-military facilities, commanders must ensure service members provide vaccination records to an MTF immunization clinic (preferably an Air Force immunization clinic) within 24 hours, for

documentation in an approved immunization tracking system IAW AFJI 48-110. This will ensure completed vaccinations are captured in their unit's Individual Medical Readiness rates.

d. Planning for 2012-2013 season: This benefit will reduce the numbers of beneficiaries who will choose the MTF for their influenza vaccine. Last year, approximately 90,000 AF beneficiaries used the benefit. Whether these individuals had previously used the MTF for their influenza vaccine is not yet known, but should be inferred unless local data suggests that there has not been a decrease in usage.
e. Additional information on the benefit: The Tricare Additional information is available at http://www.tricare.mil/mybenefit/jsp/Medical/IsItCovered.do?kw=Flu+Vaccine.

5. Timing of Annual Influenza Immunization

a. Antibodies sufficient to achieve protection against influenza infection usually develop within two weeks of vaccination and last six to nine months.
b. **Influenza vaccinations should begin as early in the season as is possible. Begin immunizing as soon as vaccine becomes available. Although mass immunization programs can be efficient, withholding immunizations until such time as there is sufficient vaccine for such a campaign leads to delays in immunization and contributes to patient dissatisfaction and confusion.**
c. Influenza activity usually peaks in the United States between late December and early March. Vaccination of susceptible individuals (especially new accessions) into the summer months with un-expired vaccine may be beneficial as influenza infections occur throughout the year.
d. No prioritization is necessary when production and projected distribution schedules allow for sufficient supply of influenza vaccine.
e. Vaccination of all military members should be completed within one month of receipt of sufficient vaccine supplies. Every effort should be made to exceed a goal of 90% of AD vaccinated by Dec 1, 2011. FluMist is the preferred immunization for new accessions, but both injectable vaccine and FluMist may be administered to military members. National supply and epidemic levels may restrict vaccine availability.
f. Flying/Special Duty populations: in a study comparing rates of Duties Not Involving Flying (DNIF) among rated AF aircrew who had received either LAIV or TIV, LAIV (FluMist®) was found to have equivalent DNIF rates in the week post-immunization as injectable (relative risk of 0.88 [95% CI 0.73 – 1.06]) (Lowry & Bonnema, personal communication). Given the results of this study, LAIV is an acceptable form and often preferred by patients, even among aircrew or special duty populations. In order to reduce the operational impact, clinics should consider vaccinating only half of an operational unit in the first week and the other half in the next. Also immunizing on Fridays allows for recovery over the weekend and should also help reduce the operational impact.
g. For other beneficiaries: healthy persons 2 to 49 years of age without medical contraindications may be offered FluMist®. Vaccination of these individuals with injectable vaccine should be deferred until the target populations who require TIV have had ample opportunity to receive the vaccine. Pediatric dosage prefilled injectable vaccine should be reserved for the appropriate pediatric populations (6 months to 36 months) that require injectable vaccines.

h. Other Prioritization Plans
   (1) "It is DoD policy that the recommendations for immunization of the Centers for disease Control and Prevention and its Advisory Committee for Immunization Practices shall generally be followed, consistent with requirements and guidance of the Food and Drug Administration and consideration for the unique needs of military settings and exposure risks." DoDD 6205.02E
   (2) In the event of a severe influenza epidemic, extreme vaccine shortage, or unforeseen distribution delays, target populations will be prioritized in accordance with Assistant Secretary of Defense, Health Affairs policy guidance. If necessary, more specific priority alterations will be given at the direction of AFMSA/SG3PM.
   (3) Immunization clinics should make every attempt to comply with state law related to vaccines preserved with Thimerosal. If Thimerosal-free vaccines are not available in local communities that require them, do not withhold immunizations, but obtain consent for immunization. Provide the patient information regarding the local statute, scientific evidence that vaccines containing Thimerosal are safe, and the potential risk of not receiving the vaccine.

