

**Immunization Advisory Committee Meeting**  
**Minutes**  
**May 16, 9:00 a.m.**  
**109 Governor Street, Conference Room 535**  
**Richmond, Virginia**

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

**Members Present:** Tia Campbell, RN, MSN, NCSN (DOE); Melissa Canaday (VA Native American Community); David Goodfriend, MD; Julia Gwaltney, RN; Heidi Kulberg, MD, MPH (VAAFP); Carolyn Moneymaker, MD (EVMS); Bill Moskowitz, MD (VAAP); Tim Musselman, PharmD (VA Pharmacists Association); Cindy Robinson, RN (Reston Hospital Center); Laura Lee Viergever (VAHP); Nancy Welch, MD (VDH); Linda D. Wilkinson, MPA (Virginia Association of Free Clinics); Sandra Zieve, MD (Patient First)

**VDH Staff Present:** Jim Farrell; Laurie Forlano, DO, MPH; Laura Ann Nicolai; Cynthia Romero, MD, FAAFP; David Trump, MD, MPH, MPA

**Others Present:** Tami Brown (Merck); Lauren Bull (Hillbridge Group for VACEP/AAP); Heather Crouch (GSK); Bindi Patel (Merck Vaccines) and Ellen Shannon (Sanofi Pasteur)

**Members Unable to Attend:** Barbara Allison-Bryan, MD (Sentara Pediatric Physicians-Gloucester); Michael Ashby, MD (Martha Jefferson Hospital); Chris Bailey (VHHA); Bill Berg, MD, MPH (VDH); Aline Branca, MD (EVMS); C. W. Gowen, Jr., MD (EVMS); Robert Hicks (VDH); Parham Jaber, MD (VDH); Manikoth Kurup (DMAS); Marissa Levine (VDH); Douglas K. Mitchell, MD (International Adoption and Travel Medicine Clinic); Molly O'Dell, MD; Lilian Peake, MD (VDH); Holly Puritz, MD (VACOG); Bob Ramsey, MD (VCEP); Trinetta Randolph (VA Community Health Association); Jeniece Roane, RN, MS, NE-BC (VA Nurses Association); Jay Schukman, MD (Anthem BC/BS); Sandra Summer, PhD (VDH); Jodi Wakeham, RN, PhD (VDH)

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**Welcome/Introduction/Roll Call**—Dr. Forlano introduced herself and welcomed attendees and presented the agenda. Roll was taken and is presented above.

**Quarterly Data Snapshot**—Jim Farrell presented brief data snapshots for committee thoughts and input:

- Pertussis cases to date—Late provisional numbers from 2012 are 625 reported cases, a 57% increase over 2011.
  - As of April 30, 2013, 81 reported cases (down from 137 reported cases this time last year), indicating that we are either in the middle of a cycle or the Tdap initiative is having an impact, perhaps a little bit of both. Thank you to clinics, private physicians, and local health districts (LHDs) for their support and participation in this program. Virginia has not had over 500 reported cases since 1959.
  - VDH Tdap Program: Free Tdap immunization for 19 years and older that aims to eliminating the reservoir of unvaccinated adults who come in contact with unvaccinated infants and children (e.g., grandparents, caregivers, etc.). This vaccine was not available for adults until 2006. VDH plans to expand this program to get the vaccine to additional groups in the adult population.

- Dr. Trump asked about ACIP considering a pertussis second dose and maybe continuing the pertussis component of Td for adults indefinitely. Mr. Farrell agreed that a second dose is probably forthcoming, as the first dose of the pertussis vaccine is not lasting as long and probably ultimately replacing the 10-year Td booster to include pertussis. *[Note post-meeting: The ACIP's pertussis work group now is recommending against a second booster dose of Tdap for adolescents and adults, instead calling for using the diphtheria and tetanus toxoids vaccine as a booster dose.]*
- Dr. Forlano reminded the committee that Tdap now is recommended for each pregnancy.
- School Immunization Survey—Jim Farrell presented 2012 compliance data. The percentage of students on day 1 who are compliant with school regulations, not immunization coverage rates.
  - 2010 school year heavily impacted (compliance rates fell dramatically due to changes in the requirements) vs. 2011. Rates began to recover in 2011.
  - 83% compliant in 2012 on day 1 with the second dose of varicella the primary cause of non-compliance.
  - We still struggle getting information out to private schools—only 75% compliant at school entry.
  - 6<sup>th</sup> grade compliance is pretty much where we want it—we would like to see 95% across the board; public schools have done well, and private schools have done fairly well.
- Medical and religious exemptions—slide shows percentage by school year:
  - Medical exemptions tend to be nonproblematic.
  - Religious exemptions in private schools are increasing each year.
    - VA religious exemption is very liberal—only a notarized signature on a form that does not need pastor of the church to validate—result is that many religious exemptions are likely philosophical exemptions.
    - For example, in 2012 the public kindergarten religious exemption rate was 0.28%, as compared to the private kindergarten religious exemption rate of 1.76%. The trend, especially for private schools, continues to be upward.
    - We have to work with the private schools (e.g., outbreak occurred recently in one private school that spread to the community).
    - The trend for religious exemptions continues upward each year, and we may have to look at strengthening our religious exemption.
  - Dr. Romero asked if the trends are similar or different compared to national rates. Mr. Farrell responded that VA (0.91% exemption rate for all kindergartens) is below the national average (1.2%), but the concern is that we are seeing an increasing trend.
  - Dr. Romero asked if we have a plan for addressing the issue with private schools. Mr. Farrell recommended keeping open dialogue with the private schools but that there is no one umbrella organization to communicate with all private schools. We will continue to work with partners at DOE and Virginia Council on Private Education and Virginia Association of Independent Schools to improve immunization coverage rates in these students. Dr. Romero added that she may have some ideas for additional strategies to be discussed at a later time.
  - The question was asked as to how home schooled children are reported and followed? Mr. Farrell noted that the child's parent or custodian is responsible for immunizing but that VDH does not have the resources to follow up with home schools. Dr. Forlano noted there

