Vaccine Advisory Committee (VAC) Quarterly Meeting
Red Lion Hotel

April 18, 2019

Chair/Facilitator:

Dr. Scott Lindquist	Washington State Department of Health

Members Attending:	**Representing:**
Dr. Jenny Arnold	Washington State Pharmacy Association
Carla Bacon	Washington State Association of Local Public Health Officials
Dr. John Dunn	Managed Care, Kaiser Permanente Washington
Jean Gowen	Washington State Health Care Authority
Dr. Beth Harvey	Consultant
Dr. Lisa Johnson	Washington Academy of Family Physicians
Dr. Mary Alison Koehnke	Washington Association of Naturopathic Physicians
Dr. Ed Marcuse	Consultant
Dr. Daniel Moorman	Washington Chapter of American Academy of Pediatrics
Libby Page (for Dr. Jeff Duchin)	Public Health Seattle King County
Amy Person	Washington State Association of Local Public Health Officials
Dr. Stephen Pearson	Washington Chapter of American Academy of Pediatrics
Dr. Usha Rao	Washington Academy of Family Physicians
Ann Song	Office of the Superintendent of Public Instruction
Dr. Susan Westerlund	Washington Academy of Family Physicians
Dr. Rachel Wood	Washington State Association of Local Public Health Officials

Washington State Department of Health Staff:

Sheanne Allen
Dr. Kathy Bay
Chas DeBolt
Greg Endler
Michele Roberts
Michelle Weatherly
Mary Huynh

Meeting Setup and Logistics:

Cicely Bacon	Washington State Department of Health

Guests:

Jennifer Coiteux	Washington State Department of Health Office of Immunization and Child Profile IIS Section Manager

Agenda Item	Presented Information	Member Discussion
Welcome, Introductions, Announcements **Dr. Scott Lindquist sitting in for Kathy Lofy**	VAC Chair gave a statement welcoming members, guests, and the public for attending the meeting and asked them to sign in, gave an overview of the meeting expectations and processes, including the timing for public comment and notice about room capacity. The chair also introduced new VAC member, Dr. Usha Rao, who is joining VAC representing the Washington Academy of Family Physicians (WAFP). Dr. Rao's CV is in the packet. This is Dr. Lisa Johnson's last meeting, who has represented WAFP on this committee. The chair recognized and thanked Lisa for her valuable service to the committee. The chair also introduced Jennifer Coiteux who joined the Office of Immunization and Child Profile in November as the new Immunization Information System (IIS) manager.	
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	
OICP General Update (Handout) **Michele Roberts, OICP Director**	Michele reviewed the program update handout and highlighted a few items. Clark County measles outbreak started at the same time as the beginning of legislative session. HB 1638 was introduced by the representative for Clark County in response to the measles outbreak. This was not DOH requested legislation. It previously passed out of the House and last night passed out of the Senate (25 yay 22 nay). The Senate version is slightly different than the version that passed the House. Concurrence vote will be next. If passed, we expect the Governor to sign the bill. He has already said he supports this legislation. These decisions are not taking lightly but hope this is a good step to keep our communities protected. Once the final bill is signed by the Governor, we will communicate broadly with schools, providers, and the public, including sample letters for families. Legislation for Foundational public health services, which modernizes how the state defines and pays for these governmental public health services, and passed and has been signed by the Governor. No final information about the funding and final budget for that bill as of yet. Session ends April 28th. SBOH and DOH work on rulemaking regarding school and child care immunization compliance. Scope includes ACIP schedule reference update, immunization documentation, and conditional status. Next step is to release the draft language that was done through gathering comments from the Technical Advisory Committee (TAC) and informal public comment. Then the draft rule changes will be open again for formal comment. This will happen this summer.	

