Vaccine Advisory Committee (VAC) Meeting

April 10 2025

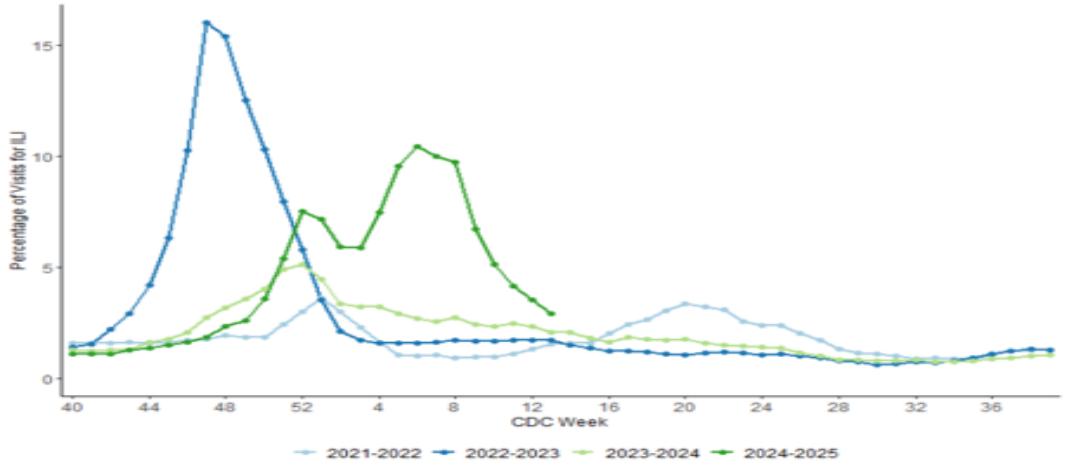
Chair/Facilitator:
Dr. Tao Sheng Kwan-Gett Washington State Department of Health

Members:	**Representing:**
Dr. Beth Harvey	Consultant
Dr. Ed Marcuse	Consultant
Charisse Gumapas	National Association of Pediatric Nurse Practitioners
Dr. Gretchen LaSalle	Washington Academy of Family Physicians
Libby Page	Public Health Seattle – King County
Dr. John Dunn	Kaiser Permanente
Dr. Frank Bell	Washington Chapter of the American Academy of Pediatrics
Dr. John Merrill-Steskal	Washington Academy of Family Physicians
Lauren Greenfield	Childcare Health Program Public Health
Dr. Mary Alison Koehnke	Naturopathic Medicine
Dr. Mark Larson	Washington State Association of Local Public Health Officials
Dr. Stephen Pearson	Washington Chapter of the American Academy of Pediatrics
Tam Lutz	Northwest Tribal Epidemiology Center / Lummi Nation
Magali Sanchez	Student Representative, University of Washington
Sarah Kim	School Nurse Representative, Bellevue School District
Seema Abbasi	Washington Chapter of the American Academy of Pediatrics
Annie Hetzel	Office of Superintendent of Public Instruction
Jenny Arnold	Washington State Pharmacy Association
Korrina Dalke	Health Care Authority
Mary Anderson	American College of Physicians
Wendy Stevens	American Indian Health Commission for Washington (AIHC)
Dr. Alisa Kachikis	American College of Obstetricians and Gynecologists

Washington State Department of Health Staff:

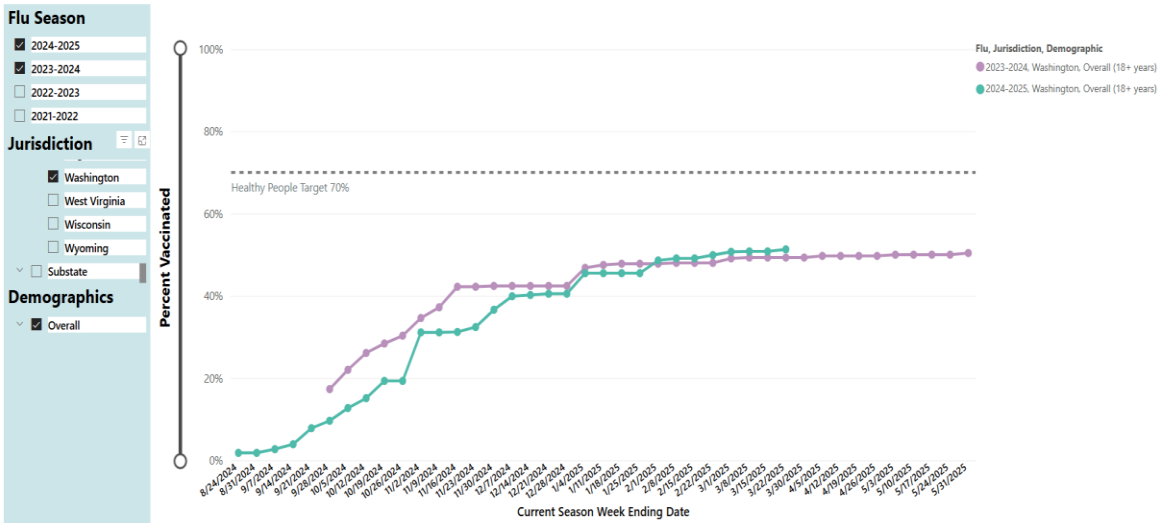
Jamilia Sherls-Jones	Amanda Dodd	Kelley Meder	Cheryl Ann Barnes
Poornima Jayaraman	Mary Huynh	Adriann Jones	Marissa Davison
Trang Kuss	Jessica Haag	Chas Debolt	Khalle Bymers
Meredith Cook	Trevor Christensen	April Mcclellan	Jeaux Rinedahl
Lisa Balleaux	Teri Maitri	Kimberly Carlson	Sherry Carlson
Janel Jorgenson	Phillip Wiltzius		

Topic	Presented Information
Welcome, Announcements, Introductions, Land Acknowledgement Tao Kwan-Gett	Tao Kwan-Gett welcomed the committee members and notified them that packets are available for them. Tao Kwan-Gett did an overview of the agenda and housekeeping. Tao Kwan-Gett provided a land acknowledgment and recognition.
Conflict of Interest &	Cheryl Ann read the committee's Conflict of Interest Policy.

Approval of Previous Meeting Minutes Meghan Cichy Tao Kwan-Gett	Cheryl Ann did roll call for the following who were present: John Dunn, Wendy Stevens, Karrina Dalke, Mary Koehnke, Gretchen LaSalle, Seema Abbasi, Libby Page, Lauren Greenfield, Magali Sanchez, Ed Marcuse, Frank Bell, John Merrill-Steskal, Tam Lutz, Beth Harvey, Jenny Arnold, Mary Anderson and Annie Hetzel No conflicts of interest were declared. Tao Kwan-Gett asked committee members to review the minutes from Jan 9, 2025. The meeting minutes were approved and will be published on the website.
Public Comment Tao Kwan-Gett	Public comments were received during the meeting. As a reminder, the Committee does not respond directly to comments. Members receive comments and take them into consideration during discussions. 2.30 minutes were given for public comment. Derek Kemppainen Bob Runnells Natalie Chavez
Office of Immunization Program Director Updates Jamilia Sherls	**Topics** • Respiratory Vaccines – Flu, RSV, COVID • Pop-Up Vaccination Clinic Guide Webinars • Laminated immunization schedules • Award nominations – Immunize WA & Immunization Champion Award • Adult & Maternal Immunization work • Funding **Flu Season Surveillance** Washington State Influenza Update **Figure 4: Syndromic Surveillance, Percentage of Hospital Visits for a Chief Complaint of ILI, or Discharge Diagnosis of Influenza, by CDC Week, Washington, 2021-2025**  **Using Market Research to Change Campaign Messaging** • Flu Free WA originally launched in 2023 and was adapted for the 2024-2025 season • With season-high infection and hospitalization rates spiking, we decided to extend campaign and explore new messaging • Survey fielded to our Market Research Online Community (MROC) in March • Of the n=314 respondents, 45.9% had not yet received the flu vaccine this season

- We tested the current campaign messaging with potential new messages for believability, motivation and resonance
- We utilized the message that was the most believable, motivating and resonant for the updated campaign assets

Figure 4A. Influenza Vaccination Coverage, Overall by Selected Demographics, 2024-25 and Jurisdiction, Among Adults 18 Years and Older *,†,‡,§,±
Data Source: National Immunization Survey–Adult COVID Module



2025-2026 Flu Vaccine Composition

- Influenza Vaccine Composition for the 2025-2026 U.S. Influenza Season | FDA
  - FDA made recommendations to vaccine manufacturers for the virus strains to include in flu vaccines next season.
  - Recommendations similar to previous year's strain selection.
  - FDA, CDC, and DoD staff evaluated and analyzed U.S. and global surveillance data related to the epidemiology and antigenic characteristics of flu viruses currently circulating.

Egg-based flu vaccine

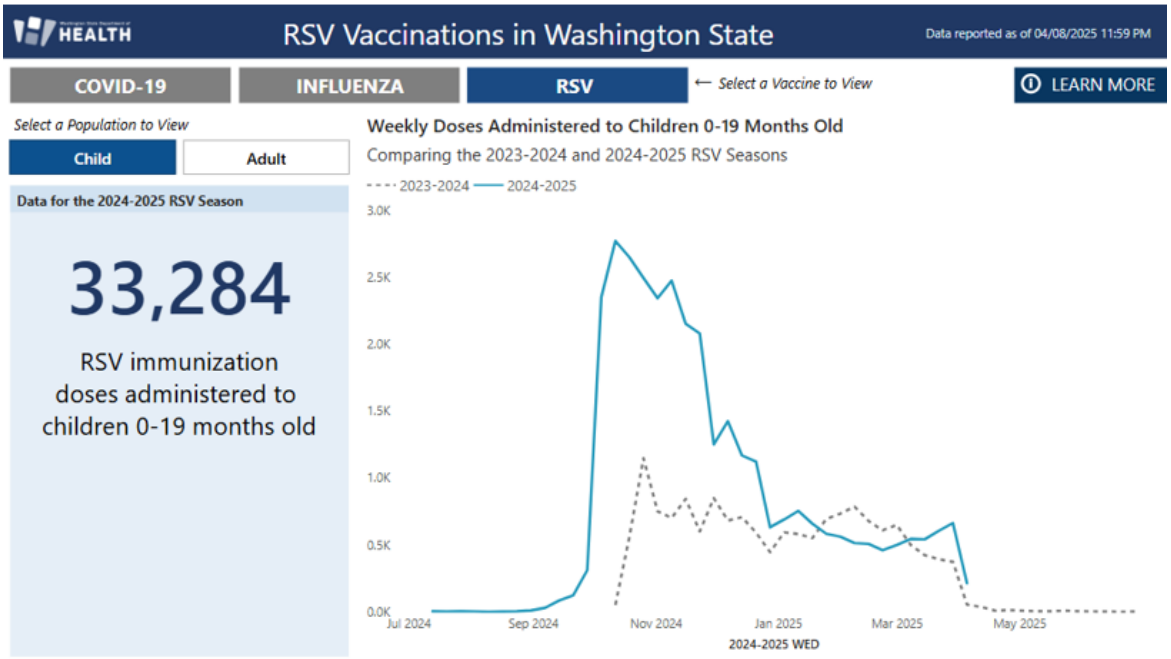
As a result of the meeting with the federal partners, the FDA recommends that the trivalent formulation of egg-based influenza vaccines for the 2025-2026 U.S. influenza season contain the following:

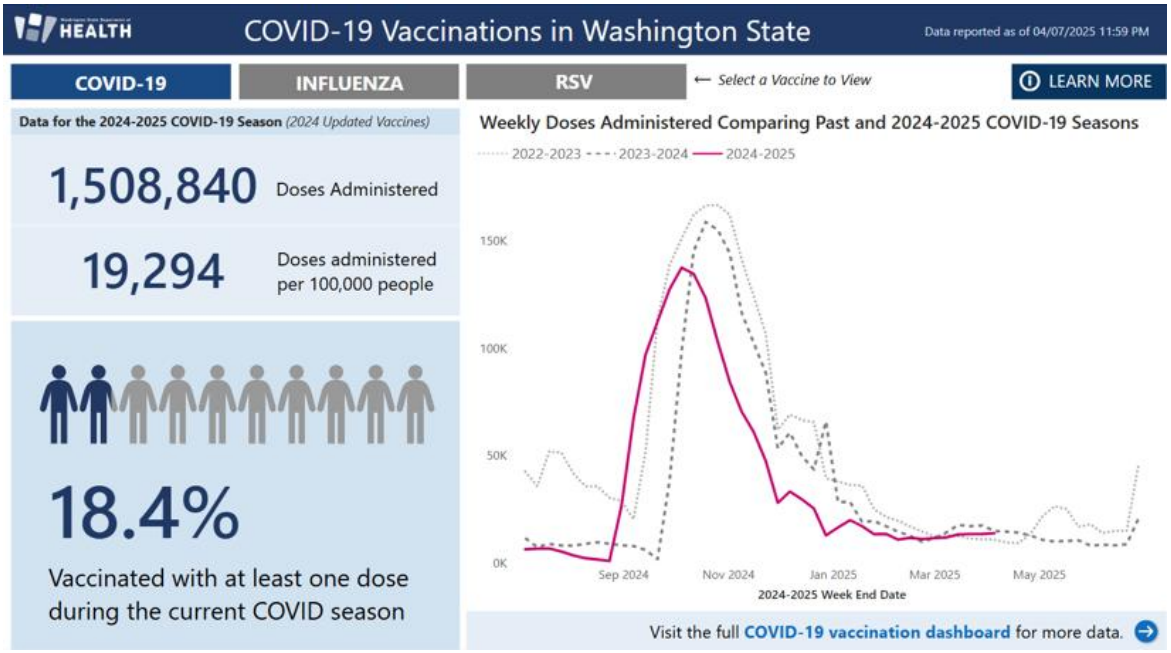
- an A/Victoria/4897/2022 (H1N1)pdm09-like virus;
- an A/Croatia/10136RV/2023 (H3N2)-like virus; and
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus.