are two separate laws—one addressing parents and custodians responsible for immunizing their children and one addressing immunizations required before entering public school.

- Home-schooled students in sports should be immunized; cannot guarantee since the students are registering through an athletics department vs. the school registrar.
- Home-schooled student curricula are not approved by DOE, rather each county approves. Ms. Campbell will look into who handles home-schooled student curricula to see if a component could be added to address immunizations.
- Dr. Kulberg asked for the specific numbers of outbreaks of private vs. public schools (or odds ratio) in order to be equipped when addressing schools and leaders in the community. Dr. Forlano and Mr. Farrell will provide that data.

**Programmatic Updates**—Mr. Farrell presented the Division of Immunization budget:

- \$57.6 million total budget (over 90% for vaccine; operations/administrative component is \$5.2 million total budget). Operations are all federal funds; state provides \$3.7 million for vaccine.
- \$1.7 of \$5.2 million is sent to LHDs to support their infrastructure; 3 vaccine categories: 317 basic grant \$3.7 million; entitlement Vaccines for Children (VFC) \$45 million; and state general fund \$3.7 million.
- Since 1994, VFC provides private physicians vaccines for children who meet the program criteria (primarily Medicaid patients). Buying vaccine via federally negotiated contracts is significantly less expensive than reimbursing private physicians for vaccine purchased at market price.
- This year VDH received 2 partial awards (due to continuing resolution at national level) for only \$3.4 million (35% cut). VDH has been told there will be an additional award—the amount not known at this time—needs to be \$1.8 million to remain at level funding. Sequestration will further affect at another 5% decrease (\$300,000).
  - Enhancements to the VIIS registry may suffer if we don't receive the \$300,000. We won't know until midsummer what the final numbers will be. IT costs are significant; reducing resources obligated to LHDs is a possibility; only 6 or 7 months left to make the cuts presents further difficulty. We won't have a final strategy until the final budget is known in midsummer.
  - Vaccine budgets (VFC) most likely will not be affected; 317 vaccine budget will probably take a reduction. We are giving fewer vaccines in the health department as more children are receiving them at their providers and Medicaid managed care has helped. Vaccine supply is not in jeopardy, rather the operational end will be affected.
- Dr. Romero noted that reduction in all areas of health department is in question and health care reform making us really focus on what is true public health and focus on the communities; there may be opportunities in private sector to pick up where VDH has reduced funding to ensure quality of care doesn't suffer.
  - Mr. Farrell agreed and noted that is the direction in which his staff is moving. Patients trust their doctors, and it is VDH's role to ensure the doctors are prepared to provide the resources to talk with parents. Their focus is heavily on private sector in educating and getting the word out (e.g., Ms. Nicolai's work with pharmacists and their role in vaccination).
  - Dr. Romero noted that the health department also should focus on surge capacity/emergency preparedness and ensuring private partners focus on education.

**Current Topics**—Laura Ann Nicolai presented a summary on the Mumps outbreak at the University of Richmond and around the state, as well as the measles outbreak in North Carolina (refer to slide presentations). A question and comment period followed:

- Question/Mumps Outbreak: Any gender differences? Early cases were primarily males at first because it began in a fraternity but within 10 days spread evenly.
- Question/Mumps Outbreak: Are there any plans for serology after dose 3? Titers were not completed following third dose vaccination to determine immune response in vaccine recipients. Serology (IgM and IgG) only was used as a diagnostic test for symptomatic individuals who presented for medical evaluation. In addition to an acute blood draw, CDC encouraged a second blood draw about 10 days out since vaccinated individuals may have a delayed IgM response. We were able to get a few of these collected; but in most instances, once students were feeling better they were not interested in going back to the Student Health Center for a second blood draw. Overall, PCR was a much better method of confirming mumps. Many (but not all) of our PCR positive cases were IgM negative.
- Question/Mumps Outbreak: What are the criteria for positive vs. probable cases? Confirmed cases were either PCR positive or culture positive; a probable case could be either IGM positive and symptomatic with 2+ days of symptoms; or, what most U of R cases were, Epi linked and 2+ days of perititis. A probable case did not have to be laboratory confirmed but did have to be Epi linked unless it is Igm positive. In this situation once we met outbreak criteria, the cases were considered Epi linked.
- Question/Mumps Outbreak: What determines a qualifying Epi link? Transmission of the virus is primarily face to face contact within 3 feet or more during period of infectivity, which is 3 days prior to perititis onset to 5 days after. There were known epi links with boyfriend/girlfriend attending 2 different colleges. At U of R, we were at outbreak status.
- Dr. Forlano emphasized that the mumps outbreak highlighted the importance of vaccines and precautions (e.g., masks) for providers, their staff, and patients to avoid cost and time as a result of additional cases. For example, several healthcare workers had to be furloughed, for a relatively long incubation period.
- Dr. Trump reminded the committee that both measles and mumps imported into our communities as a result of international travel is likely, and we need to remain prepared clinically and from the public health perspective.
- Dr. Forlano reminded the committee that Virginia's college law for vaccine requirements is for first-time 4-year full-time students at public universities, but not private universities. Private universities almost universally have their own vaccine requirements. U of R was excellent in this regard. Reminds us of the importance of connecting with private as well as public. The State Council for Higher Education in Virginia was instrumental in distributing communication (covers community colleges as well).
- Question/Mumps Outbreak: Is third dose of mumps vaccine recommended or required? Neither. Third doses are recommended only during outbreaks to curb the spread of the disease.
- Question/Mumps Outbreak: Will insurance cover a third dose? No, as it is not recommended for prevention. There is no evidence that immunity has waned, but perhaps the dosage during childhood did not generate a full response. The mumps component of the MMR is the weaker component of the three and always has been. ACIP considered a routine third dose at its last meeting, but it was not approved. It still is to be considered after more data collection and analysis.

- Dr. Romero shared that as the mumps outbreak occurred, ASTHO called to ask if VDH needed help. She asked if any other state had experienced this and was told that Idaho performed a statewide vaccination campaign. They discussed the possibility of a third dose, but it was not approved as a preventive measure.
- Question: Do community colleges have vaccination requirements equivalent to four-year colleges? The committee confirmed that community colleges do not. Ms. Campbell noted that more students are attending community colleges and then transferring to four-year colleges and that perhaps the current law should be updated to include community colleges.

**H7N9 Virus Update**—Dr. Forlano informed the committee this may have an impact on immunization. It is a fairly significant situation in China, although the case counts have fallen off some from April (126 reported cases including 24 deaths in various provinces).

- The disease has presented with severe disease in adults who had contact with infected poultry; no evidence of sustained human-to-human transmission. All evidence continues to point to infected poultry and contaminated environment as source of infection.
- CDC is not recommending any restrictions for travel to China but are encouraging common sense intervention when in China, such as hand washing, food safety, and avoiding contact with animals.
- The risk in United States is low; but because of pandemic potential, CDC is following closely and maintaining close contact with state health departments.
- CDC is taking proactive steps to be ready if virus presents as transmissible from human-to-human, including shipping H7N9 diagnostic kits in late April to state public health labs to increase the efficiency of diagnosis vs. all testing done at CDC.
- CDC has identified candidate viruses for vaccine, and clinical lots of vaccine are being developed with a variety of formulations. Tracking and documentation of doses are critical; and CDC predicts if the vaccine is necessary, everyone would need two doses (as was done with certain populations during H1N1). A nasal product likely would not be available due to time constraints.

**Policy Discussion: Pharmacists and Childhood Vaccinations**—During the previous committee meeting, there was some related discussion not intended to suggest there be legislation authorizing pharmacists provide vaccination.

- The issue addressed how pharmacists immunize children via prescriptions. There are instances when physicians don't have the vaccine in inventory (either none available or is too costly to carry).
- Only under those circumstances should the physician send the patient to the pharmacist for the vaccination. There is a role for the pharmacist when the physician involved, and flu season is definitely a time when pharmacists administering vaccinations is necessary.
- Mr. Musselman pointed out that current training covers all vaccinations well, and it was noted that Ms. Nicolai is involved with training webinars and providing related assistance to VA Pharmacists Association.
- Dr. Romero noted this is an opportune time for the use and promotion of VIIS.

## Open Discussion

- **Updated CDC Storage and Handling Toolkit Instructions**—Ms. Wilkinson stated that the VA Association of Free Health Clinics members are interested in knowing more about the changes. Dorm-style units are off limits.
  - Must have 2 doors (one for refrigerator and one for freezer).
  - Not necessary to buy large expensive unit.
  - Mr. Farrell noted the ideal situation is to have two separate units.
  - VFC providers are given specific instructions by VDH that follow the CDC guidelines, and VDH is in the process of publishing guidelines based on the CDC update to include temperature monitoring.
- **Immunization Regulations**—Dr. Romero, after reviewing the immunization regulations and history, raised the concern that a gap exists between the ACIP guidelines and Virginia's regulations. She recognizes the challenges in the process but supports moving toward eliminating that gap.

**Adjourn/Closing Remarks**—Dr. Forlano provided closing remarks and thanked everyone for their time and input. The meeting ended at 10:50 a.m.