i. The CDC's National Center for Immunization and Respiratory Diseases (NCIRD) strongly recommends that providers draw vaccine only at the time of administration to ensure that the cold chain is maintained and that vaccine is not inappropriately exposed to light. **Do not pre-draw doses before they are needed.**

j. Although **pre-drawing vaccine is strongly discouraged**, a limited amount of vaccine may be pre-drawn in a mass immunization setting if the following procedures are followed:
   (1) Only one vaccine type may be administered at the clinic. If more than one vaccine type is to be administered, separate vaccine administration stations must be set up for each vaccine type to prevent medication errors.
   (2) The type of vaccine, lot number, and date of filling must be carefully labeled on **each** syringe, and vaccine should be administered promptly (same day, preferably within the same hour as drawn), and should be kept within the manufacturer's specifications as far as temperature handling before administration.
   (3) Vaccine should not be drawn up in advance of arriving at the clinic site. Because of the lack of data on the stability of vaccine stored in plastic syringes, **the practice of drawing up quantities of vaccine hours or even days before a clinic is not acceptable**.
   (4) Unused pre-drawn vaccine drawn up during a mass immunization clinic **must be discarded.**

k. Deployers or travelers who were not vaccinated during the preceding fall or winter and are deploying/traveling to the Southern Hemisphere during April-September or to the tropics in organized groups any time of the year should receive influenza vaccine prior to travel. Caution: The shelf-lives of FDA-approved influenza vaccines are limited and variable. Follow expiration dates on the package or bottle. Do not use expired vaccines.

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6. **Target Groups and Specific Instructions for Influenza Immunization**

   a. The ACIP now has a **universal recommendation for influenza immunization for all adults and for all children older than 6 months.**
   b. Follow AFJI 48-110 and the most recent ACIP recommendations for high-risk and target populations.
   c. Influenza vaccination should proceed in parallel for military members, medically high-risk individuals, and other target populations.
   d. Pediatric-specific vaccinations should begin as soon as appropriate vaccine is received; do not await acquisition of adult/Service member supplies to begin providing pediatric vaccinations.
   e. **Improve annual influenza vaccination coverage for the following groups**
      (1) Mandatory: All AD and ARC members in accordance with AFJI 48-110.
      (2) Required: All civilian healthcare personnel (HCP) "who provide direct patient care" in DoD MTFs as a condition of employment, unless there is a documented medical or religious reason not to be immunized IAW ASD(HA) Policies. **Healthcare workers who provide direct patient care can reasonably be interpreted to include any worker whose daily activities include contact with patients or involve work in common areas or clinic/hospital rooms where patients are likely to be present (e.g. clerical staff who interact with patients, food service personnel, and cleaning or janitorial staff.)**
      (3) Beneficiaries aged ≥ 65 years. Achieve Healthy People 2020 Target of 90%.
      (4) Persons aged 18 to 64 years. Achieve Healthy People 2020 Target of 80% of all healthy adults aged 18 to 64.
      (5) Persons aged 18 to 64 years with underlying chronic medical conditions. Achieve Healthy People 2020 Target of **90% for high-risk adults** (aged 18-64 years).
      (6) Children aged 6 months to 18 years. Achieve Healthy People 2020 Target of 80% for all children aged 6 months to 18 years.
      (7) Hospitalized patients. Hospitalized patients are often in high risk groups, including beneficiaries aged ≥ 65 years & aged 2-64 years with underlying chronic medical conditions.

7. **ACIP Recommendations for the Prevention and Control of Influenza**

   a. **Target Groups for Vaccination.**

   Influenza vaccine should be provided to all persons who want to reduce the risk of becoming ill with influenza or of transmitting it to others. However, emphasis on providing routine vaccination annually to certain groups at higher risk for influenza infection or complications is advised, including all children aged 6 months--18 years, all persons aged ≥50 years, and other adults at risk for medical complications from influenza or more likely to require medical care should receive influenza vaccine annually. In addition, all persons who live with or care for persons at high risk for influenza-related complications, including contacts of children aged <6 months, should receive influenza vaccine annually. Approximately 83% of the United States population is included in one

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or more of these target groups; however, only 42% of the U.S. population received an influenza vaccination during the 2009-2010 season.