Cell- or recombinant-based flu vaccine

The FDA recommends that the trivalent formulation of cell- or recombinant-based influenza vaccines for the 2025-2026 U.S. influenza season contain the following:

- an A/Wisconsin/67/2022 (H1N1)pdm09-like virus;
- an A/District of Columbia/27/2023 (H3N2)-like virus; and
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus.





Update on Novavax COVID-19 Vaccine

- Novavax ordering has been turned off in the IIS for all providers.
- The last lot of Novavax COVID-19 vaccine will expire on April 30, 2025. Please note that this vaccine will not have a shelf-life extension.
- These doses will be the final Novavax vaccines available for the 2024–2025 season

POP-Up Vaccination Clinic Guide Webinar Series

Date: April 22, 23, 29, 30

Time: 12PM-1PM

Why You Should Attend:

- Expert Insights: Learn from experienced Department of Health public health professionals who will share their expertise and best practices in establishing effective pop-up vaccination clinics.

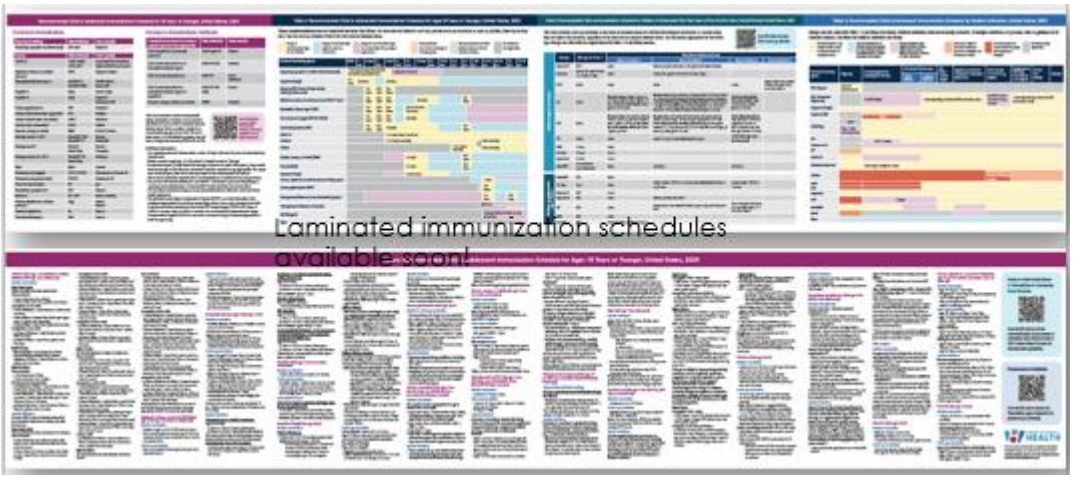
- Actionable Strategies: Gain practical techniques that you can implement to enhance clinic efficiency and reach underserved populations.
- Continuing Education Credits: Earn valuable CE credits for MAs, nurses, pharmacists, and pharmacy technicians, to enhance your professional development.

Promotional Video

For Details and Registration Information Click HERE

- Host: Cheryl Ann Barnes, MPH
- Email: cherylann.barnes@doh.wa.gov
- Phone: 564-233-5421
- Website: Immunization Training

Laminated immunization schedules available soon!



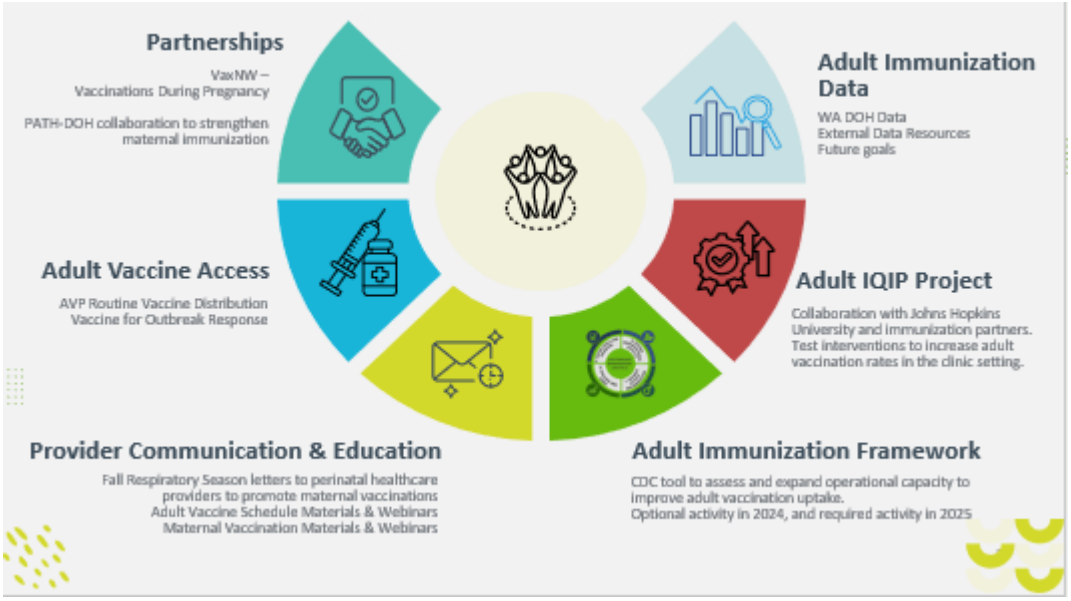
Immunization Awards:
Immunize WA 2025

- Nomination period June 1-July 15, 2025
- Providers must self nominate their clinics
- Award Announcements on Aug 20, 2025

Immunization Champion awards
Nomination Period Now Open for the 2025 Immunization Champion Award!

- The Washington State Department of Health, in conjunction with Association of Immunization Managers (AIM), has launched the nomination period for the 2025 Immunization Champion Award!
- We look forward to receiving your 2025 Immunization Champion nomination for Washington state by April 28, 2025. Individuals can be recognized for their work in childhood, adolescent, or adult vaccines. Our nomination period will be open from March 28, 2025, to April 28, 2025.
- The Immunization Champion Award is a national award hosted by AIM that honors individuals going above and beyond to foster and/or promote immunization in their communities.
- Access the nomination form on AIM's website here. Completed nominations should be emailed to Elizabeth Guajardo (OIEngagementPlanning@doh.wa.gov) at the Washington State Department of Health.
- Additional information about this award can be found at the AIM Immunization Champion Award web page or on the Centers for Disease Control and Prevention (CDC) website.

ADULT & MATERNAL IMMUNIZATION WORK



Funding Terminations

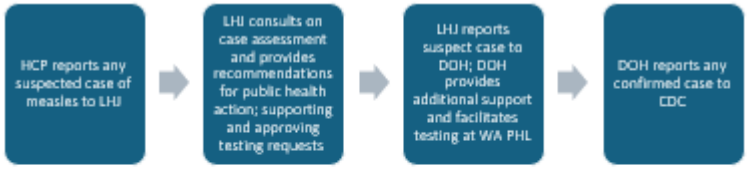
- HHS terminated funding for several COVID-related awards as of March 24
    - For WA DOH Immunization Office – this impacted investments in local health contracts, tribal contracts, Care-A-Van contracts, POP staffing, and immunization staffing.
    - Additional impacts to other program areas at DOH – totaling $130 to $140M
    - WA joined 23 states and DC in a legal challenge. Temporary restraining order obtained on April 3 for the 24 entities part of the suit. Able to resume use of funds for now, as the legal process unfolds.
    - Nationally, an abrupt termination of $11 billion in critical public health funding

Pandemic Funding Termination Impacts to Immunization

- Unable to sustain mobile vaccinations services (Care-A-Van). Immediate reduction in ability to vaccinate those at-risk for COVID and other VPDs.
- Reduction in respiratory virus health promotion campaign (Covid/Flu/RSV)
- Reduced ability to respond to emerging VPD outbreaks for mpox, measles, and H5N1 (directed to use COVID funding to support efforts given lack of other funding sources)
- Reduced capacity for fulfilling data requests and assessment of immunization data
- Direct impact to local health jurisdiction and tribal funding and ability to respond at the local level to COVID and other VPD outbreaks
- Data quality efforts will be reduced
- Health education for COVID and other VPD limited

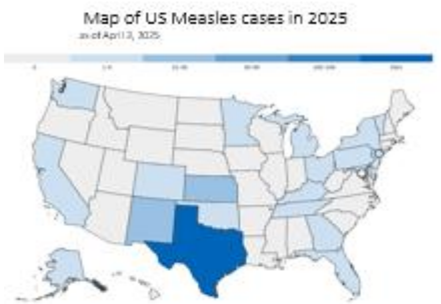
Routine Immunization Funding Application

- "*Strengthening Vaccine–Preventable Disease Prevention and Response*" grant was submitted in early March and under review by the CDC. Expect to receive a Notice of Award in late June.
- Required activities under 7 priority strategies:
    - Strengthen Program Infrastructure and Management
    - Increase Vaccine Access
    - Improve Vaccination Equity
    - Promote Vaccine Confidence and Demand
    - Enhance Data and Evaluation
    - Strengthen Program Support for Partners
    - Enhance Vaccination Response Readiness
- 3 components

	• Core (routine immunization) - $9.55M (target award) • Rapid Small-Scale VPD outbreak (funded, use upon consultation/approval) - $250K • Rapid Large-Scale VPD outbreak (approved, unfunded) - $3M **Seeking Feedback** • How do we continue to improve coverage rates? • What are things we should continue to be mindful of as we plan future immunization work? **Questions and Discussion** JD: Can we have data on pregnant woman vaccinated on Nirsevimab. Women only need to be vaccinated once, not for multiple pregnancies. It can be tricky to determine doses. Providers don't have time to read. Can we tease it out a bit more for them. Work with Health Educators to make it easier for them.
Measles update Amanda Dodd Trang Kuss Trevor Christensen Poornima Jayaraman Philip Wiltzius Adriann Jones	**Measles Surveillance** **Case Reporting:**  **Legal Reporting Requirements** 1. Health care providers and Health care facilities: **immediately notifiable to local health jurisdiction** 2. Laboratories: **immediately notifiable to local health jurisdiction**; specimen submission required - isolate or clinical specimen associated with positive result (2 business days) 3. Local health jurisdictions: **immediately notifiable to Washington State Department of Health (DOH) Communicable Disease Epidemiology (CDE)** **Global Measles**  [WHO Measles and Rubella Global Update March 2025] **Measles in the US** • *Total of 607 confirmed cases in the US reported as of April 3, 2025* • *6 outbreaks (> 3 cases)* • *93% of cases are outbreak-associated* • *72% of cases have been < 19 years old* • *97% of cases were unvaccinated or had unknown vaccination status* • *12% of cases hospitalized*

- *3 deaths (2 confirmed deaths from measles and 1 death under investigation)*

Health Alert Network (HAN) 00504– Increase in Global and Domestic Measles Cases and Outbreaks: Ensure Children in the US and Those Traveling Internationally 6 Months or Older are Current on MMR Vaccination



https://www.cdc.gov/measles/data-research/index.html

Measles in Washington State

Year	Cases	Deaths
2005	1	0
2006	1	0
2007	3	0
2008	19	0
2009	1	0
2010	1	0
2011	4	0
2012	0	0
2013	4	0
2014	33	0
2015	10	1
2016	0	0
2017	3	0
2018	8	0
2019	90	0
2020	1	0
2021	0	0
2022	1	0
2023	12	0
2024	6*	0

*Preliminary

Statewide case data published annually by WA DOH

Year	Case Count	
2019	90	2019 Clark County and Sea-Tac Airport Outbreaks
2020	1	COVID-19 Pandemic
2021	0	COVID-19 Pandemic
2022	1	COVID-19 Pandemic
2023	12	
2024*	6*	
2025*	3*	

*Preliminary case counts

2025 Washington State Measles Cases Summaries

February 26 – first measles case identified in an infant from King County

- Associated with international travel
- Several public exposure locations
- Monitoring for secondary cases:
    - First incubation period for possible secondary cases to present ended March 18
    - Second incubation period will end on April 8

March 17 – second measles case identified in an adult from Snohomish county

- Known exposed contact to the first case (linked to first case)
- No public exposure locations identified
- Healthcare exposures occurred
- Monitoring for secondary cases:
    - Secondary cases from healthcare exposures could present through approximately April 10

April 1 – third measles case identified in an infant from Snohomish county

- Associated with international travel
- Multiple public exposure locations
- As of April 7:
    - Identifying close contacts for immunization history and PEP
    - Public media release distributed with exposure locations identified

Please reach out to vpd-cde@doh.wa.gov with any questions

Measles Vaccine Recommendations

Vaccination is the best protection

One dose of MMR (measles-mumps-rubella) vaccine is 93% effective at protecting against measles infection

Two doses of MMR are 97% effective

- Two doses of the MMR vaccine is the best way to protect against measles, mumps, and rubella.
- MMR usually protect people for life against measles and rubella; but immunity against mumps may decrease over time.
- High rates of vaccination have made these diseases much less common in the United States.
- 1 dose of MMR is 93% effective. Two doses are 97% effective at preventing measles. It is uncommon for someone fully vaccinated to develop measles. However, breakthrough infections (when someone becomes infected after they have been vaccinated) can occur, especially in communities experiencing an outbreak where high levels of measles virus are circulating.
- When more than 95% of people in a community are vaccinated (coverage >95%), most people are protected through community immunity (herd immunity). However, vaccination coverage among U.S. kindergartners has decreased from 95.2% during the 2019–2020 school year to 92.7% in the 2023–2024 school year

Presumptive evidence of measles immunity

At least one of the following:

- Written documentation of adequate vaccination:
    - one or more doses MMR for preschool-age children and adults not at high risk
    - two doses of MMR for school-age children, adolescents, and adults at high risk, including college/vocational students, healthcare personnel, and international travelers
- Lab evidence of immunity or disease (verbal history of measles does not count)
- Birth before 1957

Health care workers born before 1957 who do not have evidence of immunity should receive 2 doses of MMR vaccine.

