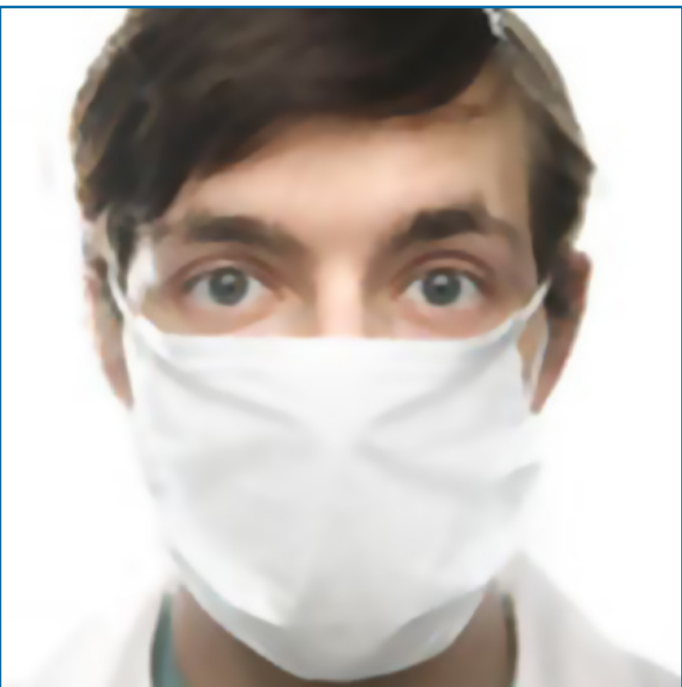


H1N1 – Are You Ready for the Next Wave? Q & A Responses

Disclaimer: the information provided below is based on current recommendations of the Centers for Disease Control (CDC) and other nationally recognized authorities, and is not to be construed as medical or legal advice. Individuals are advised to contact their personal healthcare provider for advice regarding their individual medical situation, health issues, and concerns.



1. What strategies do you suggest providers/medical groups could institute to encourage patients to receive the H1N1 vaccine given concerns about the vaccine's safety?

Some providers have conducted public education sessions for various groups (parents, students, general population) in conjunction with local community partners and hospitals. These programs typically focus on general flu information and vaccine safety.

Other providers have successfully used posters, buttons, and other visible cues to raise awareness of the importance of vaccination in combination with education materials on vaccine facts. Intranet sites and “ask a nurse” flu hotlines can also help to allay fears and help explain the current CDC recommendations regarding the importance of vaccination and vaccine safety. Strategies should also include the distribution of general and vaccine-specific fact sheets, which are available from the CDC at no cost to the providers.

These include:

- <http://www.cdc.gov/flu/freeresources/index.htm>
- http://www.cdc.gov/h1n1flu/vaccination/public/vaccination_qa_pub.htm
- http://www.cdc.gov/flu/freeresources/2009-10/pdf/h1n1_take3.pdf

2. Does the seasonal flu vaccination provide any protection against the H1N1 virus?

The seasonal flu vaccine is not expected to provide protection against 2009 H1N1.

- http://www.cdc.gov/h1n1flu/vaccination/public/vaccination_qa_pub.htm

3. When will the vaccine become available?

According to the Department of Health and Human Services, there will be availability in early October, although not all of the vaccine will be immediately available and delays may occur. Batches of the vaccine will continue to be shipped as available and distributed throughout the flu season.

- http://www.cdc.gov/H1N1flu/vaccination/statelocal/centralized_distribution_qa.htm

4. What are the current recommendations regarding the timing and number of doses? Who should receive the vaccine?

Timing and Number of Doses

While the seasonal flu and 2009 H1N1 vaccines may generally be administered on the same day, the seasonal vaccine will be available earlier than the 2009 H1N1 vaccine, so individuals are encouraged to get their seasonal flu vaccine as soon as it is available. Additionally, some formulations of the vaccines cannot be given at the same time (e.g., live-attenuated formulations of both vaccines).

The U.S. Food and Drug Administration (FDA) has approved the use of one dose of 2009 H1N1 flu vaccine for persons 10 years of age and older.

Children aged six months to nine years receiving influenza A (H1N1) 2009 monovalent vaccines should receive two doses, with doses separated by approximately four weeks. However, if the second dose is separated from the first by at least 21 days, the second dose can be considered valid. Infants younger than six months of age are too young to get the 2009 H1N1 and seasonal flu vaccines.

