

Vaccinate Vermont

Vermont Department
of Health

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Changes in 2015 Immunization Legislation - Act 37

Vermont lawmakers voted to remove the philosophical exemption during the 2015 legislative session. As a result, the Health Department will develop rules that address the statutory requirements over the next six months, and the public will have an opportunity to provide input during this process. Some of the modifications outlined in Act 37 (formerly known as House Bill 98) will impact your practice in the following ways:

Philosophical Exemption

After July 2016, parents will not be able to claim a philosophical exemption for children entering child care, school (K-12, public and independent) or college. Please be aware that the number of children who need to receive catch-up doses of vaccine is likely to increase. Catch-up schedules can be found on the [CDC website](#).

The other two exemptions - medical and religious - are still available. In 2016, health care providers may sign a medical exemption when a vaccine could be detrimental to a patient's health. Medical exemptions will terminate when the cited condition no longer applies. The religious exemption, to be completed by parents, will remain unchanged. Both of these forms will be

updated and made available on the Vermont Department of Health's [web-site](#).

Required VAERS Reporting

Act 37 requires that health care practitioners who administer vaccines report all significant adverse events to the Vaccine Adverse Event Reporting System (VAERS), even in cases when you are unsure about the cause of the adverse event. VAERS is a national vaccine safety surveillance program co-sponsored by the Centers for Disease Control and Prevention and the Food and Drug Administration. All reports can be filed online at the VAERS [website](#).

Immunization Registry

Act 37 maintains the requirement that health care providers in Vermont must report all pediatric immunization data to the [registry](#) within seven days of the immunization. The Health Department can now give confidential registry information to health care provider networks serving Vermonters and, with the approval of the Health Commissioner, to researchers who have approval from the institutional review board (IRB). It also allows for the exchange of confidential registry information between Vermont and registries in other states.



www.oktoaskvt.org

2015 Vermont Immunization and Infectious Disease Conference

Plan now to join us on **November 12, 2015** for the Vermont Immunization and Infectious Disease Conference, which is being held at the [Stowe Mountain Lodge](#). This conference is for clinicians, school nurses, epidemiologists and public health professionals across Vermont, and will feature meaningful education and networking opportunities. Plenary speakers include:

- *Andrew Kroger, MD, MPH* - "Immunization Update 2015 and Vaccine Safety."
- *Anna Acosta, MD* - "Acellular pertussis vaccine effectiveness among children and adolescents in the setting of pertactin-deficient *B. pertussis*, Vermont, 2011–2013."
- *Brendan Nyhan, PhD* - "The Challenge of Vaccine Myth: Recommendations for Practice."

Registration is now open. Take a look at the [schedule](#) and follow this link to [register](#). The conference is sponsored by the Vermont Department of Health.



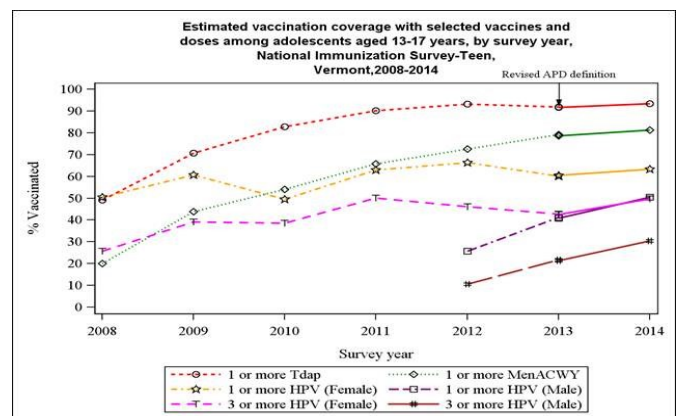
HPV Vaccine Update from NIS-Teen Data

According to the 2014 [National Immunization Survey-Teen](#), more Vermont teens are getting Tdap and MenB vaccines, but most are not fully vaccinated against human papilloma virus (HPV) infection.