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	Excited to share some follow-up from the survey on college immunization requirements that was completed a couple years ago, and that we shared in a past meeting. Previous to the survey and follow-up discussions, UW had an informal immunization policy. Now they have an official policy in place and we commend them for their initiative in revising how immunizations are handled at their institution.	
Immunization Data Sources (handout) **Michele Roberts**	The IIS is a lifetime immunization registry for people of all ages. Immunization rates are calculated using active patients and valid vaccine doses, and gives a point-in-time estimate and real-time medical record data. This data is used to compare within the state, including small areas. However, this source has the potential to underestimate rates. Public and private schools report student immunization data to the department. This data allows the state and the public to track immunization rates by school, district, and more. Reporting data is shared with the CDC each spring. Data is typically posted to department webpages in May. Currently the data is provided by parents to schools and is not verified by a health care provider. Scorecards for schools are intended as a quick glance of their rates. These can help inform school administrators, health care providers and policy makers. National Immunization Survey (NIS) data. This annual data collection survey is done by phone calls to families. Annual survey. It's considered less accurate and has the potential to overestimate and under-represent true vaccination coverage rates. IIS, NIS, and school report data are not comparable because they are not collected in the same way. More information and data are posted on the DOH website at: www.Doh.wa.gov/immdata We know that of the distributed vaccine doses for kids, about 98 percent make it back into the IIS each year as a dose administered. The IIS is still missing some toddler doses for older kids – historical data.	How is the user defined? Providers who participate in the Vaccine for Children program. There are 1040 providers who participate and report data to the system. Can the IIS communicate with EHRS? Yes – there are well over 2000 connections across the state. DOH is Challenged in meeting the demand for data exchange because of a funding gap to address connection capabilities. There are currently over 200 providers on the waitlist. Challenge – two-part last name, sometimes Child Profile uses one name or the other and confuses the system. Data exchange between states is still a challenge. Technology differences and funding are barriers. Suggestion regarding Zoster vaccination score card – update age. Also concern about ongoing shortage for this vaccine. • Supply is increasing and expect to improve in 2020.
Member Updates	Thank you to Dr. Arnold and her organization's support during the measles outbreak, including helping understand immunoglobulin supply.	

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	Thank you for the support to Clark Co. during the outbreak – specifically Chas, Scott, and the lab. A lot of testing and it was very helpful. It takes a village – thank you. Staff worked 130 days straight w/o a day off. Madigan connections with preventive medicine helped with military medical databases. Members mentioned concern regarding the Tdap immunization requirement for child care workers and volunteers with regard to coverage. Some may have payment issues. Questions around Medicaid reimbursement – contact Jean Gowen at the Health Care Authority or DOH staff.	
Vaccine Supply and Distribution **Sheanne Allen**	Vaccine loss policy regarding storage and accountability has been shared with providers. Vaccine choice started on Monday and goes through the end of the month. October was the first time Men B was available on the order set. Website with a timeline, explanation of choice is being developed now. An FAQ will be included to help answer questions for providers. Hep B is still on allocation. We continue to be able to fill every order in Washington. May not be preference but they are being filled. The vaccine is interchangeable. We are in the midst of an investigation of Hep B outbreak in eastern Washington. IV drug user and homeless population. Mainly 20 yrs and older. Not kids. Hep A is also on allocation. We haven't seen an outbreak like other states but are watching closely. Year-end data shared with the over 1000 provider sites that participate in the Childhood Vaccine Program, included comparison to other provider's data. • 2% state wastage. • Last year 1.4%. This year's increase due to changes in policy that better tracked wastage. • Flu waste – doesn't include what was unordered at McKesson. This data of 1.3% represents what providers returned. Men B – Added to the order form last October. We heard that it would be easier to have it all in one place. VAC approved revised MenB guidance and it has been updated on our website. • We've gotten some questions and suggestions about IIS forecasting for Men B. There are issues with functionality. It's going to take some work to fix – not a big priority but will revisit and survey VAC regarding how to prioritize.	

