

**Immunization School/Facility/College Law Advisory Committee  
Meeting Minutes, May 21, 2012**

**Voting Members Present:**

Judy Booker, Oregon Association of Child Care Directors  
Ann Occhi, Oregon Association of Education Service Districts  
Kathryn Eisenbarth, Pacific University/Oregon College Health Association

**Voting Members Joining by Conference Call or Webinar:**

Kim Bartholomew, RN, Oregon School Nurses Association  
Julie York, Oregon Department of Education  
Donalda Dodson, Oregon Child Development Coalition  
Merrily Haas, Oregon Association for the Education of Young Children  
Karyn Walker, Local Health Departments  
Jim Lace, MD, Oregon Pediatric Society & Oregon Medical Association  
Paul Lewis, MD, Clackamas, Multnomah & Washington County  
Kathryn Miller, Child Care Division  
Mark Siegel, Oregon Federation of Independent Schools

**Non-Voting Members Present:**

Janis Betten, Health Educator, Immunization Program, OPHD  
Paul Cieslak, Program Manager, Acute & Communicable Disease Program, OPHD  
Stacy de Assis Matthews, Health Educator, Immunization Section, OPHD  
Lorraine Duncan, Program Manager, Immunization Section, OPHD  
Peggy Hillman, Health Educator, Immunization Section, OPHD  
Jacki Nixon, Admin Specialist, Immunization Section, OPHD

**Guest Present:**

Marcy Baker, Sanofi Pasteur  
Susan Wickstrom, Public Affairs Specialist 3, Immunization Section, OPHD

**Chairperson:** Lorraine Duncan

**Recorder:** Jacki Nixon

**Updates:** Wednesday, Immunization Program Staff will be participating in demo about Michigan's School Law Module that is part of their immunization information system (IIS). We will be looking at it get ideas if Oregon can do something similar in ALERT IIS. Wisconsin also has a School Law Module in their IIS, which is built on the same platform as ALERT IIS. Our Assistant Attorney General will be attending the demo to look at whether this would be possible to do in Oregon from a legal standpoint.

**Declarations of Conflicts of Interest:** Annual conflict of interest forms were filled out and submitted by members. The committee frequently includes members who may have potential or perceived conflicts of interest, since members are chosen for service based on the expertise in the

areas in which advice is sought by the Oregon Health Authority (OHA). Members with potential or perceived conflict of interest may participate in committee discussions and vote, so long and the conflict is declared.

Those who called in or are on the webinar will receive their form by email. We ask, once it is signed, to please fax (971-673-0278), scan or email back the document so we can mark you off as signing.

**Minutes:** The minutes from the November 30, 2011 meeting were reviewed and approved.

### **HPV for Males-ACIP Update:**

Dr. Paul Cieslak, Medical Director for Oregon Immunization Program, discussed the quadrivalent HPV4 vaccine (Gardasil) for males. In 2006, HPV4 was licensed for prevention of cervical, vaginal & vulvar cancers and anogenital warts in females. ACIP recommended HPV4 for females 11-26 years of age. In October 2009, HPV4 was licensed for prevention of genital warts in males. ACIP issued a permissive recommendation for males aged 9-26 years old. In December 2010, HPV4 was labeled by FDA for prevention of anal cancer in males and females. In October 2011, HPV4 was recommended by ACIP for males 11-21 years of age.

### **HPV-associated conditions include:**

- Oncogenic types (including HPV 16 & 18)
  - Cervical cancers
  - Anal cancers
  - Vulvar/vaginal cancers
  - Penile cancers
  - Oropharyngeal cancers
- Nononcogenic types (including HPV 6 & 11)
  - Anogenital warts
  - Recurrent respiratory papillomatosis (RRP)

There are no data available as to the efficacy of HPV4 vaccine for prevention of penile cancers, oropharyngeal cancers, and RRP. The cost effectiveness of HPV vaccination would be better if HPV4 were effective in preventing these conditions. In addition, as more females are vaccinated, the cost effectiveness of vaccinating males decreases. Cost effectiveness estimates in males vary widely depending upon assumptions of what conditions HPV4 protects against, and what proportion of the male and female populations are vaccinated.