Rates of HPV vaccination increased just slightly for girls and boys in Vermont, with one exception: boys age 13 to 17 who received the second dose of HPV vaccine rose significantly from 26 percent in 2013 to 41 percent in 2014, higher than the national average of 31 percent. Thirty-one percent of teen boys in Vermont completed the vaccination series and received all three doses, higher than the national average of 22 percent. Teen girls who received three doses of HPV vaccine rose slightly from 43 percent in 2013 to 50 percent in 2014, higher than the national average of 40 percent.

Overall rates show an upward trend, but there is more work to be done to protect teenagers from vaccine preventable diseases. The Immunization Program has partnered with the Vermont Child Health Improvement Program, the Vermont chapter of the American Academy of Pediatrics, and the Hicks Foundation to provide information to parents and health care providers about the

importance of the HPV vaccine for cancer prevention. The Vermont Immunization Registry also provides detailed quarterly reports to health care provider practices on their HPV immunization rates.



≥1 Tdap: ≥1 dose of tetanus, diphtheria, acellular, pertussis vaccine at or after age 10 years.

≥1 MenACWY: ≥1 dose of meningococcal conjugate vaccine.

≥1 HPV: ≥1 dose of human papillomavirus vaccine.

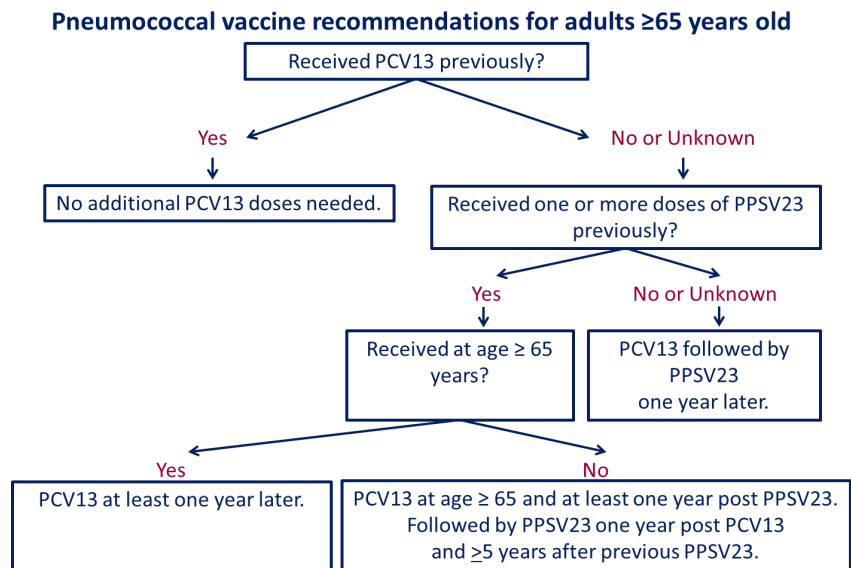
≥3 HPV: ≥3 doses of human papillomavirus vaccine.

APD: Adequate provider data. A revised APD definition was implemented in 2014, retrospectively applied to 2013 data and revised estimates were calculated for purposes of comparability to 2014 data. Revised 2013 estimates will differ from those previously provided. Estimates using different APD definitions may not be directly comparable.

Pneumococcal Conjugate Vaccine Changes

The CDC pneumococcal recommendations have been confusing to both patients and providers. In order to simplify the schedule and be consistent with Medicare rules, the ACIP revised the recommendation. Now, for people age 65+, the timing between PCV13 and PPSV23 is always one year regardless of which was given first. The updated algorithm has been provided to assist you in administering the right pneumococcal vaccine at the right time.

Follow this link for [details](#).



Highlights from the 2014 - 2015 Child Care Report

Child care providers are required to maintain proper documentation reflecting each child’s immunization status and report this data to the Health Department annually by January 1.

Each child’s immunization status is assessed, and the child is determined to be either: up-to-date (UTD), exempt or provisionally admitted. Provisional admission means that a child who is missing vaccines is admitted to a facility, but the parents are in the process of getting the child up-to-date. This status cannot exceed six months.

