Immunization Advisory Committee Meeting
Minutes
July 30, 9:00 a.m.
109 Governor Street, Conference Room 535
Richmond, Virginia

The Immunization Advisory Committee shall provide guidance and serve as an advisory body to the Division of Immunization at the Virginia Department of Health. The Committee will address issues related to best practices in immunization in a clinical setting, vaccine supply, vaccine legislation, vaccine preventable disease control, and other key programmatic issues as they arise. The Committee will meet quarterly, agendas will be available prior to the meeting, and minutes of each meeting will be the responsibility of the Division of Immunization staff.

Members Present: Barbara Allison-Bryan, MD (Sentara Pediatric Physicians-Gloucester); David Goodfriend, MD (VDH); Julia Gwaltney, RN (VDH); Robert Hicks (VDH); Parham Jaberi, MD (VDH); Heidi Kulberg, MD, MPH (VAAFP); Douglas K. Mitchell, MD (International Adoption and Travel Medicine Clinic); Bill Moskowitz, MD (VAAP); Lilian Peake, MD (VDH); Holly Puritz, MD (VACOG); Trinette Randolph (VA Community Health Association); Cindy Robinson, RN (Reston Hospital Center); Jay Schukman, MD (Anthem BC/BS); Laura Lee Viergever (VAHP); Nancy Welch, MD (VDH); Sandra Zieve, MD (Patient First)

VDH Staff Present: Jim Farrell; Laurie Forlano, DO, MPH; Joe Hilbert; Marissa Levine, MD; Laura Ann Nicolai; Sandy Sommer, PhD, David Trump, MD, MPH, MPA; Julia Wonch

Others Present: Tami Brown (Merck); Lauren Bull (Hillbridge Group for VACEP/AAP); Heather Crouch (GSK); Kathleen Glassner for Bindi Patel (Merck Vaccines); Nicole Pugar (Williams and Mullen for ACOG); and Ellen Shannon (Sanofi Pasteur)

Members Unable to Attend: Michael Ashby, MD (Martha Jefferson Hospital); Chris Bailey (VHHA); Aline Branca, MD (EVMS); Tia Campbell, RN, MSN, NCSN (DOE); Melissa Canaday (VA Native American Community); C. W. Gowen, Jr., MD (EVMS); Manikoth Kurup (DMAS); Carolyn Moneymaker, MD (EVMS); Tim Musselman, PharmD (VA Pharmacists Association); Molly O'Dell, MD; Bob Ramsey, MD (VCEP); Jeniece Roane, RN, MS, NE-BC (VA Nurses Association); Cynthia Romero, MD, FAAFP; Jodi Wakeham, RN, PhD (VDH); Linda D. Wilkinson, MPA (Virginia Association of Free Clinics);

Welcome/Introduction/Roll Call

- The meeting began at 9:01 a.m. Dr. Forlano introduced herself and welcomed attendees and presented the agenda. Roll was taken and is presented above.
- Dr. Forlano noted that the agenda would be changed to allow Dr. Marissa Levine, Chief Deputy Commissioner, and Joe Hilbert, Director of Governmental and Regulatory Affairs and Legislative Liaison, to be present for discussing the draft legislative proposal.

Current Topics

- **Draft Legislative Proposal**—Joe Hilbert discussed how the Virginia legislative process works and the role of a committee:
  - An annual opportunity to develop legislative proposals
  - Developed by VDH staff, reviewed by VDH leadership, and then through the Office of Secretary of Health and Human Resources and the Governor's office.
  - Key part of the proposal process is identifying and engaging all of the relevant stakeholder organizations, as the Governor wants to know who is "for it" and who is "against it."