During an outbreak, healthcare facilities should recommend 2 doses of MMR vaccine for unvaccinated personnel regardless of birth year if no lab evidence of immunity.

MMR vaccine recommendations – Children

- Dose 1 at 12-15 months
- Dose 2 at 4-6 years
    - Dose 2 can be given as early as 28 days after dose 1

- Early dose may be considered at 6-11 months
    - International travel
    - Domestic travel to community with measles outbreak
    - Early dose doesn't count toward series completion; need 2 more doses at 12-15 months and 4-6 years

MMR vaccination of infants 6-11 months

DOH shared two letters from CDC related to giving an early MMR dose

- The level of protective antibodies is lower and may remain lower in children vaccinated at younger than 12 months of age than in children vaccinated later.
- Infants younger than 12 months of age are at greatest risk of severe illness. Vaccination of infants aged 6–11 months minimizes the risk of disease and death that could occur in these infants during measles outbreaks.
- Providers should weigh the benefit of protection from measles during an outbreak against the risk of decreased immune responses in infants vaccinated with MMR before 12 months of age.

CDC measles message
CDC MMR Travel and Outbreak Recommendations
Prevention of Measles, Rubella, Congenital Rubella Syndrome, and Mumps, 2013

- Consultation with local or tribal public health is not required before administering early dose for travel-related exposure to international destination or a domestic location affected by an outbreak.
- Consultation with local or tribal public health is required before administering early dose to an infant who is not traveling, unless public health has issued the recommendation for an early dose because of a local outbreak.
- Texas Department of State Health Services (DSHS) recommends infants 6 through 11 months receive an early dose of MMR vaccine in affected counties in Texas. Subsequent doses should follow CDC's recommended childhood schedule. Reference: CDC HAN alert

MMR Vaccine Recommendations – Adults

Number of MMR doses	Considerations

No doses	• Birth before 1957 except healthcare worker (HCW)
	• Born 1957 or later, already received ≥1 doses and at low risk:
	  o Not international traveler
	  o Not HCW
	  o Not in college/post-high school education
	• Lab evidence of immunity or lab confirmation of measles
	• Documentation of live measles vaccine in 1960s

1 dose	• At low risk, born 1957 or later
	• No documented live measles vaccine
	• No lab evidence of immunity or measles infection
	• Vaccinated before 1968 with inactivated (killed) measles vaccine or measles vaccine of unknown type
	  o Killed measles vaccine available in 1963-1967 not effective
	• Received MMR before 1989 and at high risk
	  o Healthcare worker
	  o International travelers born in 1957 or later
	  o Attending college/post-high school education

2 doses	• High-risk • No documentation live measles vaccine • No lab evidence of immunity or measles infection • Vaccinated before 1979 with killed mumps vaccine or mumps vaccine of unknown type at higher risk

MMR vaccine recommendations – International Travel

- Infants 6-11 months should receive one dose of MMR vaccine at least two weeks before travel.
- Before leaving the United States, travelers 12 months and older, including adults born during or after 1957 who do not have evidence of measles immunity should receive two doses of MMR vaccine (ideally with the second dose given at least two weeks before travel and at least 28 days apart).

MMR vaccine recommendations – Domestic Measles Outbreak

- Health care providers should follow vaccination recommendations issued by local or tribal public health for areas experiencing sustained, community-wide measles transmission. Additional vaccinations may be recommended beyond the routine MMR vaccination schedule:
  - Second dose of **MMR vaccine for adults** who received one dose and living in or traveling to affected areas. Adults with no documentation of vaccination should receive two doses, at least 28 days apart.
  - Second dose of **MMR vaccine for children aged 1 to 4 years** who received one dose and live in or plan to travel to the outbreak area. Children with no documentation of vaccination should receive two doses, at least 28 days apart.
- Vaccination of **visitors to outbreak-affected areas** should be consistent with guidance for residents of the outbreak-affected community. For example, if no vaccination recommendation was made by the local health department for infants aged 6–11 months living in the outbreak community, then vaccination of infants visiting the outbreak area would also not be recommended.

2025ProviderLetterMMRTravelOutbreakRecommendations.pdf

Measles Vaccination FAQs

- Adults with evidence of immunity do not need any further vaccines. No "booster" doses of MMR vaccine are recommended for adults or children. They are considered to have life-long immunity if they received the recommended number of MMR doses or have other acceptable evidence of immunity.
- Two documented doses of MMR vaccine given on or after age 12 months and separated by at least 28 days is considered proof of measles immunity. **Documentation of appropriate vaccination supersedes the results of serologic testing for measles, mumps, and rubella.**

MMR Vaccine FAQs

- Titers are not necessary for adults born before 1957, received two doses of MMR vaccine, or had measles disease. However, IF serologic testing is done for people born before 1957 and shows no immunity, 1 or more doses can be given.
- Titer results sometimes show someone is not immune to some combination of measles, mumps, and/or rubella. If a person is at increased risk and doesn't have documentation of either MMR vaccine or disease, and titers are negative, they should receive two doses.

Ask The Experts About Vaccines: MMR (Measles, Mumps, and Rubella) | Vaccine Recommendations | Immunize.org

Resources

- Send email to immunenurses@doh.wa.gov for vaccine questions
- Ask The Experts About Vaccines: MMR (Measles, Mumps, and Rubella) | Immunize.org
- Measles Vaccination | Measles (Rubeola) | CDC
- MMR Vaccination: For Providers | CDC
- Measles | Washington State Department of Health

- Plan for Travel | Measles (Rubeola) | CDC
- WA Measles Updates 2025 - April 2, 2025 | Washington State Department of Health

Adult Vaccine Program - Outbreak Response

- AVP vaccines are normally limited to uninsured adults 19+
- However, AVP vaccine can be used for additional populations beyond uninsured adults when used for **outbreak control and post-exposure prophylaxis (PEP)**.
    - ***Consultation with DOH and pre-approval is required*** *to utilize AVP vaccine for additional populations.*
    - Limited funding for vaccine. Prioritized for jurisdictions managing case(s) and PEP needs for susceptible contacts.

AVP Outbreak Provider Agreement

- The Adult Vaccine Program has an Outbreak Provider Agreement that will be used for future independent outbreaks without requiring full enrollment into AVP.
- This provider agreement is intended for providers who are not enrolled in AVP but would like to support vaccination **in case of an outbreak**. They will receive notification and information of an outbreak and be able to place orders through this enrollment.
- *Feel free to share this with providers and partners to prepare for an outbreak in your jurisdiction.*
- For questions about the Outbreak Provider Agreement, please contact the AVP team at WAAdultVaccines@doh.wa.gov
- If you or another provider would like to enroll in the full Adult Vaccine Program, please visit the AVP website.

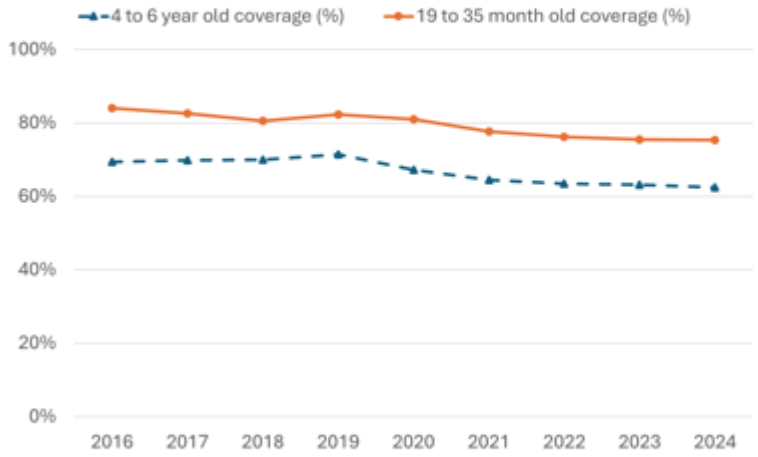
Washington State Immunization Information System

WAIIS

- Administrative database first, surveillance system second
    - Holds on to everything resulting in duplicates, fragmented data
    - Data elements necessary for surveillance must sometimes be inferred
- Surveillance utility dependent on high, uniform population capture
    - Generally true for children, less so for adults

Limitations

- IIS denominator inflation results in underestimates
- Race and ethnicity data are based on provider report to WAIIS
- Current data is used to calculate estimates retrospectively, so, depending on data vintage, historical estimates will shift

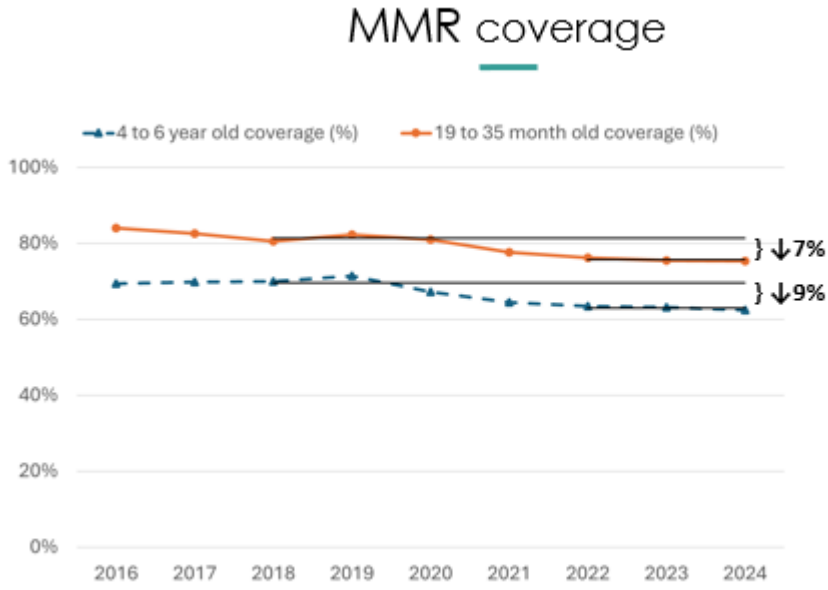


4 to 6 year olds covered if **2+** valid doses on record

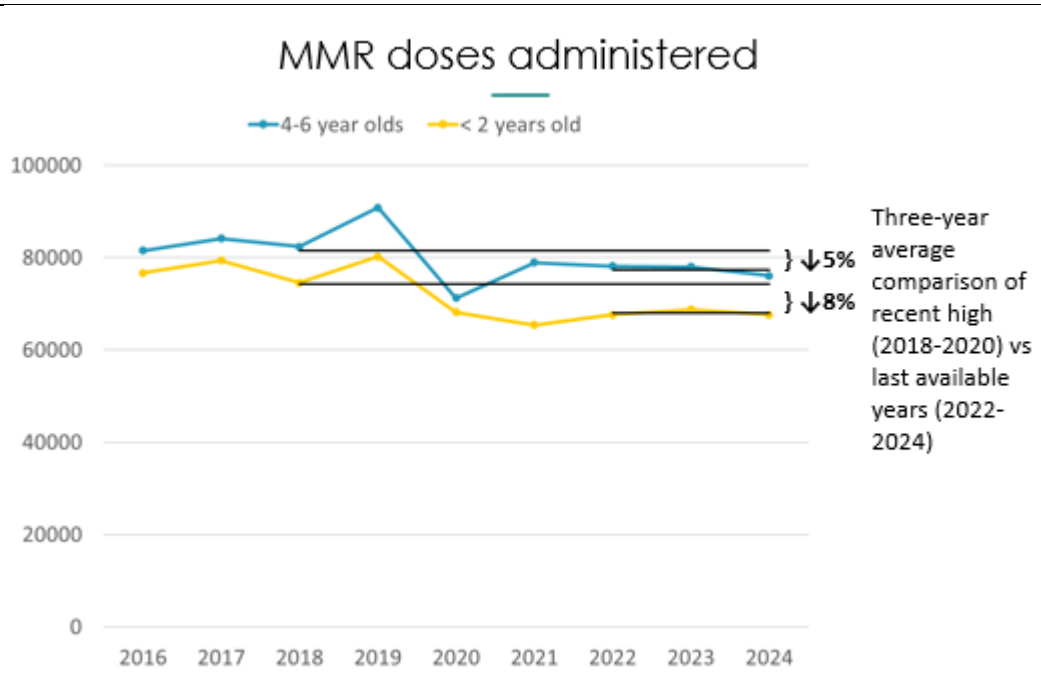
19 to 35 month olds covered if **1+** valid doses on record