Target Groups by Priority

The CDC has also developed recommendations for the prioritization of vaccine administration to groups which are at higher risk of severity of illness or complications. The CDC's Advisory Committee on Immunization Practices (ACIP) has recommended that certain groups of the population receive the 2009 H1N1 vaccine when it first becomes available. These target groups include pregnant women, people who live with or care for children younger than six months of age, healthcare and emergency

medical services personnel, persons between the ages of six months and 24 years old, and people 25 through 64 years of age who are at higher risk for 2009 H1N1 because of chronic health disorders or compromised immune systems.

The committee also recognizes the need to assess supply and demand issues at the local level. Therefore, the committee further recommends that once the demand for vaccine for these target groups has been met at the local level, programs and providers should begin vaccinating everyone from 25 through 64 years of age. Current studies indicate the risk for infection among persons age 65 or older is less than the risk for younger age groups. Therefore, once vaccine supply and demand among the younger age groups is met, programs and providers should offer vaccination to people over the age of 65.

- http://www.cdc.gov/h1n1flu/vaccination/public/vaccination_qa_pub.htm

5. What should the public know about social distancing from a public health perspective? What does social distancing typically entail?

During a pandemic, individual control measures may not be adequate to reduce the spread of the disease. State and local health departments have the authority to recommend or authorize measures that decrease social contact within groups or whole communities (e.g., self-shielding, cancellation of public events, mass gatherings, snow days). The purpose of social distancing is to increase the physical space between people (recommended at least six feet) and to reduce the frequency of close contact.

Individuals can also take steps to reduce the spread of disease in public settings:

1. Persons with influenza-like illness (ILI) (i.e., fever with either cough or sore throat) should be advised to stay home until at least 24 hours after they are free of fever (100° F [37.8°C]), or signs of a fever without the use of fever-reducing medications. This recommendation applies to camps, schools, businesses, mass gatherings, and other community settings where the majority of people are not at increased risk for influenza complications. This guidance does not apply to

healthcare settings where the exclusion period should be continued for seven days from symptom onset or until the resolution of symptoms, whichever is longer.

2. Persons who are at high risk of complications from 2009 H1N1 flu infection (for example, persons with certain chronic medical conditions, children less than five years, persons 65 or older, and pregnant women) should consider their risk of exposure to novel influenza if they attend public gatherings in communities where novel influenza A virus is circulating. In communities with several reported cases of 2009 H1N1 flu infection, persons who are at risk of complications from influenza should consider staying away from public gatherings.
3. All persons should be reminded to use appropriate respiratory and hand hygiene precautions.
4. Based on currently available information, for non-healthcare settings where frequent exposures to persons with 2009 H1N1 flu are unlikely, masks and respirators are not recommended.

Large public gatherings also offer a good opportunity for public health officials and event organizers to deliver key educational messages about measures attendees can take to help reduce the spread of 2009 H1N1 flu infection. Event organizers should consider communicating to attendees about the need to remain home if ill and to use good hygiene practices while at the event. Such information may be communicated through a variety of means such as letters, newspaper notices, public service announcements, Web site postings, and text messages.

- http://www.cdc.gov/h1n1flu/guidance/public_gatherings.htm

6. Can you address why some healthcare workers are refusing to take the vaccine?

First, Marsh recognizes and respects the fact that many organizations and occupational groups have strong opinions on this matter. Some healthcare workers are of the opinion that they should be free to refuse vaccination and other forms of mandated work practices (e.g., mandates to wear medical masks if they refuse the vaccine) as a civil rights issue. This may be due to personal beliefs of freedom of choice or other concerns, as well as opposition regarding

requirement of mandatory vaccination as a condition of employment. Similar responses have arisen with other vaccination programs in the past. The CDC, the World Health Organization (WHO), and their technical advisory committees continue to stress the importance of vaccination of healthcare workers regarding both seasonal influenza and 2009 H1N1 influenza. Many well-known healthcare organizations have successfully implemented these programs during the past seasonal flu season.

It is worthwhile to note that while employers will likely be unable to force employees to take the vaccine, they may have the ability to impose a leave of absence if an employee's medical condition poses a "direct threat" to safety in the workplace. The employer has a clear obligation to take steps to protect the safety of others in the workplace, as supported by OSHA's General Duty Clause.

7. A recent unpublished Canadian study raises the concern that those who receive the seasonal flu vaccination are more likely to contract H1N1. Thoughts?

This study has not been published or scientifically peer-reviewed, so Marsh cannot comment on the validity of the findings. However, the CDC has noted that there are no current studies in the United States which validate the reported findings of this study.