### **Summary of ACIP Recommendation of HPV4 vaccine for males:**

- Routine vaccination of males at 11-12 years of age with 3-dose series of HPV4
- Start as early as 9 years of age
- Catch-up vaccination through age 21
- Males aged 22-26 years may be vaccinated
- Immunocompromised males: catch-up through age 26 recommended

### **Reviewing of Human Papillomavirus (HPV) Against Twelve Criteria for School/Facility/College Immunization Requirements**

This document is being revised to incorporate information about the ACIP recommendation for HPV4 for males. Proposed changes include the following:

- **Section 1, page #3:** Added, “recommended that all adolescent males 11-21 years of age receive HPV vaccine. In addition, males in certain high risk groups are recommended to receive HPV vaccine through 26 years of age. The provisional recommendation that HPV vaccine may be given to other males 22-26 years of age remains.”
- **Section 1, page #3:** Added, “On October 25, 2011, the Advisory Committee on Immunization Practices (ACIP) recommended routine use of quadrivalent human papillomavirus (HPV) vaccine (HPV4; Gardasil, Merck & Co. Inc) in males aged 11 or 12 years. ACIP also recommended vaccination with HPV4 for males aged 13 through 21 years who have not been vaccinated previously or who have not completed the 3-dose series: males aged 22 through 26 years may be vaccinated.”
- **Section 2, page #4:** Added anal cancer information.
- **Section 3, page #5:** Added a range of cost effectiveness estimates for HPV for males using low and high coverage scenarios and assumptions of protecting against different HPV-related conditions.
- **Section 4, page #5:** Revised to read, “appears to be safe in males. It is difficult to demonstrate disease outcomes as potential cases of anal cancer may not appear until many years later.
- **Section 7, page #6:** Data for the percentage of adolescent receiving HPV vaccine in Oregon were updated using data from the Oregon Sentinel Region. A recommendation was made to use NIS-Teen data for this section.
- **Section 8, page #7:** Clarified that HPV vaccine for males is currently not covered under 317 funding.
- **Section 10; page 7:** Deleted information about different recommendations for HPV for students of different genders, as there is now a universal recommendation for both girls and boys.

Changes to the document were accepted by the committee, and a table will be added to summarize rates in section 7. A motion was made and seconded to recommend against adding HPV vaccine to school immunization requirements. All voting members present voted in favor of the motion. A final copy of the document will be available on the website.

**School Exclusion 2012 Data:** A summary was presented of school and children’s data collected from the Immunization Primary Review Summary in 2012. Some rates of immunization for individual vaccines are falling below the goal of 95%. Religious exemptions have been increasing steadily since 2000. In 2012 for the first time, full data were collected for religious exemptions by individual vaccine.

### **Religious Exemption Options:**

A partner is interested in looking at an option to the legislature for changing the religious exemption process in Oregon. The Advisory Committee discussed the pros and cons of ten different options. These options are ideas have been brought up in Oregon, or that are used by other states. Feedback will be provided to partners based on this discussion of the different options.

1. Follow the current policy. Pro: Immunization coverage of school-aged children is high with the current policy. Con: Religious exemptions are increasing and potentially compromising herd immunity.