Routine vaccination schedule is 12-15 months and 4-6 years old

4 to 6 years old is a period of recommended vaccination and 19-35 months old is not



Three-year average comparison of recent high (2018-2020) vs last available years (2022-2024)



New report for Local Health Jurisdictions

- Coverage of 2+ MMR (up-to-date) among 7-10 year olds
- Breakdowns by gender, language spoken, Hispanic ethnicity and two types of race categorization
- Small area estimates by county and Census tract
- Estimates as of March 4, 2025

Demographic differences in coverage

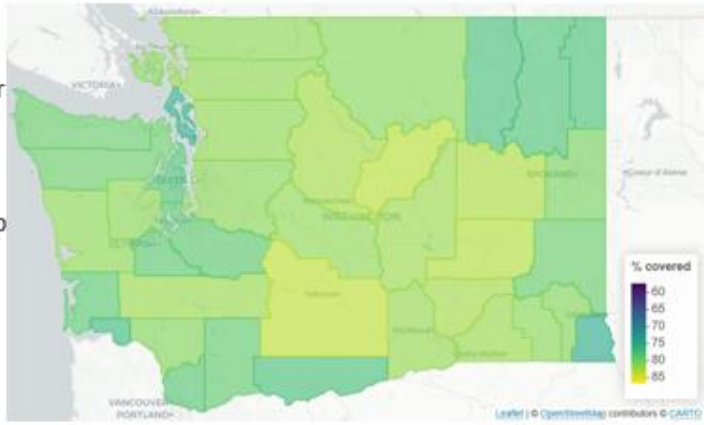
Coverage ratios ranged up to 1.11 or 11% higher than the reference group

MMR coverage was…

- 11% higher among Asian children than those who were not Asian
- 9% higher among Hispanic/Latino than those who were white, non-Hispanic
- 8% higher among those who speak Spanish than those who speak English
- 6% higher among those who are American Indian or Alaska Native than those who are not

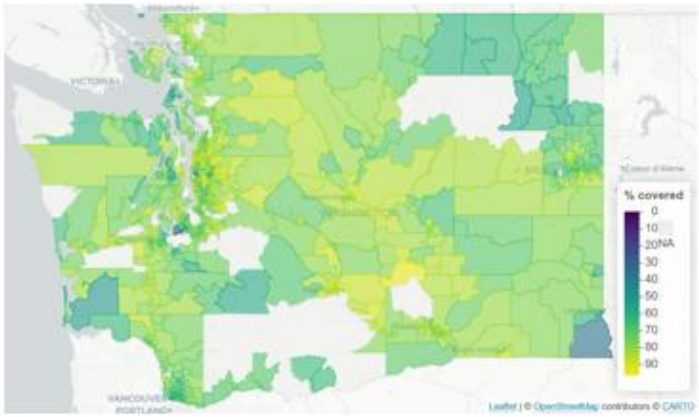
County MMR coverage, 7-10 year olds, March 2025

- 7-10 years old is after active vaccination period
- Of about 0.5M records, 75.6% are up to date



Census tract MMR coverage, 7-10 year olds, March 2025

- Excludes tribal Census tracts and those with small numbers

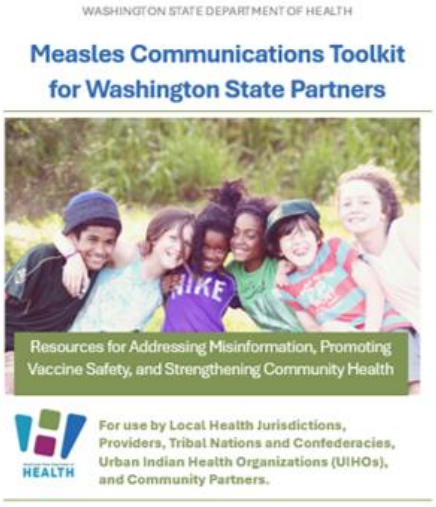


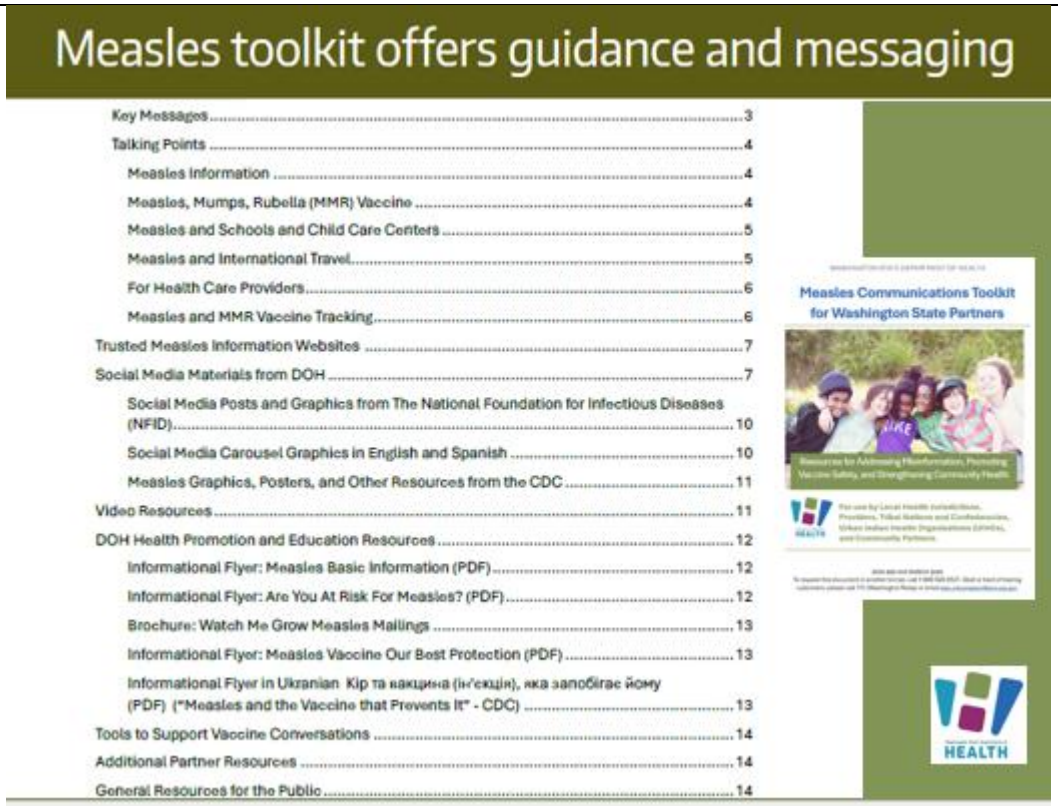
Summary

MMR coverage declined over the COVID-19 pandemic and has not recovered

- Some areas of the state have lower rates of coverage
- Close inspection of small area estimates helps identify potential explanations for lower rates
  - Border communities
  - Non-residential areas
  - Highly transient population (e.g., near military bases)

Measles Communications





Download the Measles Communications Toolkit PDF from the DOH Measles page today!

Measles | Washington State Department of Health
https://doh.wa.gov/you-and-your-family/illness-and-disease-z/measles

Let's work together to promote immunization awareness and strengthen community health!

UPDATES TO MEASLES MATERIALS AND CONTENT

WEB UPDATES

- Over the past year, our team has worked to update vaccine/disease pages across Office of Immunization and Vaccine Preventable Disease.
- This allowed us to pivot quickly given the increase in measles over the last year.
- We've made sure our recent measles landing page, the VPD measles page, was prepared for more public eyes.
- As part of this overall effort, we also updated links and materials across pages.

DOH Landing Page, end of March, 2025

WEB HIGHLIGHTS

- Alignment of OI and VPD content, plaintalked measles overview
- New links from CDC site changes
- Updated public resources
  (often 3-6 years old)
- Relevant WMGW content
- Addition of short NFID videos on measles

Resources and Materials

- Measles Basic Information (PDF)
  - Amharic (PDF) | Arabic (PDF) | Burmese (PDF) | Chinese Simplified (PDF) | Chinese Traditional (PDF) | Dari (PDF) | Hindi (PDF) | Khmer (PDF) | Korean (PDF) | Nepali (PDF) | Pashto (PDF) | Russian (PDF) | Somali (PDF) | Spanish (PDF) | Swahili (PDF) | Tigrinya (PDF) | Ukrainian (PDF) | Vietnamese (PDF)
- "Are You at Risk for Measles?" flyer (PDF)
  - ¿Corre riesgo de contraer el sarampión? (PDF)
- Vaccine Safety - Office of Immunization
- Learn about the MMR vaccine
- "Measles Vaccine: Our Best Protection" flyer (PDF)
- Frequently asked questions about measles in the U.S. (CDC)
- Measles information for travelers (CDC)
- Washington school immunization data and reports
- "Protect Your Family and Community from Measles" brochure (PDF)
- Кір та вакцина (ін'єкція), яка запобігає йому (PDF) ("Measles and the Vaccine that Prevents It" flyer - Ukrainian) (CDC)
- "This is how easy it is to spread measles" video (NFID)
- "Five things you need to know about measles in 30 seconds" video (NFID)

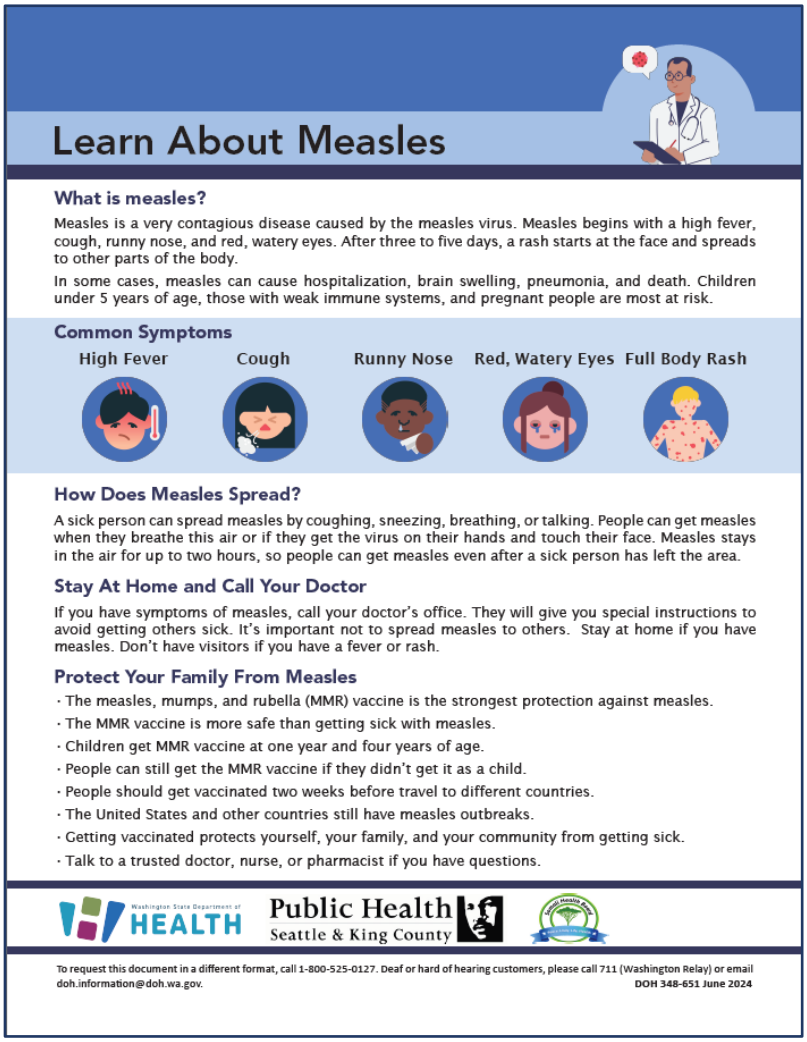
For Local Health Jurisdictions and Healthcare Providers

- **Measles Communications Toolkit for Washington State Partners (PDF)**
  Resources for addressing misinformation, promoting vaccine safety, and strengthening community health
- **Immunization Response Guide: Measles (PDF)**
  This partner guide lays out immunization-specific needs in a measles response including key considerations and response strategies. The focus is on general vaccine guidance, distribution, policy considerations, staffing considerations, Immunization Information System (IIS) utilization and communication strategies.
- **Measles Post-Exposure Prophylaxis (PEP) for Non-Symptomatic Susceptible Contacts (PDF)**

BASIC MEASLES INFORMATION

Public handout

- Available in 19 languages
- Originally a collaboration between DOH, Somali Health Board, and SeaKing Public Health
- More visuals, plain talked.



Learn About Measles

What is measles?

Measles is a very contagious disease caused by the measles virus. Measles begins with a high fever, cough, runny nose, and red, watery eyes. After three to five days, a rash starts at the face and spreads to other parts of the body.

In some cases, measles can cause hospitalization, brain swelling, pneumonia, and death. Children under 5 years of age, those with weak immune systems, and pregnant people are most at risk.

Common Symptoms

High Fever | Cough | Runny Nose | Red, Watery Eyes | Full Body Rash

How Does Measles Spread?

A sick person can spread measles by coughing, sneezing, breathing, or talking. People can get measles when they breathe this air or if they get the virus on their hands and touch their face. Measles stays in the air for up to two hours, so people can get measles even after a sick person has left the area.

