Vaccine Advisory Committee (VAC) Quarterly Meeting
SeaTac Conference Center

July 19, 2018

Chair/Facilitator:

Dr. Kathy Lofy	Washington State Department of Health

Members Attending:	**Representing:**
Dr. Mary Anderson	Physician Care Alliance and Physician's Care Network
Jenny Arnold	Washington State Pharmacy Association
Carla Dionne	Washington State Association of Local Public Health Officials
Libby Page	Public Health Seattle King County
Dr. John Dunn	Managed Care (Kaiser Permanente Washington)
Dr. Beth Harvey	Consultant
Dr. Mary Alison Koehnke	Washington Association of Naturopathic Physicians
Dr. Ed Marcuse	Consultant
Dr. Daniel Moorman	Washington Chapter of American Academy of Pediatrics
Tonja Nichols	Washington State Health Care Authority
Dr. Stephen Pearson	Washington Chapter of American Academy of Pediatrics
Dr. Amy Person	Washington State Association of Local Public Health Officials
Dr. Susan Westerlund	Washington Academy of Family Physicians

Washington State Department of Health Staff:

Sheanne Allen	Washington State Department of Health
Chas DeBolt	Washington State Department of Health
Greg Endler	Washington State Department of Health
Mary Huynh	Centers for Disease Control and Prevention Washington State Department of Health
Dr. Scott Lindquist	Washington State Department of Health
Michele Roberts	Washington State Department of Health
Julie Tomaro	Washington State Department of Health
Michelle Weatherly	Washington State Department of Health

Meeting Setup and Logistics:

Cicely Bacon	Washington State Department of Health
Alejandro Le	Washington State Department of Health

Guest Speaker

Dr. Doug Opel, MD, MPH
Associate Professor, Division of General Pediatrics and Hospital Medicine
Department of Pediatrics, University of Washington School of Medicine
Section Head, Division of Bioethics and Palliative Care
Director of Clinical Ethics, Treuman Katz Center for Pediatric Bioethics, Seattle Children's

Agenda Item	Presented Information	Member Discussion
Welcome, Introductions, Announcements **Dr. Kathy Lofy, M.D., State Health Officer, VAC Chair**	VAC Chair covered basic housekeeping and plan for the day. New member introductions: • Dr. Mary Anderson; Internist from the Seattle area and current Chief Clinical Integration and Quality Officer for the Polyclinic, Physician Care Alliance, and Physicians Care Network. Recruitment for the Tribal representative and the Washington State Local Public Health Officer (WSLPHO) seats are next. Guest presenter: Dr. Doug Opel MD, MPH presented his research on *Evidence-based Communication Strategies to Improve Parental Vaccine Acceptance* Dr. Opel is an Associate Professor for the Division of General Pediatrics and Hospital Medicine, Department of Pediatrics at the University of Washington, the Section Head with the Division of Bioethics and Palliative Care, and the Director of Clinical Ethics at the Treuman Katz Center for Pediatric Bioethics at Seattle Children's Hospital.	
Conflict of Interest Declaration (Handout) **Michelle Weatherly, OICP Senior Policy Analyst**	Ask members if they have any conflicts of interests to declare based on policy statement. None to declare	
Approval of Meeting Minutes (Handout) **All Members**	Ask members to review and provide feedback or approve. Approved	
Consumer Representative Decision **Dr. Kathy Lofy, M.D., State Health Officer**	As follow up from the January and April meetings, members discussed exploring the potential of including a consumer representative VAC member. Decision: Chair decided not to incorporate a consumer representative for the following reasons: • The purpose of VAC meetings is to provide clinical input and recommendations to the department on issues related to vaccines. • The VAC is not a voting body and doesn't make policy decisions for the department. • It's already an open meeting to the public. • The VAC can invite members of the public when consumer input is needed. • Increasing membership stretches staff capacity and is difficult to keep the membership filled.	
Added Agenda Item: High-dose flu vaccine guidance	There has been some media interest regarding an AARP newsletter and high-dose flu vaccine for older adults. The department doesn't have a preference for this vaccine but does encourage providers	