(1) **Children Aged 6 Months--18 Years**
Annual vaccination for all children aged 6 months-18 years is recommended. Annual vaccination of all children aged 6 months-4 years (59 months) and older children with conditions that place them at increased risk for complications from influenza should continue. Children and adolescents at high risk for influenza complications should continue to be a focus of vaccination efforts as providers and programs transition to routinely vaccinating all children.

All children aged 6 months--8 years who have not received vaccination against influenza previously should receive 2 doses of vaccine the first year they are vaccinated. Healthy children aged 2-18 years can receive either LAIV or TIV. Children aged 6-23 months, those aged 2-4 years who have evidence of possible reactive airways disease or who have medical conditions that put them at higher risk for influenza complications should receive TIV.

(2) **Persons at Risk for Medical Complications**
Vaccination to prevent influenza is particularly important for the following persons who are at increased risk for severe complications from influenza, or at higher risk for influenza-associated clinic, emergency department, or hospital visits. When vaccine supply is limited, vaccination efforts should focus on delivering vaccination to these persons:
(a) all children aged 6 months-4 years (59 months);
(b) all persons aged ≥50 years;
(c) children and adolescents (aged 6 months-18 years) who are receiving long-term aspirin therapy and who might be at risk for experiencing Reye syndrome after influenza virus infection;
(d) women who will be pregnant during the influenza season;
(e) adults and children who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological, or metabolic disorders (including diabetes mellitus);
(f) adults and children who have immunosuppression (including immunosuppression caused by medications or by HIV);
(g) adults and children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration; and
(h) residents of nursing homes and other chronic-care facilities.

(3) **Persons Who Live With or Care for Persons at High Risk for Influenza-Related Complications**
To prevent transmission to persons identified above, vaccination with TIV or LAIV (unless contraindicated) also is recommended for the following persons. When vaccine supply is limited, vaccination efforts should focus on delivering vaccination to these persons:

(a) HCP;
(b) healthy household contacts (including children) and caregivers of children aged ≤59 months (i.e., aged <5 years) and adults aged ≥50 years; and
(c) healthy household contacts (including children) and caregivers of persons with medical conditions that put them at higher risk for severe complications from influenza.

b. **Annual vaccination against influenza is recommended for:**

(1) All persons >= 6 months (including healthy children and adults)
(2) Children and adolescents (aged 6 months-18 years) receiving long-term aspirin therapy who therefore might be at risk for experiencing Reye's syndrome after influenza virus infection
(3) Women who are pregnant or will likely be pregnant during the influenza season **(See Note)**
(4) Adults and children who have chronic pulmonary (including asthma), cardiovascular, renal, hepatic, hematological or metabolic disorders (including diabetes mellitus)
(5) Adults and children who have immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus)
(6) Adults and children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or can increase the risk for aspiration
(7) Residents of nursing homes and other chronic-care facilities
(8) All health-care personnel
(9) Healthy household contacts (including children) and caregivers of children aged <5 years and adults aged ≥50 years, with particular emphasis on vaccinating contacts of children < 6 months
(10) Healthy household contact (including children) and caregivers of persons with medical conditions that put them at higher risk for severe complications from influenza
(11) All persons who want to reduce the risk of becoming ill with influenza or of transmitting influenza to others

Note: Inactivated injectable vaccine has a category C indication by the FDA, indicating that the manufacturers have chosen not to submit evidence for safety and efficacy in pregnant women. However, there are numerous studies demonstrating that the inactivated vaccine is safe and effective in pregnant women, and that pregnant women are especially vulnerable to influenza and its secondary complications. **Newer research also shows that receiving the vaccine reduced the incidence of both prematurity and infants born who were small for gestational age by as much as 56% during influenza season (and 40% overall).** (See reference s). Given that the FDA-approved package inserts do not fully reflect the ACIP recommendations, immunization clinics and providers who care for pregnant women should consult with