Stay At Home and Call Your Doctor

If you have symptoms of measles, call your doctor's office. They will give you special instructions to avoid getting others sick. It's important not to spread measles to others. Stay at home if you have measles. Don't have visitors if you have a fever or rash.

Protect Your Family From Measles

- The measles, mumps, and rubella (MMR) vaccine is the strongest protection against measles.
- The MMR vaccine is more safe than getting sick with measles.
- Children get MMR vaccine at one year and four years of age.
- People can still get the MMR vaccine if they didn't get it as a child.
- People should get vaccinated two weeks before travel to different countries.
- The United States and other countries still have measles outbreaks.
- Getting vaccinated protects yourself, your family, and your community from getting sick.
- Talk to a trusted doctor, nurse, or pharmacist if you have questions.

Washington State Department of HEALTH | Public Health Seattle & King County

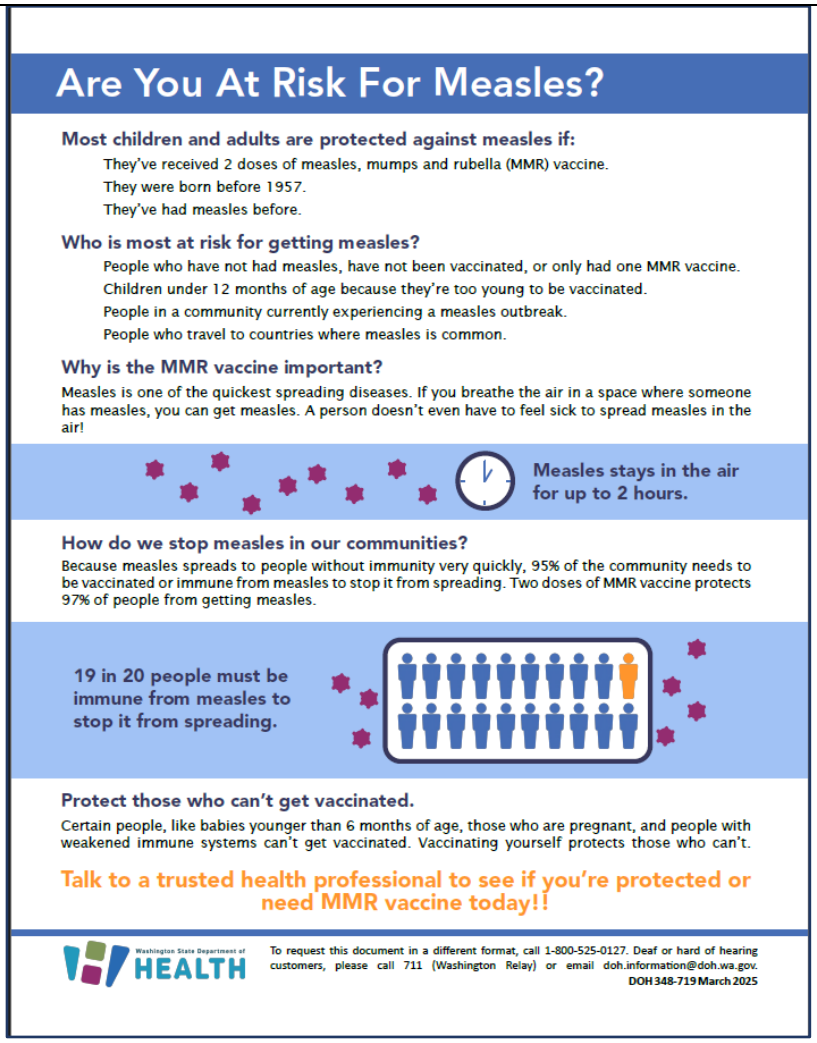
To request this document in a different format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

DOH 348-651 June 2024

Are you at risk for measles?

Public handout

- Focus on vaccination & protecting community
- Also in Spanish



Are You At Risk For Measles?

Most children and adults are protected against measles if:

They've received 2 doses of measles, mumps and rubella (MMR) vaccine.
They were born before 1957.
They've had measles before.

Who is most at risk for getting measles?

People who have not had measles, have not been vaccinated, or only had one MMR vaccine.
Children under 12 months of age because they're too young to be vaccinated.
People in a community currently experiencing a measles outbreak.
People who travel to countries where measles is common.

Why is the MMR vaccine important?

Measles is one of the quickest spreading diseases. If you breathe the air in a space where someone has measles, you can get measles. A person doesn't even have to feel sick to spread measles in the air!

How do we stop measles in our communities?

Because measles spreads to people without immunity very quickly, 95% of the community needs to be vaccinated or immune from measles to stop it from spreading. Two doses of MMR vaccine protects 97% of people from getting measles.

Protect those who can't get vaccinated.

Certain people, like babies younger than 6 months of age, those who are pregnant, and people with weakened immune systems can't get vaccinated. Vaccinating yourself protects those who can't.

Talk to a trusted health professional to see if you're protected or need MMR vaccine today!!

Washington State Department of HEALTH

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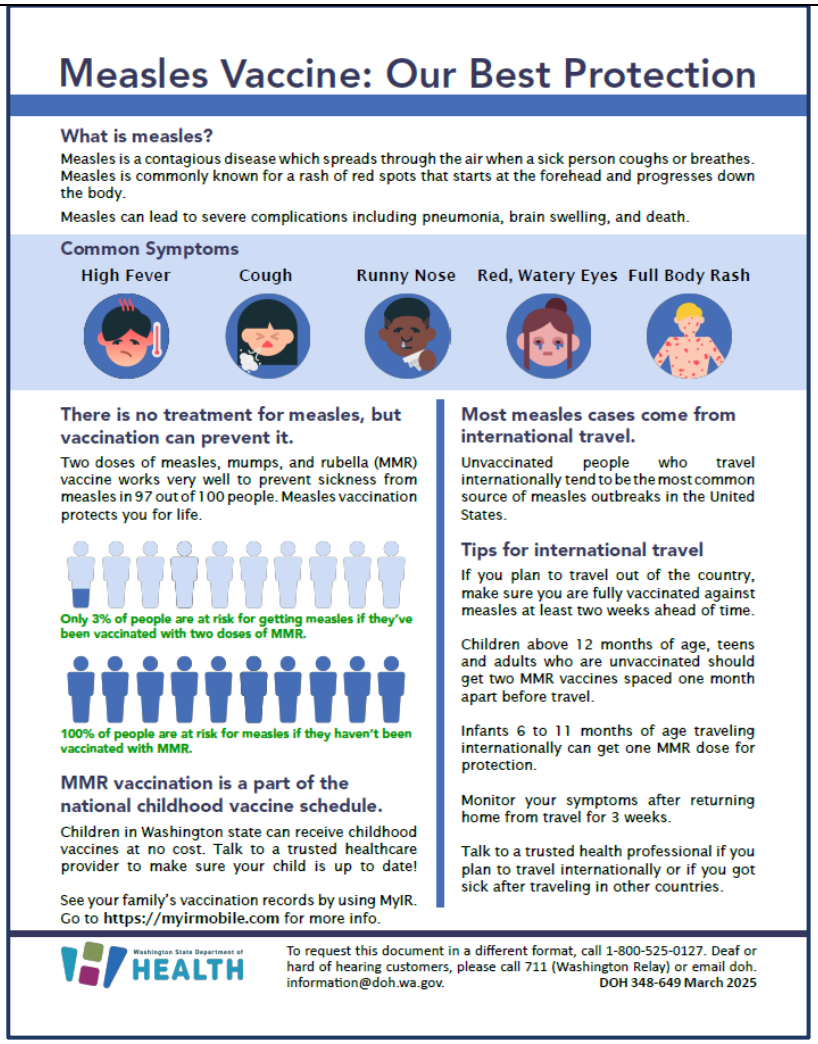
DOH 348-719 March 2025

MEASLES VACCINATION: OUR BEST PROTECTION

Public handout

- Focus on protection from measles vaccination
- Childhood vaccines offered at no cost
- Information for international travel



Measles Vaccine: Our Best Protection

What is measles?

Measles is a contagious disease which spreads through the air when a sick person coughs or breathes. Measles is commonly known for a rash of red spots that starts at the forehead and progresses down the body.

Measles can lead to severe complications including pneumonia, brain swelling, and death.

Common Symptoms

High Fever | Cough | Runny Nose | Red, Watery Eyes | Full Body Rash

There is no treatment for measles, but vaccination can prevent it.

Two doses of measles, mumps, and rubella (MMR) vaccine works very well to prevent sickness from measles in 97 out of 100 people. Measles vaccination protects you for life.

Only 3% of people are at risk for getting measles if they've been vaccinated with two doses of MMR.

100% of people are at risk for measles if they haven't been vaccinated with MMR.

MMR vaccination is a part of the national childhood vaccine schedule.

Children in Washington state can receive childhood vaccines at no cost. Talk to a trusted healthcare provider to make sure your child is up to date!

See your family's vaccination records by using MyIR. Go to **https://myirmobile.com** for more info.

Most measles cases come from international travel.

Unvaccinated people who travel internationally tend to be the most common source of measles outbreaks in the United States.

Tips for international travel

If you plan to travel out of the country, make sure you are fully vaccinated against measles at least two weeks ahead of time.

Children above 12 months of age, teens and adults who are unvaccinated should get two MMR vaccines spaced one month apart before travel.

Infants 6 to 11 months of age traveling internationally can get one MMR dose for protection.

Monitor your symptoms after returning home from travel for 3 weeks.

Talk to a trusted health professional if you plan to travel internationally or if you got sick after traveling in other countries.

Washington State Department of HEALTH

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DOH 348-649 March 2025

PROTECT YOUR FAMILY AND COMMUNITY FROM MEASLES

Public brochure

- One of our WMGW mail brochures focused on measles
- Written for families
- Focus on vaccinating infants and young children
- Great resource for pediatricians and family practice docs, regularly updated

OVERALL

- Update materials to modern DOH standards
- Meet our audience by reducing text, increasing visuals, and plaintalking more content (including for healthcare professionals!)
- Increase translated materials

Moving forward…

- Work to update our OI vaccine web pages into Spanish
- Work with other teams and offices to identify out-of-date materials that need updates quicker

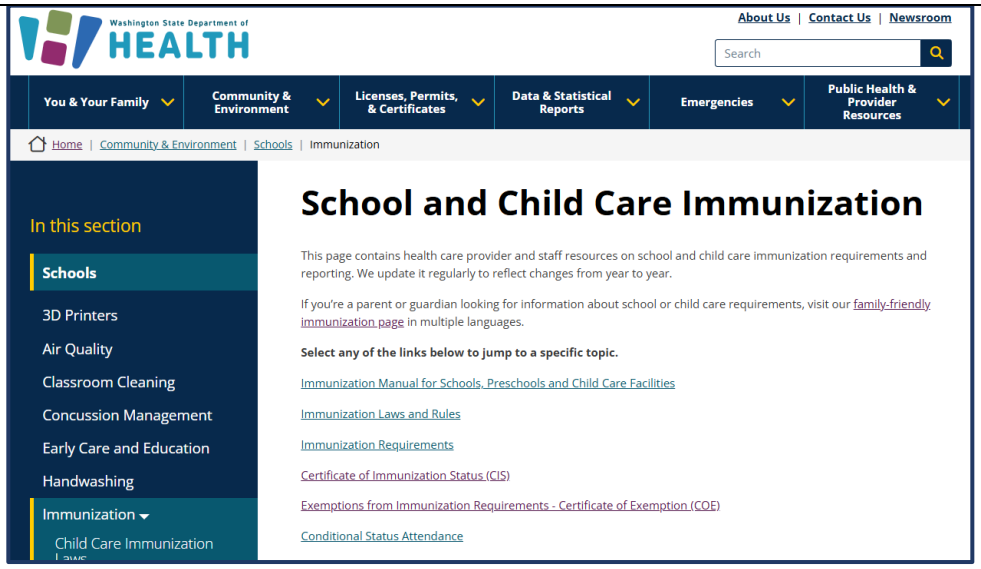
SCHOOL & CHILD CARE

https://doh.wa.gov/scci

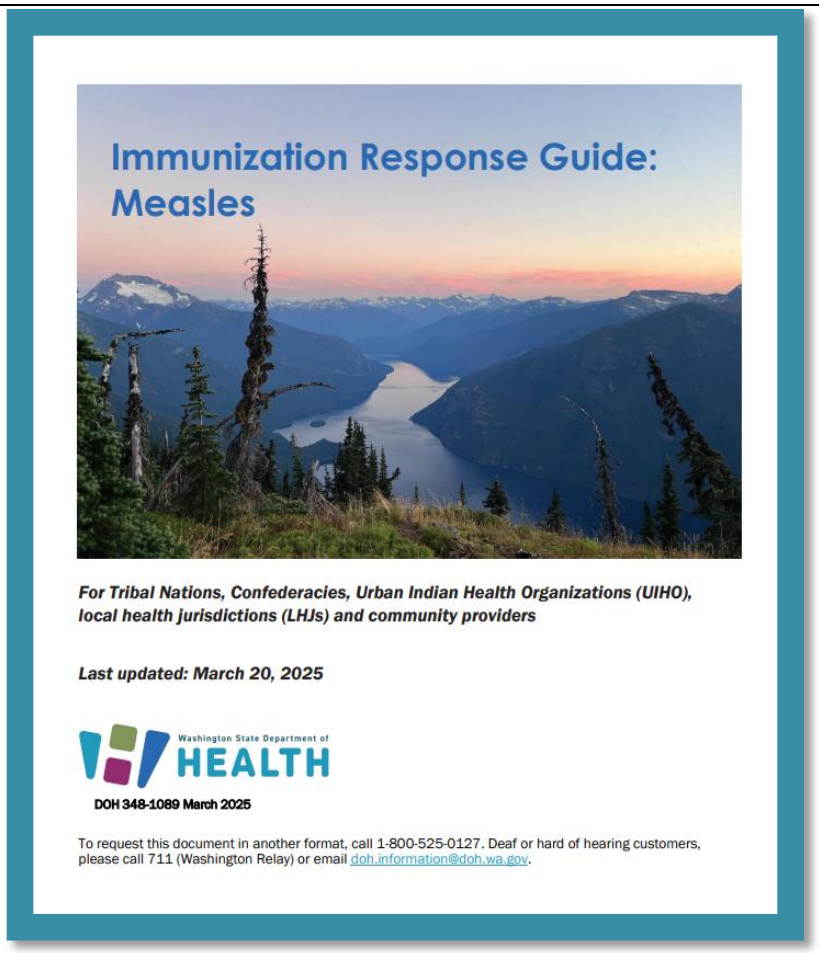
- Outbreaks & Exclusion FAQs
- Immunization Reminder Letters
- Staff/volunteer MMR requirement for child care centers info

https://doh.wa.gov/vax2school

- Student immunization charts
- Certificate of Immunization Status
- Certificate of Exemption
- (Materials in 18 languages, web page in 4 languages)