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Dr. Kathy Lofy, M.D., State Health Officer	to offer the high dose vaccine to older adults. The VAC has helped develop guidance last year. Do we want to update this document since it's a year old? Anyone opposed to updating the existing high-dose flu vaccine clinical guidance document?	Members agreed that the guidance from last season should be reviewed including: • Literature review of efficacy and side effects. • Alignment with current Advisory Committee on Immunization Practices (ACIP) recommendations. If no content changes are needed, the date should be updated and shared out with providers. No **Action:** The department will take the lead on updating this clinical guidance document and share out for review with members via email.
OICP General Update (Handout) **Michele Roberts, OICP Director**	Staffing changes at the department/Office of Immunization and Child Profile: Greg Endler, the new Health Promotion and Communication Section Manager. This position was previously held by Paul Throne. Greg comes to the Department with a lot of partnership building experience and has also worked with the Washington State Department of Social and Health Services (DSHS) in the past. Julie Tomaro, Manager of the Clinical Q/A Section has accepted another position within the Department. This is her last VAC meeting. Nurse recommendations are welcome. We'll let this group know when we have recruitment information for you to share within your medical communities. Belinda Baker, Manager of the Immunization Information System (IIS) Section is retiring. Belinda has been with the department for 19 years. Dannette Dronenburg is temporarily filling this position.	

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	State agencies are planning their legislative and budget requests for 2019. They are to be sent to the Governor's office by September 2018. Foundational Public Health Services will be included as part of the budget request. Foundational Public Health Services (FPHS) are the services that governmental public health systems provide to ensure a comprehensive public health system. The Department is working on a comprehensive FPHS request that is focused on communicable diseases (CD) and environmental public health (EPH). Immunization is part of the CD piece. We are working with local public health around areas of need to help with IIS data exchange and data quality improvements and we continue to look at school and child care immunization work with a goal of creating a comprehensive system. We will keep you posted. Another item being worked on by the department is the End Aids legislation that aims to modernize Washington's HIV laws to reflect current science and reduce HIV-related stigma. The laws related to HIV/AIDS are located in chapter 70.24 RCW. Within that law is information about adolescent consent in regards to sexually transmitted diseases (STD). There is a lot of gray area around adolescent consent so there is potential to add clarity to the law that affect STD prevention and treatment. There are public meetings being held in Spokane. Information is on the Department webpage. We encourage you to give input on that change. The Department is working closely with the State Board of Health (Board) on rulemaking to update the school and child care immunization compliance rules. We are still in the first phase of the rulemaking process to address some potential language changes. There will be a Technical Advisory Committee (TAC) to	VAC chair clarified that TACS are not to make decisions about policy but to discuss the pros and cons of rules and the potential language changes and then make recommendations to the Board for their consideration since they are the policy making body.

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	help inform those changes. They will meet on Tuesday, July 24th in Kent, Washington. The Board has authority over these rules and the Department helps implement them. The TAC will include parent, school, clinical, ethics, Tribal, local health department, VAC, state agency, Board of Education, child care, and school health consultant representatives, among others. We will keep this committee posted, especially around language changes. We would also like to remind members that there is a call for CDC HPV Champion nominations that are due August 10th. The Office of Immunization and Child Profile staff that attended the National Immunization Conference received a CDC award for outstanding progress toward Healthy People 2020 targets for adolescent immunization coverage. On behalf of the immunization community, congrats and thank you. Some of the state providers and members of this committee had questions about adult vaccine reimbursement rates for Medicaid. It's private vaccine. We've shared this information with the HCA. We need specific examples through the contract representative. Providers can share specific examples regarding reimbursement issues by emailing Jean Gowen at the Health Care Authority (HCA) directly: jean.gowen@hca.wa.gov. For providers with billing issues, they can contact HCA by phone or online web form: Phone: 1-800-562-3022 (choose "provider services") Online: Secure web form.	A member mentioned that Medicaid reimbursement was not available for some vaccines. They were reimbursed at the individual internal contract rates. There were only two doses so it may have been an anomaly.
Vaccine Supply and Distribution Update **Sheanne Allen, Vaccine Management Section Manager**	Feedback regarding best practices around vaccine returns and reimbursement is still welcome from VAC members. The next workgroup meeting on best practices in vaccine storage, handling, and accountability work will be on July 26th.	VAC Chair asked who is engaged on this issue at the clinical level. Members mentioned that it's different for each clinic.