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pregnant women about the risks and benefits of vaccination before recommending influenza vaccine.) **FluMist®** should not be used in pregnancy.

c. **Rationale for Immunization of Specific Groups**

(1) Persons Infected with HIV. Influenza can result in serious illness. As vaccination with inactivated influenza vaccine can result in the production of protective antibody titers, vaccination will benefit HIV-infected persons, including HIV-infected pregnant women. FluMist® is contraindicated, however, in persons with severely reduced immune competency.

(2) Persons Who Can Transmit Influenza to Those at High Risk
  (a) Health-care workers
  (b) Employees of assisted living and other residences for persons in groups at high risk
  (c) Persons who provide home care to persons in groups at high risk
  (d) Household contacts (especially school-age children) of persons in groups at high risk.
  (e) Household contacts (anyone who spends a significant amount of time in the home) and out-of-home caregivers of children 0-59 months old.
  (f) Healthy persons aged 2-49 years who are close contacts of severely immune-suppressed persons should receive inactivated influenza vaccine (injectable) rather than FluMist®.

(3) Persons Aged 50-64 Years. Vaccination is recommended for all appropriate persons aged 50--64 years. This group has an increased prevalence of undiagnosed high-risk conditions.

(4) Persons with or at risk for cardiovascular disease. Recent studies demonstrate a 50 to 75% reduction in the risk for both primary and secondary cardiac events in persons who receive the influenza immunization compared with those who do not.

(5) Healthy Young Children (6 months through age 18). School-age populations and children who attend daycare are the group most likely to transmit influenza to each other and their family members. Immunizing healthy children helps protect family members who may not be able to be immunized because of immune system problems.

(6) Children aged 6-59 months. This group has a substantially increased risk for influenza-related hospitalizations

(7) The Vaccines for Children (VFC) program was expanded to include additional influenza vaccine coverage as of 1 July 2008.

(8) General Population
  (a) Administer influenza vaccine to any person who wishes to reduce the likelihood of becoming ill with influenza or transmitting influenza to others should they become infected
  (b) Vaccinate persons who provide essential community services to minimize disruption of essential activities during influenza outbreaks.
  (c) Encourage students or other persons in institutional settings (e.g., those who reside in dormitories) to receive vaccine to minimize the disruption of routine activities during epidemics.

(d) Live, attenuated FluMist® should be used whenever not otherwise contraindicated in the healthy, non-pregnant 2-49 year old populations

8. Implementation Strategies to Improve Vaccination Rates.

a. Utilize reminder and recall systems to target beneficiaries at increased risk for complications from influenza.
b. Implement standing orders or standard operating procedures. Examples include:
   (1) Develop pre-written vaccine orders for adults or other high-risk beneficiaries
   (2) Administer influenza vaccine to hospitalized patients prior to discharge, unless there is a contraindication. Consider pneumococcal vaccine administration concurrently.
   (3) Administer inactivated influenza vaccine to pregnant women during routine prenatal care
c. Assess vaccination coverage rates. MTFs should regularly assess their vaccine coverage rates throughout the influenza season and attempt to improve coverage for military members, enrolled infants and children 6 months to 18 years of age, enrolled beneficiaries aged ≥ 50 years and other medically high-risk individuals. Information on vaccine completion rates for certain groups is updated regularly and available at the Air Force Corporate Health Information Processing Service (AFCHIPS) website.
d. Use self-identification questionnaires and clinic posters. Post informational materials in patient care areas, waiting rooms, prenatal and immunization clinics, and other areas likely to target high-risk groups. Appropriate materials are available at: http://www.cdc.gov/flu/
e. Employ other patient-oriented and community-based approaches to reach target populations
f. Use the opportunity to evaluate service member and beneficiary shot records to update other immunizations wherever possible
g. Persons with certain underlying medical conditions will also benefit from pneumococcal vaccination if not previously vaccinated. MTFs should identify eligible individuals and use opportunity during influenza campaign to ensure that these individuals are up-to-date on pneumococcal vaccination in accordance with ACIP recommendations or http://www.cdc.gov/mmwr/preview/mmwrhtml/00047135.htm. The Healthy People 2010 target for one-time pneumococcal vaccination for adults aged ≥ 65 years is 90%.
h. Influenza vaccination for federal civilian employees, foreign nationals or other non-DoD individuals. See AFJI 48-110 for guidance. Contractors must have influenza vaccine requirements specified in their contracts for MTFs to administer the vaccine in the early season.
i. MTFs should ensure communication of plan and local strategies to all involved parties. Public affairs resources are available through CDC at http://www.cdc.gov/flu. Additionally, August is the MHS Immunization Awareness month and several facilities in the DoD will be experimenting with communications tools to improve patient knowledge about immunizations in general.