Office of Immunization updates



Intended Audiences:

- Tribal Nations, Confederacies, Urban Indian Health Organizations (UIHO)
- Local Health Jurisdictions (LHJs)
- Community providers

Priorities

<u>Immediate Actions</u>:

1. Initiate communication, coordination, and training with your internal team and partners.
2. Ensure an adequate supply of vaccine is available in affected area.

<u>Key Priorities:</u>

- Working with providers
  - Inform healthcare providers about the outbreak.
- Working with Community Partners
  - Help partners connect to vaccination resources.

Planning Considerations for Readiness

- **Vaccine Response**

- Assess and evaluate what services you can support in relation to implementing vaccination events.

➢ **Immunization Data**
- Consider how you will assess MMR coverage or other measures of uptake.

➢ **Clinical Guidance and Vaccine Safety**
- Update and prepare educational content on Measles and MMR vaccine.

➢ **Partner and Community Engagement**
- Create or consider establishing engagement plans and culturally appropriate materials for partners and impacted communities.

➢ **Immunization, Communication, Health Promotion and Education**
- Consider partnering with affected communities to develop culturally appropriate materials, if needed.

➢ **Outbreaks in School or Childcare Settings**
- Consider vaccination coordination during a school or childcare measles outbreak with school or childcare partners.

➢ **Other Considerations**
- Consider areas where additional staffing may be temporarily needed.

Guidance

- Vaccine guidance for adults, children, evidence of immunity, and Post-exposure Prophylaxis (PEP).
- Equity considerations including identifying high risk populations and integrating a pro-equity approach to fostering trusted messengers.
- Immunization Information System (IIS): Assessment training modules and Data Requests.

Additional information includes:

➢ Clinical Immunization Education and Vaccine Safety
➢ Vaccine Distribution

Support

DOH'S Method of Engagement:

During an outbreak DOH will establish communication with:

- LHJs/Counties
- Tribal nations, Confederacies, and UIHO impacted through DOH Tribal Liaisons
- Regional Coordinators, and Partner Liaisons.

Communication & Education:

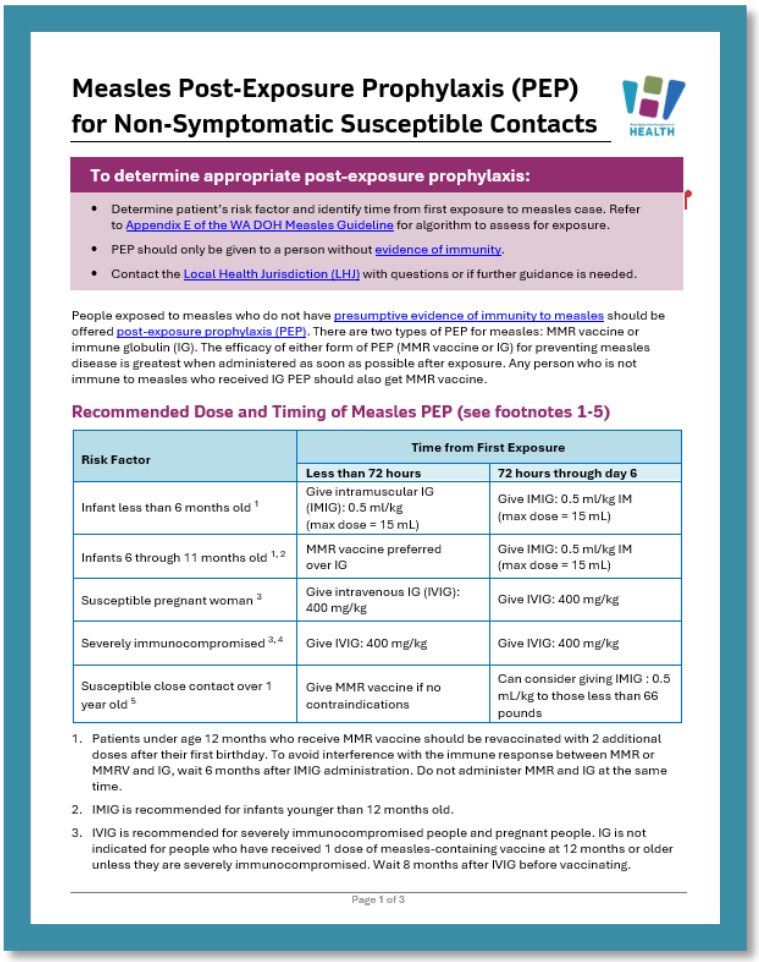
- Alerts and Publications
- Immunization Laws and Rules
- Public Communication Plain Language Examples

Appendices:

- Vaccination support
- Public Communication & Education
- Education Toolkits for Specific Audiences
- Vaccine Uptake Strategies
- Etc.

Intended Audiences:

- Tribal Nations, Confederacies, Urban Indian Health Organizations (UIHO)
- Local Health Jurisdictions (LHJs)
- Community providers
- Immunizers



Measles Post-Exposure Prophylaxis (PEP) for Non-Symptomatic Susceptible Contacts

To determine appropriate post-exposure prophylaxis:

- Determine patient's risk factor and identify time from first exposure to measles case. Refer to Appendix E of the WA DOH Measles Guideline for algorithm to assess for exposure.
- PEP should only be given to a person without evidence of immunity.
- Contact the Local Health Jurisdiction (LHJ) with questions or if further guidance is needed.

People exposed to measles who do not have presumptive evidence of immunity to measles should be offered post-exposure prophylaxis (PEP). There are two types of PEP for measles: MMR vaccine or immune globulin (IG). The efficacy of either form of PEP (MMR vaccine or IG) for preventing measles disease is greatest when administered as soon as possible after exposure. Any person who is not immune to measles who received IG PEP should also get MMR vaccine.

Recommended Dose and Timing of Measles PEP (see footnotes 1-5)

Risk Factor	Time from First Exposure	
	Less than 72 hours	72 hours through day 6
Infant less than 6 months old [1]	Give intramuscular IG (IMIG): 0.5 ml/kg (max dose = 15 mL)	Give IMIG: 0.5 ml/kg IM (max dose = 15 mL)
Infants 6 through 11 months old [1, 2]	MMR vaccine preferred over IG	Give IMIG: 0.5 ml/kg IM (max dose = 15 mL)
Susceptible pregnant woman [3]	Give intravenous IG (IVIG): 400 mg/kg	Give IVIG: 400 mg/kg
Severely immunocompromised [3, 4]	Give IVIG: 400 mg/kg	Give IVIG: 400 mg/kg
Susceptible close contact over 1 year old [5]	Give MMR vaccine if no contraindications	Can consider giving IMIG : 0.5 mL/kg to those less than 66 pounds

1. Patients under age 12 months who receive MMR vaccine should be revaccinated with 2 additional doses after their first birthday. To avoid interference with the immune response between MMR or MMRV and IG, wait 6 months after IMIG administration. Do not administer MMR and IG at the same time.
2. IMIG is recommended for infants younger than 12 months old.
3. IVIG is recommended for severely immunocompromised people and pregnant people. IG is not indicated for people who have received 1 dose of measles-containing vaccine at 12 months or older unless they are severely immunocompromised. Wait 8 months after IVIG before vaccinating.

Page 1 of 3

Guidance

Recommended Dosing & Timing

- Precautions
- Contradictions
- How to determine is PEP is appropriate

Planning Access to IG

- How to plan for obtaining before and after cases are identified
- How it is supplied

Additional Resources

- Clinical resources
- Support contacts

Measles Post-Exposure Prophylaxis (PEP)

There are two types of PEP for measles. The efficacy of either form of PEP (MMR vaccine or IG) for preventing measles disease is greatest when administered as soon as possible after exposure.

1. MMR Vaccine
   - Available through AVP & CVP

2. Immune Globulin (IG)
   - **Not available** through AVP or CVP

Located: https://doh.wa.gov/you-and-your-family/illness-and-disease-z/measles

Questions:

AH: Trust – First dose, are implications for school age children – yes still expected to do the two doses.

JA: Receiving more vaccines around the state – uptake

LP: Regarding instructions to consult providers for early doses – would like more guidance. Is there a biological or vaccine supply reason to not give doses early? They are resource constrained; they may not have the capacity to provide.

TSKG: Reason – early on at the first King County case this year, there were questions from primary care providers – parents wanted babies to be immunized. We reassured providers that since this was not an outbreak, the early dose was not needed. And asked them to consult per case. Clinicians don't have info to assess if there is an outbreak that warrants early dose. We don't want to overload local health departments with calls, and we want to ensure clinical partners have the help they need and good info on hand.

LG: Question about travel and the recommendation for vaccination of visitors needing to be consistent with guidance of recommendations of the community they are traveling to – **How can providers be aware of recommendations for recommendations in other communities?**

TSKG: The provider could pose questions to LHJ's who might pose to DOH who could get info.

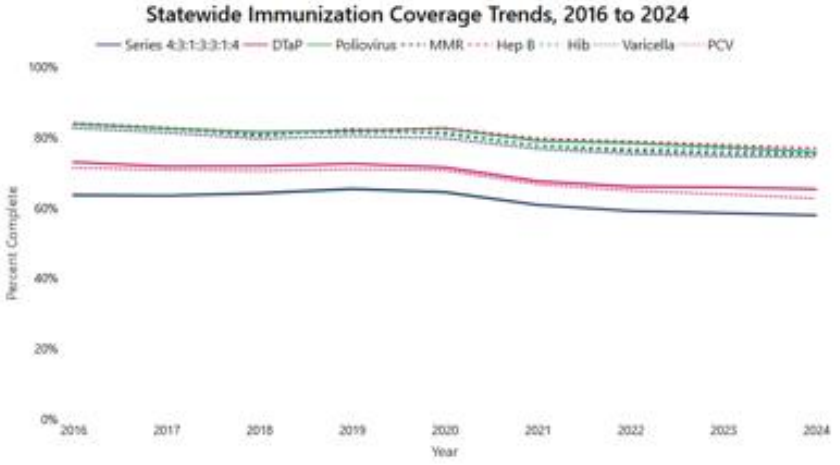
JS: CDC tracking could be something CDC catalogs. It is hard for Providers to call – no time. We will look into making that easier.

JMS: Early dose between 6-12 months is not ideal. It has a role, but that dose is not as effective as dose given at 15 months because of maternal antibodies. We need measles communication to public- strengthen communication about measles inflicting damage by weakening the immune system and how it makes a person more susceptible to secondary infections.

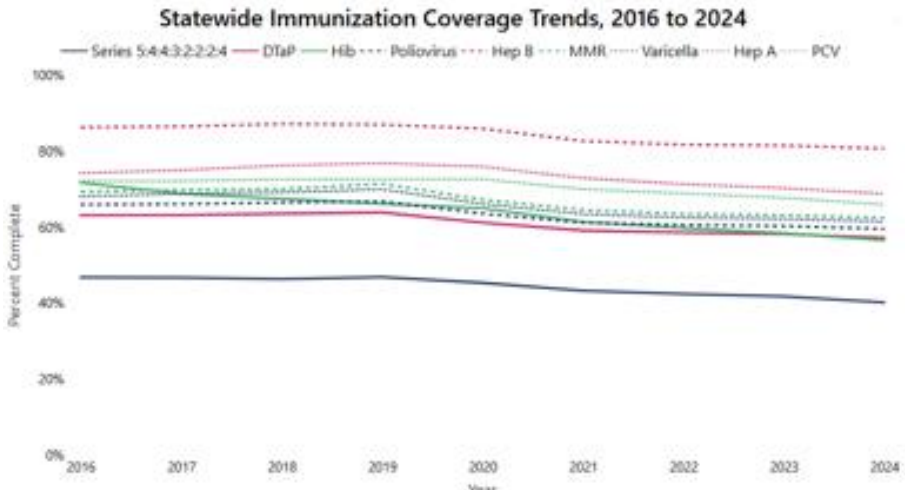
TSKG: Talk to local health before giving early dose for a recommendation. It should be a conversation.