Child care providers are required to submit aggregate data to the Health Department by January 1st. This data is collected using an online survey. The 2014 - 2015 Child Care Immunization Survey, with a 56 percent survey

completion rate, indicated that 91 percent of children enrolled in child care were up-to-date for the required immunizations. The percentage of children up-to-date with individual vaccines was high with MMR at 97 percent and DTaP, IPV, Hib, PCV at 96 percent. Hepatitis B and Varicella vaccine rates were at 95 percent. The provisional admittance rate was at 5.6 percent. Exempt means that the child’s parent or guardian has filed a signed medical, religious or philosophical exemption with the provider. Among the child care facilities that completed the survey, combined philosophical and religious exemption rates were 3.6 percent, and the medical exemption rate was 0.1 percent.

In July 2016 the philosophical exemption will be eliminated, but medical and religious exemptions are still available. Catch-up schedules can be found on the [CDC website](#).



Meningococcal B Vaccine

New Recommendation

The Advisory Committee on Immunization Practices (ACIP) met in June and passed a “permissive” recommendation for meningococcal B (MenB) vaccine. A “permissive” recommendation allows the health care provider to choose whether or not to recommend the specific vaccine for their patients. It does not have the strength of a full recommendation but was chosen because the available data indicated the Men B vaccine effectiveness may wane after a relatively short period of time and the incidence rate of the disease is very low, but the morbidity is very high. The Men B vaccines are expected to protect against the majority of MenB disease strains circulating in the US, however, the full extent of protection will not be known until the vaccine is in regular use.

Who should be vaccinated? A serogroup B meningococcal (MenB) vaccine series may be administered to adolescents and young adults 16 through 23 years of age to provide short term protection against most strains of serogroup B meningococcal disease. The preferred age for MenB vaccination is 16 through 18 years of age. As soon as the new permissive recommendation is published in the MMWR (CDC), the VT Immunization Program will provide guidance on vaccine ordering by VFC and VFA providers.

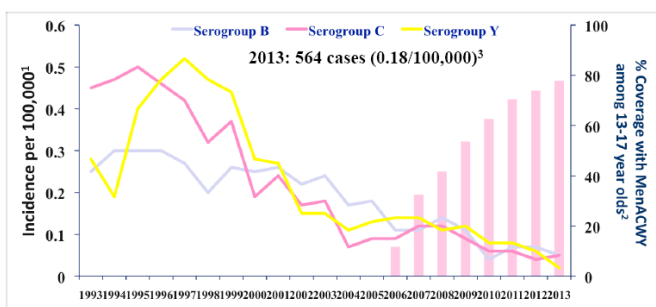
Meningococcal Disease

Meningococcal disease is a serious illness caused by a type of bacteria called *Neisseria meningitidis*. It can lead to meningitis (infection of the lining of the brain and spinal cord) and bacteremia or septicemia (infections of the blood). Meningococcal disease often strikes without warning — and can affect people who are otherwise healthy.

There are at least 12 types of *Neisseria meningitidis*, called “serogroups.” Meningococcal vaccines (Menactra, Menveo) are routinely recommended to help protect against serogroups A, C, W, and Y. Serogroup B meningococcal (MenB) vaccines (Bexero, Trumenba) can help prevent meningococcal disease caused by serogroup B, which accounts for approximately 40% of meningococcal disease in the U.S.

The good news is that incidence of meningococcal disease (serogroups B,C,Y as depicted below) has declined annually since the late 1990s and current rates are at historic lows. While cases have declined, the overall case fatality ratio remains at 10-15%, and 11-19% of survivors have long-term sequelae (e.g., neurologic disability, limb or digit loss, and hearing loss).

Meningococcal Incidence in All Ages by Serogroup and Adolescent MenACWY Vaccine Coverage, 1993-2013



For more information please visit [CDC Meningococcal Vaccination](#) and [Serogroup B Meningococcal \(MenB\) Vaccine Information Statement](#)



108 Cherry Street
PO Box 70
Burlington, VT 05402

Phone: 1-800-640-4374

Fax: 802-863-7395

AHS.VDHImmunizationProgram@vermont.gov