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9. Documentation:
All vaccinations will be documented in Air Force Complete Immunization Tracking Application (AFCITA). If you have a desktop account for AFCITA or PIMR, your privileges will automatically carry over into the web application. No additional action will be required on your part to gain access to the web app. If you do not have a ASIMS account but require one based on your job duties, please use the following link for access: https://www.asims.afms.mil/webapp/newaccount.aspx.

a. Mass immunization and workplace vaccination campaign planning must consider this requirement for AD, Reserve Component, and DoD beneficiaries (e.g., automated methods on-site or manual lists at vaccination site compiled and used to update AFCITA). The Air Force Corporate Health Information Processing System (AFCHIPS) website provides base-level influenza vaccination completion data throughout influenza season and is available at https://www.afchips.brooks.af.mil/main.htm.
b. Accurate documentation of Flu vaccines given during Flu vaccine programs continues to be a challenge. All influenza immunizations administered will be entered into AFCITA. MTFs are strongly encouraged to utilize the web enabled AFCITA when giving immunizations outside the MTF. Paper "sign-in rosters" are discouraged. **If paper rosters must be utilized, data must be entered into AFCITA within 24 hours.**

10. DoD Contracted Vaccines

a. FluZone High Dose for adults over 65 years of age is **not available through DSCP or the Prime Vendor program. Purchases of this vaccine if there is sufficient demand will be local.** This vaccine was given a permissive recommendation too late for the contracting offices at DSCP to include in this year's request for proposals.
b. Appendix 2 contains useful tables for initial reference.
c. Product inserts for the DoD contracted vaccines are found on the internet links included below:
   (1) FluZone, prefilled and vial
   http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM195479.pdf
   (2) Afluria, prefilled and vial
   http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM263239.pdf
   (3) FluMist, prefilled nasal sprayers
   http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM123743.pdf

11. Vaccine Information Statement (VIS) and Vaccine Adverse Event Reporting System (VAERS)

a. **VIS and Patient Information.** IAW U.S. Code 42, the VIS on influenza vaccine, published by the CDC, **shall be provided** to any individual receiving a vaccine or, in the case of children, to the child's legal representative (i.e. parents or guardians). **Additionally, reasonable effort to ensure that the patient or legal representative understands the materials presented is expected.** The VIS for influenza is available at http://www.cdc.gov/vaccines/pubs/vis/default.htm.

b. **VAERS Reporting.** Health-care professionals should promptly report all clinically significant adverse events after influenza vaccination of children to VAERS, even if the health-care professional is not certain that the vaccine caused the event. All vaccine-related adverse events must be reported through the Vaccine Adverse Event Reporting System. The Institute of Medicine has specifically recommended reporting of potential neurological complications (e.g., demyelinating disorders such as Guillain-Barré Syndrome), although no evidence exists of a causal relationship between influenza vaccine and neurological disorders in children. The VAERS form is available at http://vaers.hhs.gov. The form must be submitted to the Food and Drug Administration (FDA); it may be transmitted electronically through the FDA website.