- <http://www.cidrap.umn.edu/cidrap/content/influenza/swineflu/news/sep2409canada.html>

8. Why are certain indigenous populations thought to be at higher risk of contracting the flu?

Indigenous communities may have little to no immunity to outside pathogens or may have delayed access to medical care in some countries.

- http://www.wpro.who.int/health_topics/h1n1/info/info_regionsNpop.htm

9. Has there ever been a compensatory lawsuit judgment regarding influenza?

There have been a number of relevant legal decisions arising from contagious diseases. Some of the first arose in the 1920's when hospital workers contracted influenza and later died. In 1961, an orderly at a California school for impaired children contracted polio,

resulting in employer liability. Hospital workers who contracted hepatitis, a chemist who contracted HIV, and an employee who received a company-provided flu shot—who later passed out and struck his head, sustaining permanent injury, all filed successful claims.

The most well-known cases arose from cruise ships on which vacationers and crews contracted the Norovirus and recovered benefits or awards for their “injuries.” There is sufficient precedent on which to base a claim for damages arising from exposure to H1N1. Wrongful death actions may be filed by family members, or legal theories such as negligence, breach of warranty, breach of contract or failure to provide a safe workplace may also support a claim. Each claim would be decided on a case-by-case basis, under the specific facts presented.

10. What is the frequency and outcome for those infected with both seasonal influenza and H1N1 (simultaneously)?

There is insufficient data at this time to draw major conclusions regarding co-infection. However, a study from the University of Maryland demonstrated that the current pandemic virus is more transmissible than, and has a biological advantage over, prototypical seasonal H1 or H3 strains.

- [http://knol.google.com/k/daniel-perez/fitness-of-pandemic-h1n1-and-seasonal/2e4ii3cnzi06d/2?collectionId=28qm4w0q65e4w.1&position=10#Effects_of_co\(2D\)infection_of_pandemic_influenza_and_seasonal_strains_in_the_ferret_model](http://knol.google.com/k/daniel-perez/fitness-of-pandemic-h1n1-and-seasonal/2e4ii3cnzi06d/2?collectionId=28qm4w0q65e4w.1&position=10#Effects_of_co(2D)infection_of_pandemic_influenza_and_seasonal_strains_in_the_ferret_model)

11. I work for a temporary staffing agency. What types of evidence should we look for to prove that the employee did not contract the disease in the workplace, but in the home?

Due to the widespread activity of H1N1 in the United States, it would be extremely difficult to prove whether the infection was actually acquired in the workplace or the community. From an occupational health perspective, ensure that all of your workers have received information regarding your employee absence and leave policies. The CDC has provided general guidance for employers.

- <http://www.osha.gov/Publications/employers-protect-workers-flu-factsheet.html>
- <http://www.cdc.gov/h1n1flu/business/guidance/>

Should a claim for H1N1 arise from a temporary staffing assignment, the fact finder will need to determine whether the place of employment created a special exposure in excess of the common or everyday experience. There must be an increased risk as compared with the general public in order for an H1N1 claim to be compensable. An urban Mass Transit worker, who may come into close physical contact with thousands of people during a day, will be more likely to prove increased risk than a night watchman, who has infrequent contact with others. If 16 people in a 20-person department are diagnosed with the virus, the remaining four people might argue they have an 80 percent chance or more, as compared with the general population. Whether a claim by a temporary worker is successful will depend on the work being performed, the incidence of the disease in the general (presumably local) public, and the degree of exposure in the temporary job at issue.

12. How do you consider someone a “direct threat”? That seems to be a human call, not something you can determine from a set of guidelines.

Under the Americans with Disabilities Act (ADA) a “direct threat” is defined as a risk of substantial harm which cannot be eliminated or reduced by reasonable accommodation. Whether the facts presented in a specific situation meet that legal standard will always be determined on a case-by-case basis by a judge, jury, or other authorized decision maker.

13. Please provide more information on ATDs with regard to employment liability?

Cal/OSHA recently adopted a new standard, T8 CCR § 5199, regulating employee exposure to aerosol transmissible diseases (ATDs). These diseases can be spread through the air in the form of small particles or droplets. Influenza, tuberculosis, and severe acute respiratory syndrome (SARS) are just a few examples of aerosol transmissible diseases. Some of the main components of the standard include:

(a) Scope and Application

The standard applies to healthcare facilities such as: hospitals, skilled nursing facilities, clinics, medical offices, and other outpatient medical facilities, home healthcare, public health services, long term healthcare facilities and hospices, medical outreach services, paramedic and emergency medical

services including these services when provided by firefighters and other emergency responders, medical transport, and facilities where high hazard procedures are performed.

