

Texas Immunization Stakeholder Working Group Meeting Minutes
Joe C. Thompson Center, Austin Texas
June 21, 2012

Attendees:

Adelaida Perez, Superior Health Plans, Austin
Adriana Echartea, City of Laredo Health Department, Laredo
Adriana Garza, Corpus Christi Nueces County Health Department, Corpus
Alice Hallgren, Ft. Bend County Health Department, Rosenberg
Alicia Nunez, DSHS, Austin
Alisha Acosta, San Patricio County Department Public Health, Sinton
Andrea Legnon, DSHS, Austin
Andria Stricklin, Merck, Houston
Angela Herrera, DSHS, Austin
Angela Hill, Angelina County and Cities Health District, Lufkin
Barry Lachman, MD, Texas Association Health Plans, Dallas
Belinda Granados, Corpus Christi Health Departments, Corpus
Blanca Gonzales, City of Laredo Health Department, Laredo
Brian Buckles, GSK, Austin
Bruce Kieler, Wharton Community College, Wharton
Cathy Cavin, Austin Travis County Health Department, Austin
Cherri Schmidt, Hays County HD, San Marcos
Clara Taylor, DSHS, Austin
Clark Petty, San Antonio Metro Health Department, San Antonio
Coleen Christian, Austin Travis County Health Department, Austin
Dan Walters, Facilitator, Dan Walters and Associates, Austin
Danny Acosta, Immunize El Paso, El Paso
Debbie Tucker Austin Travis County Health Department, Austin
Del Negron, Novartis Vaccine, Austin
Diane Leftwich, Milam County Health Department,
Diane Romnes, DSHS HSR7, Temple
Dusty Gonzales, Northeast Texas Public Health District, Tyler
Eileen Smith, GlaxoSmithKline, Waco
Irene Banda, San Patricio County Department Public Health, Sinton
Isabel Hargrove, Austin Travis County Health District, Austin
Jack Sims, DSHS, Austin
Jason Terk, MD, Texas Pediatric Society, Keller
Jennifer Jackson, Sanofi, Mission
Jennifer Sutherland, Corpus Christi Nueces County Public Health District, Corpus Christi
Jessica Hernandez, San Patricio County Department Public Health, Sinton
Joan Aalbers, DSHS, Austin
Joel Hastings, Medimmune, Dallas
Jonathan Klock, Novartis
Joyce James, Texas Health Human Services Commission, Austin
Judy Merritt, Scientific Technologies Corporation, Oklahoma
Justin Kerr, DSHS, Austin
Karen Hess, DSHS, Austin
Kate Alfano, Texas Association Family Physicians, Austin
Katharina Hathaway, MD, Texas Association Family Physicians, Austin
Kathryn Johnson, DSHS, Austin
Kathy Clark, Blue Cross Blue Shield TX, Dallas
Keith Cunniff, Pfizer, Houston
Kenzi Guerrero, DSHS, Austin
Kim Robinson, Texas Pharmacy Association, Austin
Kyle Mauro, HillCo Partners, Austin
Larry Johnson, Texas Association Local Health Officials, Abilene
Latasha Hinson Calles, City of Houston, Houston Department of Health and Human Services
Laura Lerma, Texas Nurses Association, Austin
Laura Leslie, GlaxoSmithKline, El Paso
Lauren Miller, DSHS, Austin
Leslie Myers, Safeway Pharmacies, Arlington
Linnea Nasman, Texas Immunization Partnership, Austin
Lola Davis, DSHS Austin
Lori Ashford, DSHS, Austin
Lori Koehler, Medimmune, San Antonio
Luis Valenzuela, DSHS, Austin
Lupe Garcia, DSHS, Austin