c. **AF and DoD Reporting.** Vaccine adverse events **may be DoD reportable events** and, **if reportable,** must also be submitted through AFRESS to the US Air Force School of Aerospace Medicine (USAFSAM), Epidemiology Consult Service (contact: USAFSAM AFRESS Mailbox, usafsamafress@wpafb.af.mil).

d. **Life threatening adverse events. Incidents that are considered life-threatening or that result in death must be reported to USAFSAM within 24 hours.** Phone numbers DSN 798-3214 / 3207; Comm (937) 938-3214 / 3207. Other reports of vaccine adverse reactions or events should be faxed or mailed within 7 days of occurrence.

12. ANG and AFRES Activities

a. Air National Guard (ANG) Activities: For the 2011-2012 influenza season, ANG units should requisition influenza vaccine thru their Active Duty hosts. ANG Wing requirements are based on data in AFCITA. Each ANG Wing's and its GSUs vaccine requisition will have a unique document number linked to the local ANG MDG FY DODAAC. Delivery will be made to the ANG MDG. Flu vaccine funds for FY11 have been distributed to the Wing FMs via checkbook. Proof of receipt should include: document number, stock number, and quantity, as well as a copy of any shipping paperwork or Bill of Lading. This is necessary for your host to close the requisition and complete EOY financial reconciliation. This is a mandatory part of the process. Questions should be directed to MSgt Piers Heriz-Smith, DSN 278-8577, Piers.Heriz-Smith@ang.af.mil.

b. Air Force Reserve Command (AFRC) Activities: AFRC activities should contact the host base Financial Management account for their requirements. Contact HQ AFRC/SGPH at DSN 497-2398 or commercial at 478-327-2398 if further instruction is necessary. Individual Mobilization Augmentees will be immunized by their supporting AD MTF and should be included in requirements for the MTF.

13. Contact information

a. Influenza vaccine supply, delivery, shortage and availability issues: Contact AFMSA/SGSLC, Fort Detrick, MD. DSN 343-4170 or (301) 619-4170, fax: DSN 343-6844 or (301) 619-6844, e-mail: sgslc@ft-detrick.af.mil
b. Policy and prioritization: Contact AFMSA/SG3PM, 1500 Wilson Blvd, Suite 1600, Bolling AFB, DC 20032-7050, DSN 425-6470 or (703) 588-6470, e-mail: philip.gould@pentagon.af.mil.
c. VAERS or influenza surveillance information: Contact USAFSAM Epidemiology Services at USAFSAM/PHR , Facility 20840, 2947 Fifth St, WPAFB, OH 45433-7913. Phone: DSN 798-3214 / 3207 or (937) 938-3214 / 3207. Email: usafsamphr.flu@wpafb.af.mil

14. References

a. AFJI 48-110 Immunizations and Chemoprophylaxis, 29 Sep 2006
b. Morbidity and Mortality Weekly Report, General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Volume 55, Number RR-15, Dec 2006.
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d. HQ USAF/A1S policy dtd 22 Apr 08 "2008 Recommended Immunization Schedules"
e. Assistant Secretary of Defense, Health Affairs policy documents available at: http://www.ha.osd.mil/policies/default.cfm
f. Centers for Disease Control and Prevention (CDC) influenza home page contains provider's information, supply concerns and updates, public affairs and media materials, and patient education materials. http://www.cdc.gov/flu/professionals/patiented.htm.
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j. Morbidity and Mortality Weekly Report, Notice to Readers, Facilitating Influenza and Pneumococcal Vaccination through Standing Orders Programs. Volume 52, Number 4, 31 January 2003, pp.68-69. http://www.cdc.gov/mmwr/PDF/wk/mm5204.pdf
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l. Standards for Adult Immunization Practices. Poland, GA et al. American Journal of Preventive Medicine 2003; Vol 25, Number 2.