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	• Ordering update. There was a slight increase in ordering for Men B. If there is a big increase, we will notify the WVA. **ACTION: Member request for a breakdown of Washington Men B cases by age and college**. Sent out the provider survey about flu vaccine and received 300 responses. Less demand for multi-dose flu vaccine and more demand for single dose. Will continue to offer nasal spray flu vaccine. We plan to offer a cell–based flu vaccine as a pilot project; we are looking for providers interested in participating.	
Advisory Committee on Immunization Practices Updates **Dr. Kathy Bay, Manager, Clinical and Quality Assurance Section**	Human Papillomavirus (HPV) Vaccine: • Current recommendations for universal vaccination pre-teens through age 26 for females and 21 for males. • FDA approved for ages 27-45. • Discussion of science regarding development of precancerous state following exposure for women and possibility of extending recommendation up to age 45 years. • Anticipate vote at June 2019 meeting. Pneumococcal Vaccines: • Discussion of issues related to use of PCV13. Two options for recommendations were discussed: o Stop recommending PCV13 for adults age 65 years or older o Use individual clinical decision-making (PCV13 and PPV23) o Continue current approach. o Anticipate vote at June 2019 meeting. Influenza: • Review of case control study 2005-2006 and 2006-2007 (Vaccine Safety Datalink Project) found no association between spontaneous abortion and inactivated influenza vaccine receipt in a 28 day risk window (Irving, Obst Gyn 2013). • Second CDC funded case-control study (Vaccine Safety Datalink Project) in 2010-2011 and 2011-2012 seasons; 2012-2013, 2013-2014 and 2014-2015). Large study, N=2762 found no significant association between influenza vaccine receipt and SAB. • ACIP continues to recommend influenza vaccination for pregnant women unless there is a contraindication for a different reason. Combined vaccines: • New pediatric hexavalent vaccine: Diphtheria, tetanus, pertussis, polio, hepatitis B, and *Haemophilus* influenza type B (Hib). o Ages 2, 4, and 6 months of age o Consideration if should be preferentially recommended for the American Indian/Alaskan Native (AI/AN) population. o H. influenza Type b (Hib) in children <5 years old: Pre-Vaccine Era, 1965-1990 o Highest in AI/AN population at a younger age. o Agreed further review and exploration should be done before a recommendation given. MenB Booster Doses • Persons with complement deficiency, complement inhibitor use, asplenia, or microbiologists o MenB booster dose 1 year following completion of aMenB primary series, followed by MenB booster doses every 2-3 years thereafter, for as long as increased risk remains.	

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	• Persons at increased risk during an outbreak.
	  ○ One-time Men B booster dose if it has been >1 year since completion of a Men B primary series.
	  ○ A booster dose interval of >6 months may be considered by public health officials depending on the specific outbreak, vaccination strategy and projected duration of elevated risk.
	
	Zoster vaccines
	• Herpes Zoster (HZ) - Recombinant zoster vaccine (RZV) demand continues to outpace supply. 8.59 million doses distributed through 2018; more in 2019. >75% among Medicare beneficiaries.
	• GBS observed events higher than expected with further workup/exploration in progress. At present, but not confirmed. Further evaluation/review needed prior to changing recommendations.
	• Plan: FDA exploring options for analysis of GBS following RZV in the CMS database. CDC will continue to monitor preliminary data and continue enhanced monitoring for RZV in VAERS to include review of all GBS reports following RZV.
	
	Hepatitis Vaccines: Work group information provided at meeting; no plan identified.
	• Noted that the Hep A vaccine is largely responsible for the marked reduction in US cases.
	• Identified adults who are at increased risk for Hep A:
	• Less exposure early in life.
	• Low two-dose vaccination coverage for high risk (travelers, chronic liver disease).
	• Outbreaks-shifting epidemiology, person-to-person transmission among unvaccinated vulnerable populations.
	• About 1 million persons living with HIV in the US. Work group review of medical monitoring project data indicates 40% would not receive the vaccine based on current recommendations (PWID [Persons Who Inject Drugs] in last 12 months, non-injection drug use in past 12 months, MSM in past 12 months, chronic liver disease, clotting factor disorder, or homeless in past 12 months.
	
	Japanese Encephalitis (JE) caused by mosquito-borne flavivirus and occurs in most of Asia and parts of Western Pacific; highest risk in rural agricultural areas. Most infections asymptomatic, but the clinical disease is often severe; 20-30% case fatality with 30-50% of survivors have sequelae.
	• Traveler risk is low
	• Reviewed existing recommendations with newly available safety, immunogenicity, and travelers risk data.
	• Plan:
	  ○ Update MMWR recommendations and reports
	  ○ Revise language to say moving to JE-endemic country to take up residence or long-term (> 1 month) travel or with higher risk areas during shorter term traveler.
	  ○ Not recommended for travelers with very low risk itineraries.
	  ○ Age ranges and booster.
	Anthrax:
	• Discussion of coverage and which vaccine (AVA [FDA approved] or AV7909 [not currently approved] for large-scale event. Language change done for MMWR to allow optional use of AV7909 if AVA not available.	