Facilities, services, or operations that:

- Receive persons arriving from the scene of an uncontrolled release of hazardous substances involving biological agents
- Are at increased risk for transmission of an ATD infection: correctional facilities, homeless shelters, drug treatment programs
- Perform aerosol-generating procedures on cadavers
- Transport or detain cases or suspected cases of aerosol transmissible diseases and police services provided in conjunction with healthcare or public health operations
- Laboratories that perform procedures with materials that contain ATPs-L or zoonotic aerosol transmissible pathogens
- Public health services provided to cases or suspected cases of aerosol transmissible diseases
- Any other facility, service or operation that has been determined in writing by the Chief of the Division of Occupational Safety and Health through the issuance of an Order to Take Special Action
- Maintenance, renovation, service, or repair operations involving air handling systems or equipment or building areas that may be contaminated with ATPs or ATPs-L

Occupational exposure to animals infected by aerosol transmissible pathogens is covered by a separate, newly adopted standard, T8 CCR § 5199.1 *Aerosol Transmissible Diseases – Zoonotic*.

The following are not covered by the standard:

- Outpatient dental clinics or offices are not required to comply with this standard if they do not perform dental procedures on patients identified to them as ATD cases or suspected ATD cases; the Injury and Illness Prevention Program includes a written procedure for

screening patients for ATDs and employees are trained in this procedure.

- Outpatient medical specialty practices whose policy is not to diagnose or treat ATDs are not required to comply with this standard if they do not perform aerosol-generating procedures on cases or suspected cases of ATD; the Injury and Illness Prevention Program includes written screening procedures, and employees have been trained in the procedures.

(b) Definitions

The standard contains 59 definitions.

(c) Referring Employers

A Referring Employer provides initial treatment only, does not treat people with ATDs, but only screens them. A Referring Employer does not transport, house, or provide airborne infection isolation to patients infected with suspected ATDs, but only refers them to facilities that do treat them. (See the *Aerosol Transmissible Diseases – Referring Employers Loss Control Bulletin*)

(d) Aerosol Transmissible Diseases Exposure Control Plan

Certain employers must write an ATD Exposure Control Plan (except certain laboratories which may write a Biosafety Plan instead).

(e) Engineering and Work Practice Controls and Personal Protective Equipment

Employers must use feasible engineering and work practice controls to minimize employee exposures to ATPs. Where engineering and work practice controls do not provide sufficient protection, the employer shall provide respiratory protection and/or other personal protective equipment. Guidance from the CDC must be used, such as *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*.

(f) Laboratories

Applies to laboratory operations where employees perform procedures capable of aerosolizing ATPs-L or zoonotic aerosol transmissible pathogens as defined in Section 5199.1.

(g) Respiratory Protection

The standard specifies which respirators must be used. A minimum of an N95 filtering facepiece must be used for routine occupationally exposed tasks. As of September 1, 2010, high hazard procedures with possible ATD exposure must be done using a powered air-purifying respirator (PAPR) with a High Efficiency Particulate Air (HEPA) filter(s), or a respirator that provides equivalent or greater protection unless there are effective engineering controls. There is an exception to the PAPR requirement when the employer determines that the use of a PAPR would interfere with the procedure being performed. The justification for the exception must be documented in writing. Paramedics and EMTs may use a P100 respirator.

When respirators are required, the employer must establish and implement a written respiratory protection program in accordance with T8 CCR § 5144 *Respiratory Protection*. (In some instances, an alternate medical questionnaire to the one in Section 5144 can be used). Also, until January 1, 2014, in some cases fit testing may be conducted every two years after the initial fit-testing has been done.

(h) Medical Services

Each employer who has any employee with occupational exposure to ATDs or infection with ATPs or ATPs-L shall provide the employee with medical services in accordance with applicable public health guidelines for the type of work setting and disease. These services may include vaccinations, tests, post-exposure follow-up (including treatment), latent tuberculosis infection testing, and precautionary removal.

(i) Training

The standard outlines the training that employees with occupational exposure must receive, including training on the employer's ATD Exposure Control Plan and/or Biosafety Plan. Training must be provided at least annually. Dental clinics and outpatient medical specialty practices not covered by the standard must be trained in screening procedures in accordance with their Injury and Illness Prevention Program.

(j) Recordkeeping

The employer must keep medical records, training records and other records related to the implementation of the ATD Plan and/or Biosafety Plan.