- Amendments to 32.1-46—It is necessary to know how everyone on the committee thinks regarding this amendment and to share today and throughout the process by providing comments within the next week or so.
- VDH is required to review relative sections of the Code annually and report findings and recommendations to the General Assembly; VDH submitted its report early this year (June), which still under review at SHHR. It contains recommendations to amend Code Section 32.1-46.
- No questions were asked about the general process or proposed amendment. Dr. Forlano acknowledged this committee is relatively new (1.5 years), and it is anticipated this group will be instrumental as a stakeholder group.
- Goal is to update the Code with ACIP recommendations with the most up-to-date science and evidence-based practices:
    1. TDAP—ACIP eliminated the need for a minimum interval for tetanus-containing vaccines (refer to strike through text).
    2. Eliminate "susceptible" in varicella language, mainly because it is confusing; does not mean all children have to receive varicella vaccine if they have had the disease.
    3. Pneumococcal and PCV: PCV 13, as PCV 7 is not given anymore, and move out age window through 59 months of age.
- Dr. Forlano had received some comments from committee members via email and then asked for additional:
    - Dr. Allison-Bryan asked what the difference is between Code and Regulation, as the language does not clarify that a child is required to receive a Tdap vaccine for entrance into 6th grade—only a booster of a cellular pertussis.
    - Sandy Sommer provided the following explanation:
        - The Code divides it into antigens (diphtheria, tetanus, pertussis); none can be given separately, but we need to deal with Code as it is currently structured. Goal is to see that child gets pertussis booster at the appropriate time.
        - Based on questions over the years and by leaving this requirement for a booster of tetanus or diphtheria containing vaccine, regardless of interval, issues arise surrounding children who have received the Tdap licensed for a single dose.
        - There is no recommendation for an additional dose; but if we leave the requirement in for a booster of tetanus containing vaccine, regardless of interval at entry into 6th grade, it would require a child to get a booster dose of Td.
        - If we leave booster language as is, it does not coincide with ACIP unless it has been 10 years from the last dose. The primary impetus is to protect the child against pertussis that is in the school setting.
        - Dr. Forlano noted that the one-page vaccine information sheets given to parents successfully clarify what is needed and when.
        - Dr. Trump further explained the Code is law passed by General Assembly, which directs the BOH to create/change regulations. It is better to keep the Code as generic as possible and make changes to Regulations, which is done at the BOH or Health Commissioner level.

- Dr. Mitchell noted that having the word "acellular" is problematic for immigrants and the international adoption population creates a situation where the Code is not being followed. Ms. Sommer explained "whole cell" is acceptable but just not available in this country, which is when the Code was written. She recommended it would be better to eliminate both words.
- Ms. Viergever noted that VA law mandates health insurance cover the immunizations but will confirm with the plans to ensure these changes are still covered.
- Dr. Mitchell noted that the ACIP guideline for HPV is males and females now. Dr. Levine cautioned changes to the Code with what we add/change to avoid inviting other potential issues. Dr. Trump noted that the committee's actions don't preclude the Governor or any legislator from proposing a bill to address this issue. He pointed out that it is not clear paragraph A has 2 components: 1) Children should be vaccinated according to ACIP recommendations, and 2) The list of vaccines presents the minimum requirements for the BOH to set forth in regulations for the immunizations of school children (what we want to require for attendance at school is the intent of the more detailed list.) The list does not eliminate the requirement in Item 1.

- **Strategic Planning**—Jim Farrell presented a strategic plan outline designed for informational purposes to update SHHR. It is an aside to the strategic plan required for the CDC scheduled for submission in August 2014. VDH expects CDC guidelines before the end of August 2013, at which time it will know how to proceed with the plan and how to involve the IAC. Mr. Farrell anticipates starting the process before January 1, 2014.
  - Mr. Farrell referenced data provided to the committee during the first/second meeting and discussed its critical role in strategic planning:
    - VDH has good state data, but obtaining good local data (locality specific) is still a problem.
    - Long-term solution is getting VIIS data complete with both historical and current data that can be used for providing locality-specific data.
    - Completion of data is dependent on compliance and site visits at VFC providers:
      - Will allow VDH to review provider coverage rates before future site visits and provide recommendations and recalls
      - Long, labor-intensive process.
    - Interim needs and plan of action:
      - Local health districts (LHDs) need data for their counties in order to identify and follow up on "pockets of need."
      - Sample size training—VDH continues to train LHDs on increasing local sample sizes
      - Capacity building necessary in financially challenging times, need to maximize the appropriate utilization of current funding to be more competitive for future federal resources.
    - Vaccine access:
      - National distribution system in effect with CDC for a few years reduces cost for VDH and works well
      - Need to increase the number of VFC providers (currently 900 sites and most are Medicaid providers)
      - Goal is to enroll providers and provide vaccine when needed in a timely manner (VFC, free clinics, FQHCs)

- Increase availability to LHDs—number of vaccine doses provided by LHDs has decreased over the years—could be that patients are staying with the provider in their medical home.
- Comprehensive provision of services—make use of every opportunity to vaccinate—low cost or no cost
- Reminder recall—VDH is working on an autodial reminder system for clients served in local health departments.
- Maintain viable vaccine supply with constraints of shortages, products go offline, etc.
- Provider education—It is well-established that parents highly value recommendations of physicians with respect to immunizations. Evidence of VDH record searches shows that some physicians are deferring immunizations to later dates, off the recommended ACIP schedule. Goal is to eliminate missed opportunities through education (e.g., CDC tool kits for physicians).
- Consumer education—Provide good science and good information to the parents all the time. Internet can be a challenge with respect to this.