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	• AVA Pre-Exposure prophylaxis with need for more data identified to change current practice. Continue current recommendations. • Booster of AVA may be given every three years to persons not currently at high-risk if previously primed and wish to maintain protection.	
Vaccine Preventable Disease Surveillance Update **Chas DeBolt, Senior Epidemiologist** **Dr. Scott Lindquist** **(Presentation)**	2019 measles outbreak and response: Beginning of January, Clark County announced one confirmed case in an unvaccinated child. By mid-January Clark County declared a public health emergency for the measles outbreak. The Governor declared a state of emergency on January 25, 2019. In response, DOH instituted department-wide Incident Management Structure to assist with disease investigations and deploy an epidemiology strike team to Clark County. DOH helped with lab testing, vaccine supply and distribution, communications policy engagement, and other efforts to help protect communities. There were a total of 71 confirmed cases out of 267 that were investigated. The cost of the investigation came in at a combined total exceeding $1.6 million.	Confirm susceptibility to measles? Started with students with exemptions, students in out-of-compliance (OOC) status, and conditional status to help determine exclusions. Only excluded if there was an exposure in a school. Families were very cooperative. Vaccination response happened through the childhood vaccine program. Weeks of urgent provider orders in Clark County. About six weeks. Peace health and legacy health systems did vaccination clinics towards the end. When the risk changes people get vaccinated. Unless there was direct exposure, vaccinating early was not done. Regarding state recommendations for early vaccination of children 12 months and younger, if we were to do that, we would bring it back to this committee Quarantine issue. Only exposed people were quarantined. It may work if they are not employed but is difficult for some people to achieve without hardship. However, quarantine helped and was a strong contributor to ending this outbreak. At least 15-20 infants got IG because they were exposed. None developed measles. Three pregnant women were exposed. There is only a three day window for post exposure prophylaxis.

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		We do look at strain and can identify whether or not it was related to the vaccine strain. It is a clinical challenge and balance in judging when to sound the alarm. Because this disease was considered eliminated in the US for many years, some providers may have not seen any cases or have difficulty in recognizing symptoms as measles. More education is needed for providers.
Connections with Pharmacies **Dr. Jenny Arnold** **Jennifer Coiteux**	Dr. Jenny Arnold – VAC membership – 10 years. Pharmacies – 3rd most common health care provider. Bring them into the system. First line of disease recognition. 93% of Americans live within five miles of a pharmacy and visit at least 1.9 times per week. Washington was the first state to allow vaccine administration in 1979, the first to have a collaborative therapy agreement, no limits in for age of vaccine administration, and pharmacists began vaccinating in 1994. Pharmacists are open to referrals and partnership: • Encourage registry use or refer them to Dr. Arnold for help. • Include them in quality initiatives. • Discuss community needs and opportunities for intervention. Washington State law regarding the Immunization Information System (IIS): • No state mandate • Implicit consent • Opt out state The IIS is a state-wide web based system, includes records for over nine million people, and immunization data comes from over 2100 organizations. The majority of the state population has a record in the IIS. Pharmacies can share data with the IIS through electronic data exchange, uploads, and direct data entry – 53 pharmacy organizations and 752 facilities shared data with the IIS in 2018.	Pharmacies are great partners in protecting public health and during a disaster response. More people got vaccinated through the pharmacy than in mass vaccination clinics during the measles outbreak.

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	The IIS has several useful tools for health care providers: • Patient forecast • Certificate of Immunization Status (CIS) • Coverage rate reports and reminder recall	
Future Agenda Items	Ideas for future agenda items? • Men B • Immigrants/Refugee – how to interpret different types of vaccine types and amounts. DOH staff mentioned that the agency's Refugee Health Program could present in the future. • Update on the next immunization awards. • Pertussis updates. • Checklists/Screening tools (IAC) Review – April updates are significant about questions that are asked. Partners need to be aware.	

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 provides a high-level overview of the topics and information shared during the public comment period.

- SHINGRIX supply concern. There are doses coming in, significantly more. Most go through McKesson. Only 10 doses at a time. Trying to help increase the supply. Resources www.shingrex.com
- Comments and concerns were shared about vaccine safety, side effects of vaccination, and that the vaccine program is not for the best interest of children.
- Concern shared regarding potential conflicts of interest between the department, VAC members, and pharmaceutical companies.