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Mark Murray, DFPS, Austin
Mary Martinez, San Patricio Department Public Health, Sinton
Mary Stitt, Superior Health Plans, Austin
Maureen Moore, Texas Immunization Partnership, Houston
Melissa Berger, Ft. Bend County Health Department, Rosenberg
Melissa Samples-Ruiz, DSHS, Austin
Michelle Nelson, Pfizer, Austin
Paul Sanders, Merck, Dallas
Phil Burger, DSHS, Austin
Rachel Wiseman, DSHS, Austin
Rekha Lakshmanan, Merck Vaccines, Houston
Sandra Hermosa, San Antonio Metropolitan Health District, San Antonio
Sarah Adams, Angelina County and Cities Health District, Lufkin
Sarah Murphy, DSHS ImmTrac Intern, Austin
Sharon Currie, Corpus Christi Health Department, Corpus
Sharon Skaggs, Wesley Nurse Methodist Ministries, Austin
Sylvia Warren, Northeast Texas Public Health Department, Tyler
Stacey Schweitzer, Williamson Cities and County Health Department, Georgetown
Stephanie Milani, Pfizer, North Texas
Steve Ketterbaugh, Sanofi Pasteur, Nashville, Tenn.
Sue White, Texas Medical Foundation, Austin
Tammy Foskey, DSHS, Austin
Terry Sparks, DSHS, Austin
Thomas Colbert, Medimmune, Houston
Tina Gibson, Bell County Health Department, Temple
Tony Aragon, DSHS, Austin
Virginia Longoria, San Patricio County Public Health Department, Sinton
Vivian Harris, DSHS, Austin
Windy Hill, Texas Health Human Services Commission, Austin

New Member Orientation

Vivian Harris conducted a new member orientation where 16 attendees participated in TISWG for the first time.

Welcome, Introductions, Agenda Review

Dan Walters welcomed and greeted all attendees. He stated TISWG is an interesting group with person's representative of numerous different organizations and participate for a variety of reasons. TISWG is a complex coalition that coalesces three to four times per year. Its purpose as a working group is single purpose simply to increase vaccination rates in Texas. We pose this question at each meeting, what is it we can do together that we cannot do individually to increase immunization rates in Texas?

Attendees were asked to introduce themselves, the organization they represented and where they were from.

Center for Elimination of Disproportionality and Disparities

Dan Walters introduced the first speaker, Ms Joyce James, Associate Commissioner at Texas Health and Human Services Commission, Director Centers for Disproportionality and Disparities. Please see her bio attached. Her presentation included information on how the Center was developed and via legislation that enforced the Texas model to explore data to verify disproportionalities. Executive commissioner Tom Suehs was instrumental in creating the center in spring 2010. Since then the model has been introduced to various groups and programs and has offered an avenue to explore the measurements in other groups.

Ms James spoke of multiple definitions of disproportionality and disparities. Regardless of the definition; disproportionality and disparity exist for the same populations and ethnicity within each system. It is important to have a broader picture of how systems work to understand the

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impact. In every region, African American disproportionately present in child welfare services, discipline in schools and the juvenile system. Texas was the first state to conduct research relating to school discipline. In a study entitled “*Breaking School Rules*”, students were followed for two years post-graduation. During their education “mandatory discipline” geared for at risk or troubled students was found to be the same across the board. Of the cases of “Discretionary Discipline”, 75% were found to be African American and more males than females. The next highest disproportionate group was Hispanic males and more than Hispanic females. Following that group were those that were disabled. Youth of multiple referrals are more likely to drop out of school. Primarily Black and Brown youths suffer the highest drop-out rate. If youth drop out of school, their futures are determined by the types of jobs they obtain, the resources available to them as well as exposure and suffering of more health disparities. These youth were more likely to be certified as adults when referred to the Juvenile System, and therefore faced stiffer penalties and consequences. Ms James presentation covered specific aspects in infant mortality and HIV data depicting that the Texas Model of measuring disproportionately is very appropriate and apparent in the systems we work within. Three new pieces of legislation required the state of Texas to explore potential racial disparities in custodial child protective services outcomes of African American and Hispanic children. Participants interacted in a couple of exercises that explored how we see ourselves in addressing the needs of the persons we serve. Once faced with perceived racism it is impossible to get to the core of a matter, without facing our own attitudes and assumptions. It is based on our own stereotypes, which determines how we make decisions. One particularly interesting exercise is “Why are People Poor” and discovering how we perceive the reasons behind these circumstances. It showed us how we can subconsciously look at the situation but not see the system as a source of disproportionality in the services we provide. For once we did have the data to measure how the fix the problem /system and not the people. It was a very thought provoking session in which we were all invited to enroll in the sessions the Center has to offer. Please refer to the attached PowerPoint presentation for additional content and information.