– Active coalitions—Worked well in past years providing education, especially during legislative season; needs to be reestablished all across the state

– VDH Office of Risk Communication and Education (e.g., flu campaigns)

– Information Technology—VIIS

– Emergency Preparedness—Flu vaccine to mass clinics

– Dr. Forlano emphasized that VDH will enlist the IAC to comment as VDH moves forward with the strategic plan and that the IAC members should be a voice for their respective disciplines.

– Dr. Levine reported that VDH is taking a data-driven approach to all its public health issues. Coalitions (specifically regional) provide good data and allow a system approach to this problem. There is a need to get good data to legislators to counter incorrect information, educate parents, etc. VDH is addressing preventable conditions using the best resources available.

– Dr. Moskowitz inquired as to what are the key barriers to VIIS data?

  - Historical data gathering is labor intensive; the resources are scarce; and it is costly for physicians.
  - Physician registration:
    - Software interfaces are not as much of a challenge as in the past, but they are costly.
    - Sustaining physician participation is a challenge, especially for those without EMR interfaces. (Some states, e.g., New York City, mandate participation.)
    - HIE and federal incentive may make it more feasible.

– Dr. Kulberg inquired if there has been any progress in using EHRs with VIIS? Mr. Farrell noted that VDH has worked with many of the major vendors. Since each provider's facility requires a unique interface, VDH has worked with vendors on application modification at the provider level. Mr. Farrell suggested the VIIS program staff present an update in the near future.

– Dr. Trump recommended waiting to see what the CDC requires of VDH, including IAC input and discussion, and guidance from Dr. Levine, Dr. Romero, and SHHR, with respect to the scope of the strategic plan.

- Should it be a state plan or an agency plan?
- What role do we have in working with our state-level professional organizations to provide education (e.g., FAAFP recertification process modules for immunizations)?
- Have we looked separately at VIIS data for the cohort of children born within the conception of VIIS? Population enrollment occurred mainly from H1N1.
- Vital records populates VIIS, but follow-on immunization history is lacking.

– Dr. Mitchell recommended that states' EMR systems interface with each other, as well as military records, and school records. Mr. Farrell noted that VDH does share data, although not regularly, with other state with registries that are funded by CDC, as the platforms are required to be the same.

– Dr. Forlano and Dr. Moskowitz commented that while physicians likely understand the importance of population-based data, it is not always their first priority; time is the commodity—willingness is not the issue; prioritization is key; does this (VIIS) add to the value of how their time is spent.

- Quarterly Data Snapshot Presented by Dr. Forlano:

– Clinical Updates/Highlights from June 2013 ACIP Meeting (refer to attachment).

– Publication of national HPV coverage data tentatively scheduled for July 26, 2013 (refer to attachment).

Open Discussion

- Dr. Puritz noted that the recent *OBGYN News* headline stated HPV was down 60% in the first 4 years of routine vaccination—definitely getting a lot of press. She also noted the following:

– Often patients are seen later—after sexually activity has begun

– Parental reaction is a major barrier, as there is major resistance (safety and social reasons)

– Lack of understanding that patient can receive 2nd and 3rd dose at any time

– First pap test (and HPV screening) is now at 21, which makes it harder to address exposure both from a data and treatment standpoint.

- Dr. Mitchell noted the data is not far reaching—statistics do not reach other audiences (pediatrics, legislators, etc.) as early or as often.
- Dr. Trump referred to a recent letter sent by Dr. Romero to physician associations and nurse practitioners as a reminder for back-to school immunizations and emphasizing Tdap, Meningococcal, HPV, etc. (both boys and girls).
- Dr. Mitchell noted the message 5th graders are getting from parents is 1 HPV shot, but the reality is telling them it is 4 shots over time. Dr. Trump recommended we suggest schools provide this information, perhaps via school nurses.

Closing Remarks

- VDH will keep the committee informed on the proposed legislation and strategic plan progress. The strategic planning will be the main topic for the next few meetings.
- Committee stakeholder comments (from this point and through General Assembly session) are provided in writing to the GA and remain part of the record. (Dr. Forlano noted that written comments are more helpful when preparing for submission to the GA.)
- Meeting adjourned at 10:16 a.m.