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n. Adolescent Immunization Schedule: United States, 2009. http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2009/09_7-18yrs_schedule_pr.pdf
o. DoD Worldwide Influenza Surveillance Program (USAFSAM) . http://www.geis.fhp.osd.mil/GEIS/SurveillanceActivities/Influenza/influenza.asp
p. DoDD 6205.02E, 19 Sep 2006. Policy and Program for Immunizations to Protect the Health of Service Members and Military Beneficiaries. http://www.vaccines.mil/documents/973Policy620502p.pdf
q. National Influenza Vaccine Summit Newsletter. http://www.ama-assn.org/ama/pub/physician-resources/public-health/vaccination-resources/adult-vaccination/national-influenza-vaccine.shtml
r. ASD (HA) Policy 08-005 http://www.health.mil/HAPolicies.aspx
s. Omer SB, Goodman D, Steinhoff MC, Rochat R, Klugman KP, Stoll BJ, Ramakrishnan U, "Maternal influenza immunization and reduced likelihood of prematurity and small for gestational age births: a retrospective cohort study." PLoS Med. 2011 May;8(5):e1000441. Epub 2011 May 31.

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Influenza Vaccine Reference Tables

Age Category	Name / Manufacturer	Formulation	NSN	Comments
6 months through 35 months	FluZone (Sanofi-Pasteur)	0.25ml pre-filled syringe	6505-01-593-9356	Thimerosal free
≥ 6 months	FluZone (Sanofi-Pasteur)	5.0 ml multi-dose vial 0.25 ml for 6 mos to 35 mos 0.5 ml for ≥ 36 mos	6505-01-583-5449	Contains Thimerosal alternate to above formulation
≥ 36 months	FluZone (Sanofi-Pasteur)	0.5ml pre-filled syringe	6505-01-597-3559	Contains Thimerosal
≥5 years	Afluria (Merck / CSL Labs)	0.5ml pre-filled syringe	6505-01-595-3897	Thimerosal free
≥5 years	Afluria (Merck / CSL Labs)	5.0 ml multi-dose vial 0.25 ml for 6 mos to 35 mos 0.5 ml for ≥ 36 mos	6505-01-593-6465	Contains Thimerosal alternate to above formulation
2 years through 49 years	FluMist (MedImmune)	Nasal spray, pre-filled sprayer	6505-01-596-1110	Available for military and healthy beneficiaries

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FluMist®—live, attenuated influenza vaccine (LAIV)

Age Group	Vaccination Status	Dosage Schedule
Children age 2 years through 8 years	Not previous vaccinated or only 1 dose in first season	2 doses (0.2 mL each, 60 days apart)
Children age 2 years through 8 years	Previously vaccinated with 2 doses in first season	1 dose (0.2 mL) per season
Children and adults age 9 through 49 years	Not applicable	1 dose (0.2 mL) per season

Two doses administered are recommended for children <9 years who are receiving influenza vaccine for the first time. If a child <9 years receiving vaccine for the first time does not receive a second dose of vaccine within the same season, 2 doses of vaccine should be administered the following season. Although either FluZone® or FluMist® may be used for the purpose of initial year immunization; they are not interchangeable. The child should receive the same type of vaccine for each immunization.

FluZone® — inactivated influenza vaccine, 0.25 ml prefilled syringes

Age Group	Dosage	Number of Doses
6 months to 35 months	0.25 ml	2*

FluZone® or Afluria®— inactivated influenza vaccine, 5.0 ml vials (10 to 20 doses) (Contains thimerosal)

Age Group	Dosage	Number of Doses
≥ 9 years	0.50 ml	1

* Two doses administered at least one month apart are recommended for children <9 years who are receiving influenza vaccine for the first time. If a child <9 years receiving vaccine for the first time does not receive a second dose of vaccine within the same season, 2 doses of vaccine should be administered the following season. Although either FluZone® or FluMist® may be used for the purpose of initial year immunization; they are not interchangeable. The child should receive the same type of vaccine for each immunization.