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(Presentation)	The restitution decision paper lays out options that will be decided on at the July 26th meeting. We will report back to VAC members on what option was chosen. There are plans to develop periodic report cards that will available by the beginning of the new year. There is one adult vaccine order per year at the end of the CDC fiscal year. In October we will get a new allocation that we have for outbreak situations. This year's vaccine are: Tdap, MMR, Twinrix, and Shingrix. The demand for Shingrix was higher than anticipated by the manufacturer. GSK is limiting their private orders to push towards the private market. States are on allocation. We are developing a website and resources regarding adult vaccines to include a user manual and newsletter for providers who want to enroll in the adult vaccine program. Hepatitis B vaccine is on allocation by CDC due to continued shortages. Shortage and delay schedule is available on the CDC webpages. Doses we are able to order are based on previous ordering history. We expect this to continue through the end of the year. There are two products available and are interchangeable. Both vaccines are available to all providers to ensure that there's enough to go around. Hepatitis B recommendations for infants are unchanged. As a follow up from the last VAC meeting regarding the Meningococcal B discussion we've added it to the order form and updated the guidance from 2016. As of October, Meningococcal B vaccine will be on the order form. We will be	The workgroup is discussing how to best to communicate information so that the right people are in the loop. **Action:** To help with communication on this issue, the department will add this committee to the Vaccine Blurb newsletter.

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	communicating that out to providers in September. For the 2018-19 flu season, we haven't received flu vaccine doses just yet. We expect to get between 670,000 and 690,000 doses this season. Reminder to members that there is a month difference between when we receive and when we allocate to ensure that there is enough for all providers that order. There are four presentations for this next season including: FluLaval syringe, Fluzone multi-dose vial, Fluzone .25 syringe, and Flumist (nasal spray). So far we have secured 20,000 doses of nasal spray flu vaccine. There may be another chance to purchase additional doses. Do we want more than that or keep as is? So far there is no preference but the nasal spray flu vaccine is an option. The AAP recommends the flu shot. We placed a small order and are brainstorming allocation ideas and what it will look like for each county and clinic. Pre-Book is taking place next week.	Nasal spray flu vaccine feedback on ordering additional doses? The manufacturer presented on how it was created and why it wasn't performing well. They've made changes but there isn't great data. Until we have a season with a lot of H1N1 we won't know if the changes were successful. Everything the ACIP looked at suggests that it will work. Members suggested keeping the quantity limited to avoid confusion around how much to use with very clear information for providers around recommendations. Some are purchasing for school clinics but the department doesn't do school clinics – this is a community effort. It's helpful to understand why the strain didn't work; it failed to replicate. The manufacturer has now built in the replication process. Something has been learned in the product development to help create a better vaccine in the future.

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Vaccine Preventable Disease Surveillance Update **Chas DeBolt, Senior Epidemiologist** **(Presentation)**	Mumps cases: There is ongoing activity on both sides of the state each quarter. 2017 Q4 • 1 Grant, 2 King, 1 Pierce, 1 Snohomish, 3 Spokane, 2 Thurston 2018 Q1 • 1 Clark, 5 King, 1 Skagit, 2 Snohomish, 1 Whatcom 2018 Q2 • 2 Clark, 7 King, 4 Snohomish, 2 Spokane Mumps third (or outbreak) MMR dose recommendation: "Persons previously vaccinated with 2 doses of a mumps virus–containing vaccine who are identified by public health authorities as being part of a group or population at increased risk for acquiring mumps because of an outbreak should receive a third dose of a mumps virus–containing vaccine to improve protection against mumps disease and related complications." Vote at October 2017 ACIP meeting: Published in MMWR *Weekly* / January 12, 2018 / 67(1);33–38 • UPDATE: Feedback from stakeholders on guidance around this recommendation is currently being incorporated into the manuscript. • Will be published as an MMWR this fall. There is a new measles disease reporting system. In early July a measles case showed up in the database (IGM positive). This person would have travelled in a country with an outbreak of measles (Ukraine). Another case in California exposed in Ukraine and also in Oregon. These children came from a measles hotspot. In host families, unvaccinated presented with the disease but the vaccinated persons remained well. Symptom watch is for 21 days. The family was great about isolating and there are likely minimum exposures.	