Electronic Vaccine Inventory Expansion EVI-Demo

Ms Karen Hess provided an update and demonstration of the Texas Vaccine for Children (TVFC) Electronic Vaccine Inventory Expansion (EVI) that went live in April 2012. Ms Hess described that there were new features added since the program went live and although there were a few kinks, since uploading the new features, they are working with the contractors and the providers to resolve problems as soon as they are identified and keep everyone informed.

The demo covered six primary functions of the EVI expansion. They included the following topics with demonstrations.

- (1) Receiving vaccine orders
- (2) Transfers vaccines orders (under inventory)
- (3) Recording wastage, expired vaccines, and losses (under inventory)
- (4) Recording doses administered, (required by every provider)
- (5) Providers are expected to do a physical count of vaccines.
 - Determine what is actually in your refrigerator/freezer.
 - What is on hand, what is received, what you transferred,
 - What you lost, what you administered.
 - Encourage providers to record the receipt of vaccines & losses in the system.
 - Providers will have to explain why numbers do not match what the system says you should have vs. what you actually have in stock.
 - For every vaccine this must be recorded.
 - Do not need to worry about matching paper to system.

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(6) Placing orders

Providers will have a recommended order once you click on this tab. You can amend your order but need to make a comment for every change.

Providers in the room had practical questions about the delivery on services with the EVI expansion program. *See addendum for EVI questions.* Ms Hess also provided Vaccine Call Center numbers for additional information and Technical Assistance. Providers may contact 1-888 777-5320.

Immunization Branch Update:

Jack Sims provided an update on Immunization Branch issues. They included the following topics:

- Discussion on disparities is becoming more frequent. The Centers for Disease Control and Prevention, CDC has held a “Call to Action” inquiry on HPV disparities. States are tasked at looking to improve the outcomes of HPV vaccination.
- There is increasing awareness of the CDC Grant processes. It is time for the renewal of the five year grant period 2013-2017. As the CDC grant is being developed issues may require diversions which we focus on fully trying to fulfill the requirements.
- Health Care Reform is affecting how we will do our business. Disparities discussed today, is a beginning to take a look at all of our actions pertaining to vaccinations. Are there disparities in our systems that prevent citizens from being vaccinated?
- With the current hiring freeze, how do we hire staff? We have been pretty successful in Austin, and able to hire temporary staff now to look at billing infrastructure for the privately insured children. We are launching an RFP for a contractor to look at our best practices. We are hoping to develop an implementation plan that would be useful. One aspect of best practice is to be credentialed with a health plan.
- Progress is also being made to reach out to high schools & higher education regarding the HPV mandate.
- The ImmTrac replacement project as also moving forward. DSHS selected to proceed with the Weir model out of Wisconsin. One of the best findings about this system is that it is a consortium of resources. Anything added by one state is shared with all members which allows for cost savings.
- Best Practice – disease incidence data. Mr. Sims suggested it is nice to have incident data but it is just as important to have outcome data. In the case of both Hepatitis A and B; the disease has become more prevalent in Texas. Persons may not always know they have disease. For example; Dallas County had one third of all reported cases in Texas. Based on data reported to us, Dallas County had more than 165 cases per year over a 5 year period and now it is reported to be down to 28 cases per year. This has happened because of staff reaching out, testing persons and vaccinating if they tested positive, and stressing the recommendations.

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- Mr. Sims announced the upcoming retirement of Ms Lupe Mandujano Garcia. He thanked her for her 25 year service in state government and commended her for her many many contributions to the Immunization Branch. She was presented with tokens of appreciation from staff and stakeholders. Everyone was invited to attend the retirement reception planned for August 30th 2012 in Austin.

Surveillance Update Infectious Disease Control Unit

Rachal Wiseman provided an update on the most current disease surveillance.

Pertussis in Texas peaks every 3 to 5 years. This possibly is due to disease spread but more likely to improved diagnostics. The reported increase is being driven by a few counties seeing higher number of cases already. Not all of these reported counties are on the same 3-5 year cycle. In fact, states are not on the same cycle.