TK: King County made recommendations in 2014, and we broadcasted the message broadly. Texas has the recommendation on their webpage.

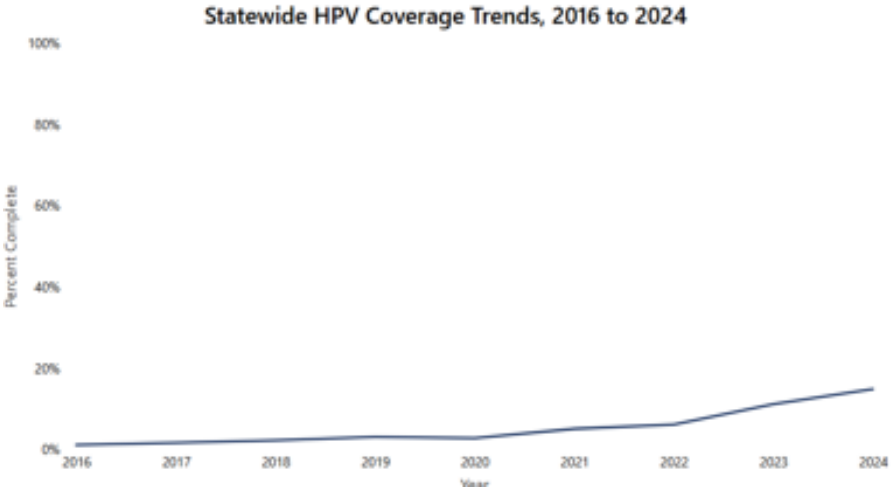
Mary: It is important to strengthen messaging around measles. I heard from parents – they are underestimating the role that the secondary effects can have – devastating risks that come with getting Measles. It could be worthwhile to add in risks of infection in communication to the public.

	MS: Regarding English/Spanish measles rates, is there rates based on age/community? Can there be a handout created in those languages as well? PW: Comparison on rates of non-English speaker/and other population has not been done. But handouts are available in 19 languages. We do need to improve services to those other communities and work with schools and partners to provide the resources they need. JD: Everything is there for talking points on DOH website. For most questions, the DOH website has everything we need. Astounding how often people don't come to the DOH website to look at it. Keep on trying to get the word out. JS: We will keep doing promotion on that, thank you. Also open to info that may not be on the site.
Routine Child Immunization Dashboard Kelley Meder	**Summary of annual Data Changes to WAIIS-based Childhood Immunization Coverage** ***December 2023 – December 2024*** **METHODS** • Extracted annual 2016-2024 data from WAIIS on February 4, 2025. • Reviewed vaccination coverage for five age groups: o 19-35 months - 4:3:1:3:3:1:4 series o 4-6 years – 5:4:4:3:2:2:2:4 series o 9-10 years – 1 dose HPV o 11-12 years – 1:1:1 series o 13-17 years – 1:1:UTD series • Assessed coverage for completeness at the state level, by county of residence, and by reported race and ethnicity **OVERALL TRENDS – DECEMBER 2023 TO DECEMBER 2024** • The small declines observed again between 2023 and 2024 were comparable to those observed between 2022 and 2023 for most age groups • There were a few exceptions: o HPV in the 9-10 year-olds increased by 3.7 percentage points from 11.2% to 14.9% o HPV increased by 2.1 percentage points, from 36.8% to 38.9%, among the 11-12 year-old age group • Coverage remains below pre-pandemic levels 19-35 month-olds 

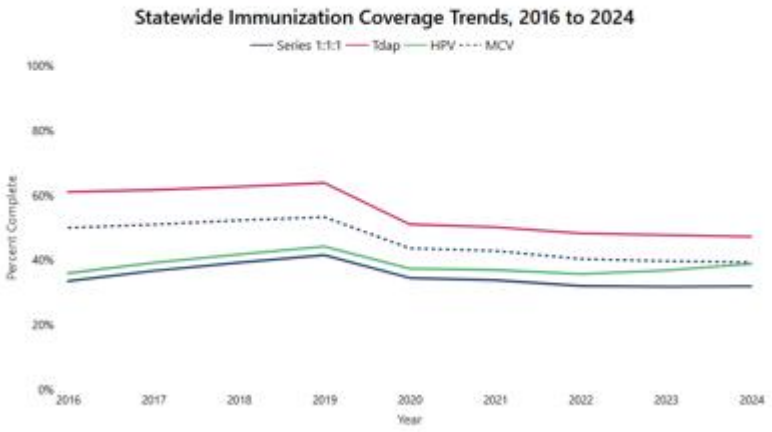
4-6 year-olds



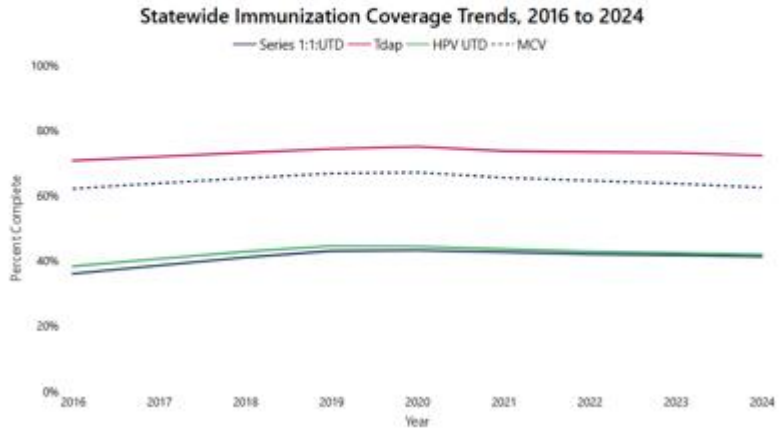
9-10 year-olds



11-12 year-olds

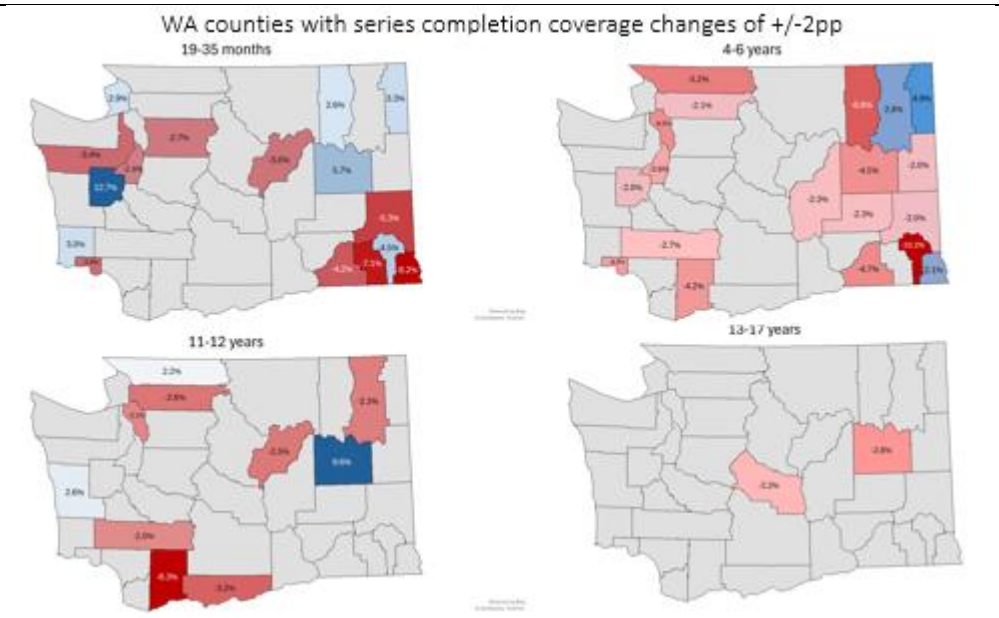


13-17 year-olds

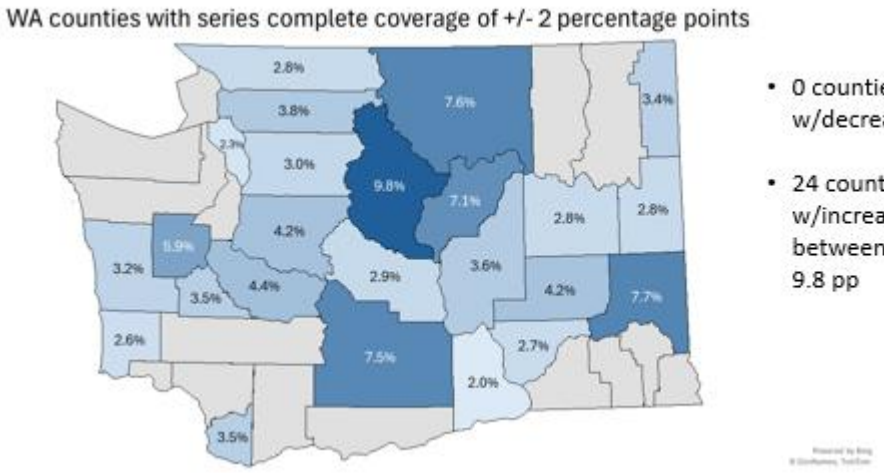


BY COUNTY COVERAGE FOR SERIES COMPLETION - DECEMBER 2023 TO DECEMBER 2024

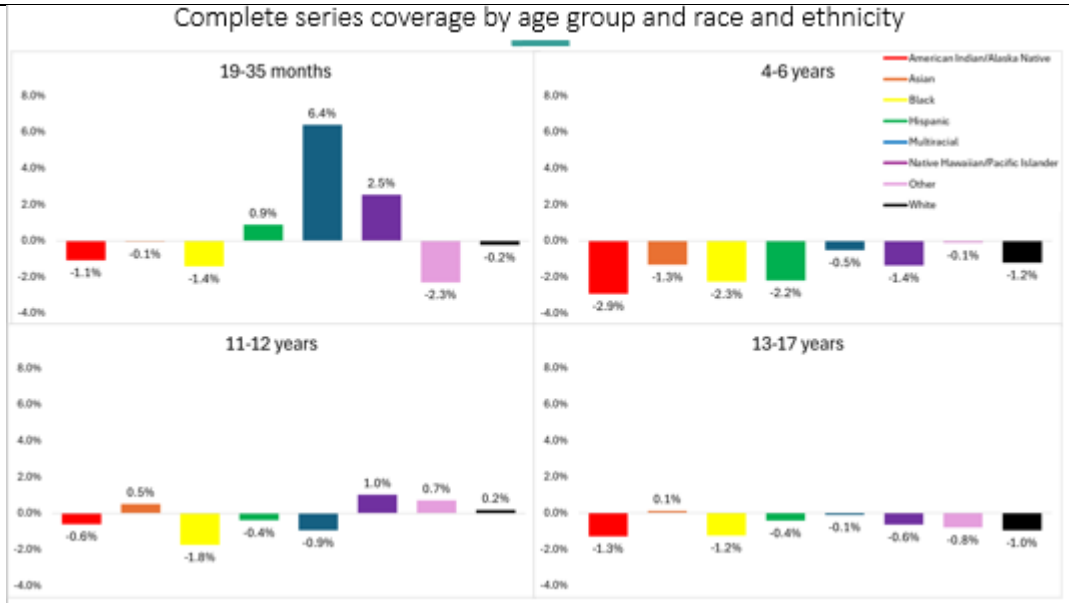
- There were fewer counties with notable changes for series completion coverage (more than +/- 2.0 percentage points) among older age groups (excluding 9-10 year-olds)
- The 4-6 year-old age group had the greatest number of counties with declines (15)
- The 19-35 month-old age group had the greatest number of counties with increases (7)
- Among the 9-10 year-olds, 24/39 counties showed significant increases for HPV coverage