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	There is a potential for toxigenic diphtheria infection through a wound. This will now be reportable but needs an isolate to be reported. We want to be on top of the toxigenic organism in the environment. The person hasn't traveled and are waiting to hear back from CDC.	
Vaccine Hesitancy and Communication Research (Presentation) **Dr. Doug Opel**	There was a request from Informed Choice Washington (ICW) for an interactive dialogue. Today we want to hear about the research and hear from member expertise. Regarding this request, is the committee interested in a separate meeting with ICW on vaccine hesitancy? If so, please send an email to Michele Roberts and Kathy Lofy if you're interested and we can help to coordinate. Dr. Opel presented his research on provider communication with vaccine hesitant parents. Three hats worn throughout this research: Researcher: looking at what is effective. General pediatrician: I have these conversations with parents. Ethicist: Seattle Children's Hospital. I'm interested in what is ethically justifiable and what is instrumental in relationships with parents. The presentation was organized by first reviewing the evidence for communication strategies (what works?), then discussing why certain strategies are effective (why do they work?), then ending with ethical issues around communication strategies. As background for the section on 'What works? The vaccine acceptance continuum was presented. In the past, there were typically two categories: those who accepted vaccines and those who didn't. But we know now that this is too simplistic. Namely, vaccine-hesitant parent represent an important 3rd group. These	Do you have recommendations for communications where the vaccine conversation comes up and the parent says absolutely, no? The approach is to try to keep the conversation going and meet the parent at that place to help understand why they're feeling that way. This helps keep the discussion open for future visits. Were MAs interactions with the patient looked at? No. There needs to be more done here. Was there any sense about the robustness of the data across age groups and race? People are building on the current work so more to be done here as well. Was the family situation taken into account when assessing? Not aware of any studies. There is a wide variety of responses. It's an emotional decision. It's more about feelings and not a cut and dry analysis. Have you tried these techniques with different populations?

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	parents generally want to trust their provider and hear what he or she has to say about vaccines. If we are going to help hesitant parents accept vaccines, we need to make sure we engender their trust and are responsive to their communication needs. Data from the CDC a decade ago on what changed parents minds about vaccines showed that it was information and assurances from their providers. They are the most important influence. What can we, as pediatric providers, say to hesitant parents that is effective at changing their mind? In my research of the vaccine discussion, I found some strategies that appear effective. One was how the provider initiated the conversation. When a presumptive format was used, more parents accepted vaccines than if a participatory format was used. Other effective communication strategies: 1) Pursue the original recommendation if the parent resists. This can lead to some parents changing their mind. 2) Bundling the recommendation for flu vaccine with other vaccines due at that visit resulted in a higher rate of acceptance. Why does how we initiate the vaccine conversation work? Insights from behavioral economics can help us understand why. Use of the presumptive format sets vaccination as the default. Defaults are decisions made for us unless we actively choose something else. Defaults leverage biases in how we make decisions. Does the default approach circumvent the parent's ability to express values and preferences? Yes, they have the potential to circumvent, but importantly, they don't	State Epidemiologist described the Tribal – ethical model. In this model there's the patient (child) and then there's the parent. We need to assess whether or not the doctor trumps the parent or does the parent trump the doctor. In this model, the parent has the ultimate decision making authority. The amount of time spent in the appt. is essential. We state that it's "time for vaccination" what are your concerns? Vaccination rates at the tribe are high. It changes a lot with demographics. There are trends by culture. And the single thing I found effective in communication is to ask, "what have you seen or what has happened?" There may be an association that may not have been accurate. When there is tension. How do we manage what is best for the child? There is a question about the intervention of CPS in cases in other states. The group discusses anecdotally. The harm principle is taken into consideration for the benefit of the child. The threshold is whether or not the child is at risk. Does refusal reach that threshold? In the absence of an epidemic, it is unlikely that the parent meets the threshold. Having spent countless hours and decades on this issue, this points out the importance of applied research in public health and it underscores the importance of this investigation work. Are there plans for future research? The presumptive approach is not effective 100% of the time. What can we say to families that will help? Motivational interviewing may help. There is not a one size fits all. Any research with race and ethnicity, especially with groups with larger disparities or at risk groups would be helpful. There is a lot of local interest in how to improve the conversation.