2. Require a multi-pronged educational approach, including an option of completing education about the benefits and risks of immunization via webinar or a discussion with a health care provider. Pro: science-based information would be shared before a parent signed an exemption. Con: education only approaches about specific vaccines have not been shown to increase immunization rates (but these might not be relevant to the process we are discussing, as the vaccines included in education only were HPV and meningococcal). More details: Other groups, if they were interested, could be certified to provide this education to parents. There is concern about some parents not having internet access. A question was raised about speakers of other languages, and a suggestion was made to have the webinars in multiple languages. An interactive webinar was suggested so parents would get tailored information about their specific vaccine concerns. A suggestion was made to have a way to verify that parents have completed the webinar, such as writing down a completion code.
3. Require that parents speak with a health care provider about the risks and benefits of immunization, similar to the approach implemented in Washington in 2011. Pro: studies have shown that health care providers are seen as trusted sources of vaccine information. Preliminary information from Washington indicates that exemption rates decreased from 6% to 4.5% in the year after implementing the law. Con: This drop in exemptions in Washington might be influenced by the pertussis epidemic in that state. A question was asked about the current level of information that parents receive. This depends on if parents actually go to a health care provider for immunizations (minimum would be the Vaccine Information Statement). If a parent does not seek immunizations for a child, they could have no information or are likely to get information from the internet.
4. Require a notarized affidavit. Pro: this would deter parents choosing exemptions out of convenience. Con: convenience exemptors are not necessarily a large proportion of exemptors in Oregon.
5. Require that parents obtain a religious exemption forms online or at another location (not with the Certificate of Immunization Status form). Pro and Con: same as number 4. A comment was made that this would just be government making something difficult, and this wouldn't likely be effective in changing parents' minds about immunization if they have concerns.
6. Encourage or require an annual parent signature for religious exemptions. This is permissible under the current law. A requirement for a statewide requirement would require an administrative rule change, but not a statute change. Several counties and schools have expressed interest in this. Pro: This would give a chance for parents to update immunization information if children are on a delayed schedule or if a parent decides to get some immunizations for their children in the future. Con: This would require school computer system changes and increase school staff workloads.
7. Encourage schools to search in ALERT IIS for immunization records for students with religious exemptions. Pro: Some parents using an alternative or delayed schedule do not update school/facility records after vaccine doses have been administered, and this would provide an opportunity to complete these records. Con: this would involve additional school staff time.
8. Change in the Administrative Rules the definition of "religion" to be more restrictive. Pro: this might provide a deterrent to some parents considering signing an exemption.

Con: there could be legal challenges, and parents who will be deterred are likely already deterred by current language on the Certificate of Immunization Status form.

9. If vaccine coverage for a specific vaccine falls below a predetermined level (for example, 90%), the option to claim a religious exemption for that vaccine could be removed for a period of time. A comment was made that this is a terrible idea. It would not address pockets of underimmunization that currently exist if the statewide level is still high.
10. A request for exemption must be submitted to state authority. Pro: ALERT could be checked to see if vaccines had been given. Con: dedicating staff time would be challenging, and having a database of exemptors might not be met with favor.
11. A request for exemption must be submitted to the local health authority. Con: This would be very taxing on county health department staff.
12. Tighten process for signing a religious exemption by disallowing exemptions signed on exclusion day or the first day of school. Pro: this could deter parents choosing exemptions out of convenience. Con: this could result in overimmunization if parents could not find an immunization record, and would result in more children being excluded from school.

A partner is interested in receiving input from the Advisory Committee on drafting legislation. Discussion about the most favorable options was held. Several members expressed support of options 2 and 6 combined. One member expressed hesitation of supporting options when we have not seen the details of legislation might be proposed. A motion was made and seconded to express general support of options 2 and 6 combined, suggest that these options are ready for further consideration, but the committee would need to see the details of any proposed legislation to decide on whether to fully support it or not. All voting members present voted in favor of the motion.

### **College Measles Requirement-Preliminary results from the 2012 report:**

An update was given on college measles immunization reporting. The reports were due May 18, and 18 of 28 surveys have been submitted. Community college reports are due in June. Several colleges identified process changes to better track measles immunization status when completing the reports. In addition, several discrepancies between Oregon immunization law and Department of Education rules were identified, pertaining to religious exemptions and requirements for incoming freshman. The Oregon Immunization Program is working on correcting these issues. A question was asked about if these reports are completed by Job Corps programs, and currently they do not. The Oregon Immunization Program will explore if reporting would be applicable, and if so, the Job Corps programs would likely report similarly to OYAs, with no exclusion cycle.