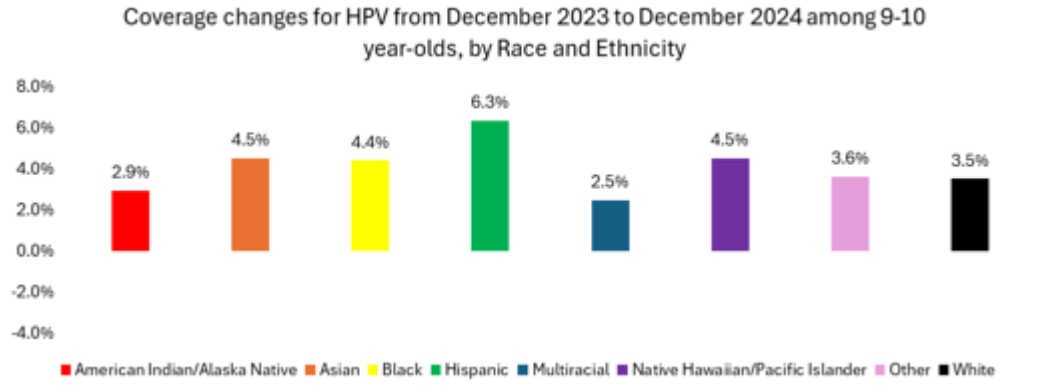


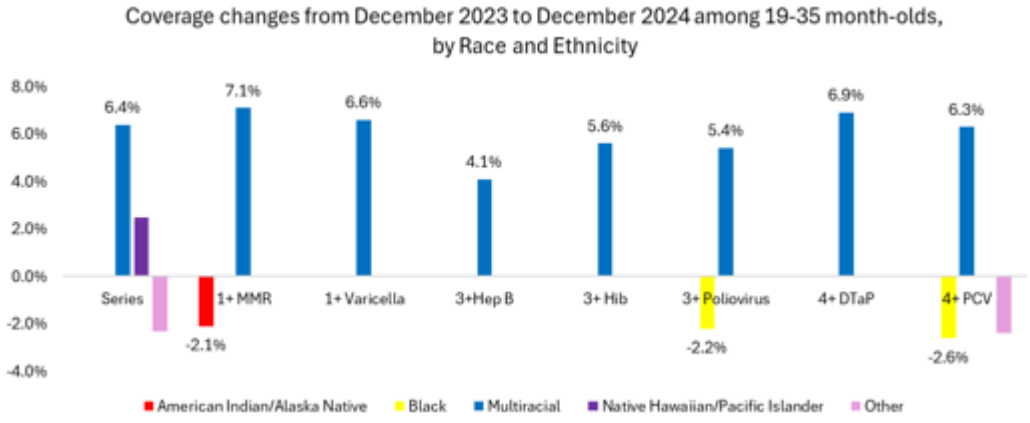
9-10 year-olds

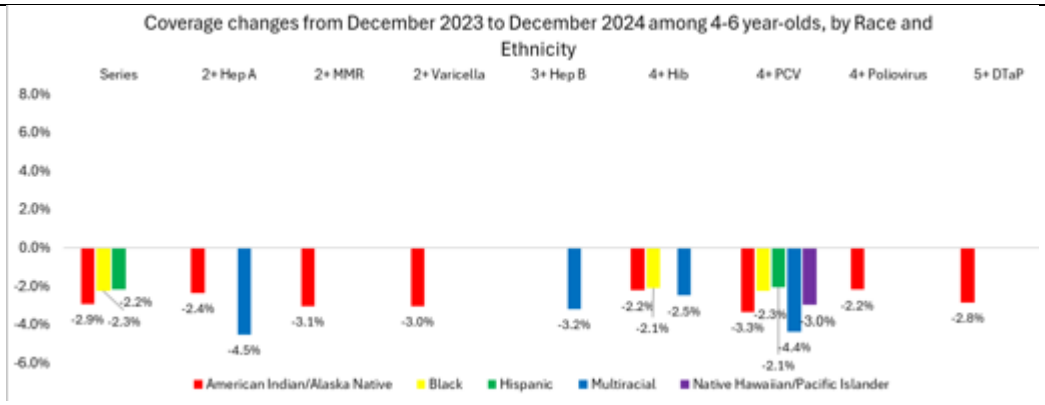


- 0 counties w/decreases
- 24 counties w/increases between 2.0 and 9.8 pp

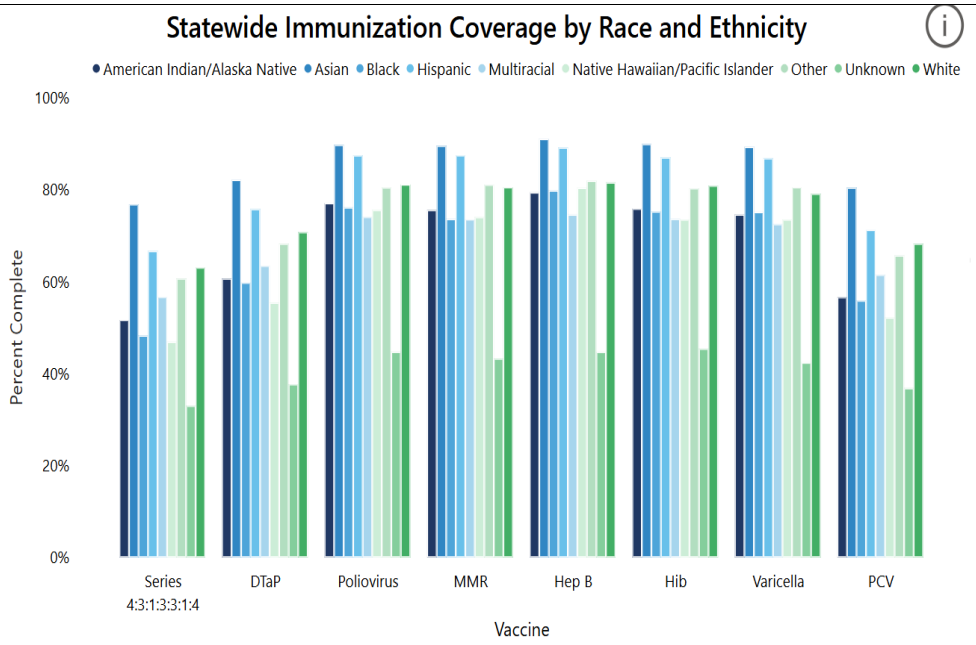

Complete series coverage by age group and race and ethnicity
19-35 months
4-6 years
11-12 years
13-17 years
American Indian/Alaska Native
Asian
Black
Hispanic
Multiracial
Native Hawaiian/Pacific Islander
Other
White


Coverage changes for HPV from December 2023 to December 2024 among 9-10 year-olds, by Race and Ethnicity
2.9%
4.5%
4.4%
6.3%
2.5%
4.5%
3.6%
3.5%
American Indian/Alaska Native
Asian
Black
Hispanic
Multiracial
Native Hawaiian/Pacific Islander
Other
White


Coverage changes from December 2023 to December 2024 among 19-35 month-olds, by Race and Ethnicity
Series
1+ MMR
1+ Varicella
3+Hep B
3+ Hib
3+ Poliovirus
4+ DTaP
4+ PCV
American Indian/Alaska Native
Black
Multiracial
Native Hawaiian/Pacific Islander
Other

	
	
	KEY TAKEAWAYS
	
	• Coverage rates for all age groups and vaccines have not recovered from pandemic levels, except for HPV among the 9-10 and 11-12 year-olds, which continues to increase
	• By county, we have seen more significant decreases in coverage than increases, with a greater number of counties in the younger age groups affected
	  • However, 62% of counties showed an increase for 9-10 year-old HPV coverage of 2.0pp or greater
	• There were large increases in the 19-35 month-olds who reported as Multiracial, but this is mainly attributed to a system change and should not be seen as a true change in coverage
	  • The 4-6 year olds saw the most frequent decreases by series vaccine type
	  • HPV coverage increased in all race and ethnicity groups among the 9-10 year-olds

Vaccine Equity
 	
Marissa Davison
	Advancing Vaccine Equity in WA State
	
	What is Vaccine Equity?
	
	• Definition:
	  ○ Vaccine equity ensures that all individuals, regardless of race, ethnicity, income, or location, have fair and just access to vaccines.
	  ○ It recognizes that different communities face unique barriers to vaccination, requiring tailored strategies to improve access and uptake.
	• Why It Matters:
	  ○ Prevents disproportionate disease burden in underserved communities.
	  ○ Builds trust in public health and vaccination programs.
	
	Immunization Disparities in Washington
	• Examples of Disparities:
	• Childhood Immunizations: Gaps in vaccine coverage for Black, Native Hawaiian/Pacific Islander , and American Indian/Alaska Native children compared to White children.
	• Maternal & Infant Vaccination: Lower uptake of maternal RSV and Tdap vaccines in historically marginalized communities.



Current Vaccine Equity Work

1. Agricultural Workers Project

- Outreach efforts to improve flu vaccination among farmworkers in response to the H5N1 outbreak.
- Partnering with local health jurisdictions (LHJs) and Care-a-Van for mobile clinics.

2. Birthing Hospital Enrollment Project

- Increasing hospital enrollment in the Childhood Vaccine Program (CVP) to improve access to Nirsevimab (RSV immunization for infants).
- Collaborating with hospitals to ensure equitable vaccine distribution.

3. Maternal Health Initiative

- Developing culturally appropriate vaccine education materials.
- Addressing barriers to maternal vaccination through outreach and provider engagement.

FUTURE VACCINE EQUITY EFFORTS

Vaccine Equity Assessment

- Equity assessment to evaluate program gaps.

Increase Access to Vaccination

- Increase access to vaccination by establishing additional or alternative vaccination providers.

Call to Action & Closing

- Vaccine equity is a shared responsibility—we must continue working together to remove barriers.
- We welcome feedback and collaboration to improve vaccine access for all communities.

VAC Member Report Out
Tao Kwan-Gett
 	
VAC Members
	No report out because of limited time
	
	Report out responses via email:
	
	<u>Libby Page</u>
	Here are responses from PHSKC. Some of the topics/issues are areas of concern and potential topics for further discussion at upcoming VAC meetings.
	I'd also like to offer a more general suggestion regarding the agenda and format of the VAC. Given the VAC's advisory role and function, consider shortening the presentations and bringing specific topics/questions/prompts for the VAC members to discuss and advise on to inform DOH's activities, policies, guidance for healthcare providers, schools, etc.
	
	• ***What issues are pressing for you that we need to be aware of/consider moving forward?***
	  • We are seeing an increased need to respond to significant policy, priority, and funding changes at the federal level (e.g., we recently submitted comments to ACIP for their April meeting). This new and challenging environment presents opportunities for DOH, VAC, LHJs and other immunization stakeholders to work closely together on messaging (e.g., stories about the impacts to Washington residents) and advocacy.
	  • Concerned about the growing threat of measles, pertussis, and other VPDs as well as LHJs' ability to respond given funding reductions and limited resources.
	
	• ***What agenda items would you like to see for upcoming meetings?***
	  • Anticipating and preparing the public and health care providers for the possibility of ACIP's move towards risk-based vaccine recommendations as opposed to universal vaccine recommendations – specifically for flu and COVID vaccines.
	  • Strategize around ways to encourage more health care providers across Washington to enroll in the Adult Vaccine Program, particularly given the discontinuation of low-barrier mobile vaccine clinics like Care-a-Van after June.
	  • How to better prepare schools and childcares to quickly assess immunity of students and staff following a measles exposure.
	<u>Dr. Frank Bell</u>
	• Ensuring the long-term success of the state immunization program, minimizing financial & access barriers for state residents
	• Opportunities to rebuild public trust in immunization; promoting vaccine communication with families & teenagers
	
	<u>Wendy Stevens</u>
	What issues are pressing for you that we need to be aware of/consider moving forward?
	Measles outbreak information.
	Sustainable funding for tribal immunization infrastructure support in Indian country.
	Immunizations health equity.
	
	<u>Seema Abbasi</u>
	What issues are pressing for you that we need to be aware of/consider moving forward?
	1. Measles is one of the most critical issues right now. As unfortunate as the current situation is, it also allows for amplifying the messaging around the MMR vaccine: Many parents who had deferred the MMR vaccine due to safety concerns are bringing their children in for vaccination. From being a theoretical risk in their minds, measles has become a real threat: It is important to remind folks that the two doses of MMR are 97% effective and provide lifelong immunity, and the need to consider vaccination even for 6-month-old to 12-month-old children when travelling abroad, even to Europe.
	What agenda items would you like to see for upcoming meetings?
	2. In the current landscape, are there other innovative approaches to getting the vaccine messaging to the public, other partners?

	Annie Hetzel ***What issues are pressing for you that we need to be aware of/consider moving forward?*** Budget issues and threats to federal funding is causing school districts to consider cutting school nurse hours. School nurses are instrumental in maintaining/increasing vaccination coverage for school age children. Considering early messaging for school nurses and school administrators to inform them on what they can do to prepare for potential measles outbreaks in the state. ***What agenda items would you like to see for upcoming meetings?*** Continued updates on vaccine preventable communicable disease outbreaks. **Dr. Ed Marcuse** Would be of interest to know if the rate of HPV immunization is similar for males and females. Is there any targeted outreach to WA counties with lowest MMR vaccination rates? Should we be emphasizing MMR immunization prior to international travel? **Dr. Mary Alison Koehnke** ***What issues are pressing for you that we need to be aware of/consider moving forward?*** 1. A colleague brought to my attention that IIS is reading that the minimum interval for Varicella is 12 weeks for catch up schedule but should read 4 weeks minimum interval for age >13 yrs. ***What agenda items would you like to see for upcoming meetings?*** 2. A recommendation for messaging; much of the measles messaging has focused on death rate and I think it would be valuable to also focus on the rates of serious and debilitating complications such as seizures, blindness, SSPE, encephalitis etc. Based on some comments I have heard from parents in office, I'm concerned that vaccine hesitant parents may be underestimating how devastating some of these complications could be for their children. Thank you for all of your work during these challenging times in public health. It's a pleasure to be on the committee with all of you. **Sarah Kim** A couple things that I am finding in school nursing: 1. Increase in exemptions. In speaking with families, I have seen a huge influx of vaccine injuries and exemptions. Can we please address this in our meetings, as this is not vaccine hesitancy, but vaccine injury. What is our response? What is the data? 2. Mandatory for school vs. recommended. I have been sending students to get mandatory vaccines (chicken pox, MMR) and providers are skipping the childhood vaccines and administering HPV and the flue shot. When students return, they say they did what their MD recommended….and are very frustrated when I have to send them back. I have had several conversations with providers and this is a huge problem that I am seeing.
Future Agenda Items **2025 Vac Meeting Dates** **Adjourn** Tao Kwan-Gett	XI. Future Agenda Items Upcoming 2025 meetings July 10th, October 9th 2025