Employers are encouraged to refer to the regulations and any guidance documents Cal/OSHA may have available at: www.dir.ca.gov/dosh.

See also: <http://www.dir.ca.gov/Title8/5199.htm>.

Other states may have regulated ATD exposure – California's regulations are likely the most well known. To determine more local requirements for employers, your State or local Health Department may be a good place to start.

14. Under the FMLA portion, it was mentioned that H1N1 will “likely” be considered a serious health condition—when do we know that it “is” considered a serious health condition?

What Marsh may consider “serious” may differ from what another person or group may consider “serious.” Our discussion referred to the definition of “serious health condition” as that term is used in Federal and State Family Medical Leave Acts (FMLAs) for purposes of determining whether a claim filed under those laws may be sustained. While legal definitions may differ by jurisdiction, Marsh suggests that an illness requiring inpatient treatment, or which results in a period of incapacity of three days or more, with continuing treatment from a healthcare provider will likely qualify as a “serious health condition” such that an employee may be entitled to Family Medical Leave.

15. Can you develop H1N1 more than once?

Generally speaking, a person who gets a specific influenza virus and recovers has immunity to that specific virus for some period, usually a decade or two. After time, or with certain immune system defects, the immune system may have a lapse in “memory” which can result in re-infection. Additionally, some viruses have been known to mutate or change just enough that people who had the virus just a short time earlier technically can be re-infected with the mutated or changed virus. The WHO and CDC are monitoring confirmed cases of the virus to detect any such mutation.

Individuals who have a confirmed case of H1N1 (by specific laboratory testing) should still practice control measures such as cough and sneeze etiquette and hand hygiene as other germs are present in the environment which can cause disease.

16. Would you caution a company which is considering asking employees (who are not known to be sick themselves) to stay home for seven days if they reveal that their children/family members are sick with H1N1? This may mean the employee is not paid for the seven days.

Because of differences in local laws, rules, company policies, and collective bargaining agreements, this question can only be answered generally. An employer has an obligation to take steps to protect the safety of employees in the workplace and may have some latitude in determining which steps are appropriate. Whether an employer or family member has a medical condition that impairs their ability to perform essential functions or poses a “direct threat” to workplace safety will be determined on a case-by-case basis. As stated above, a “direct threat” is a risk of substantial harm which cannot be eliminated by reasonable accommodation. An employer in the situation described may want to consider accommodations such as telecommuting, or reduced hours or altered schedules.

Federal law doesn’t require paid leave, but individual states may have different Family Leave rules. If the leave qualifies as protected leave under State or Federal law the employee may elect or the employer may require the use of sick pay or personal leave in some circumstances. As stated above, this will depend on company policies, collective bargaining agreements, and State law, which will govern.

17. What is the data to support vaccination?

Natural immunity to 2009 H1N1 is limited, particularly in individuals under the age of 65. The CDC’s Advisory Council on Immunization Practices has completed an extensive review of data available on the H1N1 virus prior to making its vaccination recommendations. A summary of the research and review can be found at:

- <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr58e0724a1.htm>

18. Is there any person who should not receive the 2009 H1N1 vaccine?

People who have a severe (life-threatening) allergy to chicken eggs or to any other substance in the vaccine should not be vaccinated. Those who provide vaccinations will screen for these conditions.

- <http://www.cdc.gov/h1n1flu/vaccination/>

19. What is the incubation period of H1N1 and how long can someone be contagious?

People infected with seasonal and 2009 H1N1 flu shed virus and may be able to infect others approximately one day before getting sick to five to seven days after. This can be longer in some people, especially children and people with weakened immune systems and in people infected with the new H1N1 virus.

- http://www.cdc.gov/h1n1flu/vaccination/public/vaccination_qa_pub.htm

20. How can you give a 24-hour notification of a fever if it’s not confirmed H1N1?

The main issue is that sick employees with symptoms of influenza-like-illness should not return to work until they have been fever-free for at least 24 hours without the use of fever-reducing agents. Other diseases such as seasonal influenza can also spread to others, so confirming whether an employee has H1N1 is not really the only concern.

- <http://www.osha.gov/Publications/employers-protect-workers-flu-factsheet.html>
- <http://www.cdc.gov/h1n1flu/business/guidance/>



Additional insight about these risk issues and related services can be found on global.marsh.com/risk/pandemic and www.marshriskconsulting.com.

You can also contact your local Marsh representative, or the Marsh Pandemic Response Center via email: At.Risk@marsh.com or via phone at (866) 928-7475 (outside the United States and Canada +1 (212) 345-9589).

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