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	have to. Example: "Johnny is going to get 3 vaccines today, is that alright?" This question put at the end of a presumptive initiation format gives the parent more explicit space to talk with the provider about their values and preferences, and use of the presumptive format still leverages the power of the default. In conclusion, defaults are effective; presumptive doesn't have to feel presumptive; defaults are the not the only strategy. Bundling and pursuing recommendations can also be effective for parents who are particularly hesitant. It may be worth the time to explore how bundling these strategies may help improve acceptance.	In clinic our families with more disparities have trouble getting to their checkups. They're not refusing. Any advice for the department (30% of the population that fall in this category) to help address this issue? It's helpful to share this information to clinicians and practices. CME but what other ways to disseminate. Have you given this presentation to other audiences? Yes – one person, small team. You're right, we need to find more ways to get this information out to wider audiences. How do we translate further? Residency programs are good places for this information to have them practice. Is this research approach for adults too or just children? There is some refocusing and understanding how to access the adult population. When we think about the public health approach we should also consider health literacy issues. Consider disseminating to a higher educated audience. More discussion about the risk of not vaccinating at the higher education level. It might be something to think about. Is there a difference with the amount of time in each appt. and the outcome of the vaccine decision? No. It's efficiency. If I know where the parent is on the vaccine acceptance continuum, I would do a better job preparing for that visit. It would be good to have a trial with a screening tool so that the provider understands where the parent is on the continuum prior to the appt. Time is an issue and we are trying to provide strategies for providers and give parents the opportunity to describe why they're refusing so that we can help them optimally. Getting that

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		information could provide some efficiency during appts.
Future Agenda Items	Ideas for future agenda items?	None stated.

Public comment: *The Vaccine Advisory Committee is an advisory body to the Washington Department of Health. The purpose of VAC is to provide recommendations and guidance to the department on issues related to the use of vaccines. Because this is an advisory body not set in statute/law, the department is not required to conduct an open-public meeting. However, we do so to maintain transparency and to allow public comment. There are up to 15 minutes set aside at the beginning of the meeting designated for public comment. Commenters are limited to three minutes per person or less depending on the number of people who would like to speak.*

The following section summarizes comments received from members of the public during the public comment period.

- Unethical to convince and coerce patient's and give the information necessary. DOH gives presumptive information. DOH is actively engaged in uninformed consent. It is not legal or ethical.
- How many doctors here have read vaccine inserts? *All providers in the room raised their hand.*
- Unvaccinated population parents are highly educated. I see an increasing number of children who are vaccine damaged. When we make a decision for that parent, the patient and parent do not do ok and I've seen it destroy families, especially kids with autism. Presumptive approach is a violation of informed consent. Informed consent is telling them everything they need to know.
- Don't badger their patient and tell them that if you don't vaccinate your child they could die. Change or suggest more time to have the conversation. They don't trust you. House Bill 2090; please push that bill. Handed down ICAN – HHS – decision – RK Jr. for safer childhood vaccines (1986 act). HHS searches for records and they have no safety records. ACIP is using HHS information they don't have. This is a massive problem. Reevaluate how we are vaccinating.
- Spend more time detailing the risks to parents of not vaccinating. Provide the full informed consent. Take the risks; adverse events increase from clinical trials to use in the larger population. Safety trials that have been conducted compare unvaccinated children v. vaccinated children. The right studies have not been done.
- Personalize vaccination to minimize vaccine injury. Not taught how to stick to a schedule. IOM report susceptibility to vaccine injury. Work needs to be done. Doctors are pressured by DOH, CDC, drug companies….it's coercion. They are celebrated and rewarded.
- Unquestioned recommendations are failing us and lack safety data or no data at all. Shingrix is an example with an absence of evidence. Informed consumers read widely and deeply.
- Vaccine injury is not rare. The CDC rarely allows independent research or access. Only one vaccine and ingredient have been studied. CNN reported that mitochondrial disorder can be a problem. Dismissed concerns. Told there is no connection to their issue. Pediatricians have not done their research. If HHS had done their research they would see allergies, asthma, and autoimmune disorders. There is insufficient data.
- Ed Marcuse mentioned in the white paper that they reviewed cases and agreed that 40 outcomes were recognized and mentions crones and other disorders. Policies that misinform the public must end.

- The public was misinformed. DTaP, polio, flu, Hep B, and mumps are not stopping disease. The measles vaccine is not working even in highly vaccinated populations. Relying on authority and not data that can hold up to scrutiny. Inadequate, fraudulent studies that the CDC points to.
- Vaccine hesitancy is not a problem with the consumer, it's a problem with the system. Public health is at its best when it helps 100% of the population. Sacrificing some in the name of public health is not acceptable. Re-examine vaccines with the increase in use of antibiotics. Pull this into vaccine policy. Join us in conversation along with the doctors WE work with.