For adults and older children, the recommended site of vaccination is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh.

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Health Care Personnel Who Provide Direct Patient Care Or Who Routinely Work In Hopsital/Clinic Common Areas

Healthcare Personnel	Occupational Series	Notes:
Substance Abuse Specialist	GS 0101	(also NH)
Drug Testing Program Assistant	GS 0102	
Psychologists	GS 0180	
Psychology Aid / Technician	GS 0181	
Social Workers	GS 0185	(also NH)
Social Work Aid / Technician	GS 0186	(also NK)
Recreation Specialist	GS 0188	
Medical Administrative Officer	GS 0301	If work involves direct patient care; (also NH)
Clerical Technician / Clerk	GS 0303	If work involves direct patient care; (also NK)
Medical Manpower and Organization	GS 0343	If work involves direct patient care
Medical Manpower Assistant	GS 0344	If work involves direct patient care
Physiologist	GS 0413	
General Health Science Officer	GS 0601	(also NH)
Physicians / Medical Officer	GS 0602	(also GP)
Physician Assistants	GS 0603	
Registered Nurses	GS 0610	(also NH)
LPNs / LVNs	GS 0620	(also NJ)
Nursing Assistants	GS 0621	
Medical Supply Aid / Technician	GS 0622	If work involves deliveries to patient care areas
Nutritionists / Dieticians	GS 0630	
Occupational Therapists	GS 0631	
Physical Therapists	GS 0633	
Kinesiology	GS 0635	
PT / Rehabilitation Assistants	GS 0636	
Manual Arts Therapist	GS 0637	
Recreation / Creative Arts Therapist	GS 0638	
Educational Therapist	GS 0639	
Health Aid / Technicians	GS 0640	(also NJ)
Nuclear Medicine Technicians	GS 0642	
Medical Technologists	GS 0644	(also NH)
Medical Technicians	GS 0645	
Pathology Technician	GS 0646	
Diagnostic Radiologic Technicians	GS 0647	(also NJ)
Therapeutic Radiologic Technicians	GS 0648	
Medical Instrument Technicians	GS 0649	
Medical Technician Assistants	GS 0650	
Respiratory Therapists	GS 0651	
Pharmacists	GS 0660	
Pharmacy Technicians	GS 0661	(also NJ)
Optometrists	GS 0662	
Restoration Technician	GS 0664	
Audiologists / Speech Pathology	GS 0665	

Health Care Personnel Who Provide Direct Patient Care Or Who Routinely Work In Hopsital/Clinic Common Areas

Healthcare Personnel	Occupational Series	Notes:
Orthotists and Prosthetists	GS 0667	
Podiatrists	GS 0668	
Hospital Administration	GS 0670	
Health System Specialist	GS 0671	(also NH)
Prosthetic Representative	GS 0672	
Hospital Housekeeping Supervisor	GS 0673	
Medical Records Technician / Clerk	GS 0675	(also NJ)
Medical Clerks	GS 0679	(also NK)
Dentists / Dental Officer	GS 0680	(also GP)
Dental Technicians	GS 0681	(also NJ)
Dental Hygienists	GS 0682	
Dental Laboratory Technician	GS-0683	
Public Health Program Specialist	GS 0685	
Sanitarian	GS 0688	
Facilities Operations Specialist	GS 1640	
Supply Specialist	GS 2001	If work involves deliveries to patient care areas
Supply Analyst	GS 2003	If work involves deliveries to patient care areas
Supply Technician	GS 2005	If work involves deliveries to patient care areas; (also NJ)
Chiropractors		
Custodial Work Inspector	WG-3566	
Medical Equipment Repairer	WG-4805	
Cook	WG-7404	
Food Service	WG-7408	
Medical Equipment Repairer (Leader)	WL-4805	
Medical Equipment Repairer (Supervisor)	WS-4805	
Cook Supervisor	WS-7404	
Hospital Housekeeping	WG	

Notes:

"N" prefixes are used at Edwards AFB (instead of GS)