In Texas in recent years from 2008, through 2010, very high numbers of cases were reported. Adult and late adolescents have the same case rate. Infants, however are the reasons we work so hard at surveillance and to control the spread of disease. No pertussis deaths were reported in 2010. Of all reported deaths reported, cases were under the age of 3 months and unable to be vaccinated. Prevention suggests we need to vaccinate the entire community based on casual contact. Every time a case of pertussis is reported, we are to identify everyone who may have had any contact with the case, vaccinate and treat with prophylaxis.

Cases of Chickenpox have decreased but not as quickly as previously reported. According to the CDC, we are not the only state seeing this trend due to:

- Very mild cases vs. full blown cases.
- Cases not really catching the severity of disease.
- Now there are fewer than 50 cases per 100,000. This speaks to how well vaccination is bringing down case rates; 9,000 cases less than six years ago. *Please see addendum PowerPoint presentation attached.*

Ms Wiseman also reported on the Vaccine Preventable Disease Teams' Activities and Accomplishments.

- Communicable Disease Chart updated; last updated in 2004.
- Updated Texas Administrative Code to reflect newer recommendations for school exclusion
 - Passed the council, now on to the Register
- Updated VPD Investigation Guidelines
 - Updated for chickenpox (break-through cases length of exclusions) and mumps (now in line with national recommendations). Should be implemented in 2012
- Expanded VPD website
- Implemented surveillance of death data to enhance case ascertainment
- Created acute hepatitis B workgroup to improve investigation of acute B cases
 - Continue to work with perinatal program to ensure capture of all positive moms
- With LHDs and HSRs, responded to pertussis and varicella outbreaks
- Provided training to new HSR staff on VPD investigation and outbreak response
- Revised pertussis investigation form
- Planned activities include

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- Evaluate Medicaid hospitalization data as an additional surveillance source
- Revise varicella reporting form
- Continued expansion of VPD website

ImmTrac Update

Lori Ashford provided an update on ImmTrac and its Interoperability progress.

Along with ImmTrac being the repository for childhood vaccinations, ImmTrac has also become a disaster tracking system for family members, first responders, children and adults. It allows for consolidation of records from numerous sources. Parental consent is still needed for children less than 18 years of age. Only authorized entities are allowed access to the data. ImmTrac statistics records over 22,000 provider entries with over 960,000 immunizations records every month. Currently ImmTrac contains 101.0 million records in the system. With 6.72 million children records entered, 2.27 million are under the age of six years. 92.4 % of parents grant consent for their newborns to be entered into ImmTrac, 95, 730 adult client records are entered with greater than 168, 339 history reports generated every month.

Interoperability allows different systems to receive Health Level HL7 data to ImmTrac. It was designed to help providers submit this data to ImmTrac and on regular bases. It is a system sponsored by DSHS but is funded by the American Recovery and Reinvestment Act (ARRA). This grant funding will end August 31; however, DSHS is submitting another grant by attesting to Stage 1 Meaningful Use. Onboarding providers has made great strides, as of March 12 cumulative providers have on-boarded and receiving the benefits associated with the interoperability success. To date there are already 202 sites sending data on a regular basis in the HL7 format. *Please see addendum attached for more information.*

Senate Bill 346 adapted the Lifetime Immunization Registry for Texas. Progress is in the making for implementation. Staff is working with Local Health Departments and Health Service Regions to implement new materials and to promote awareness. A focus to get the new materials to higher education is also in the making, in addition to launching a new microsite on the web.

The ImmTrac Replacement planning also continues. Dr. Lakey has approved the Wisconsin Immunization Registry (WIR) model. Michelle Hernandez has been hired as the Project Manager; she began May 21, 2012. Governance documentation is being drafted for management approval. Several implantation questions were asked by attendees and answered.

Health Care Worker Vaccination Policy Texas Hospital Association

Ms. Denise Rose provided an update from the March 2012 meeting, on the progress of the Texas Hospital Association's (THA) vaccination policy. According to the Texas 82nd legislation, hospitals were to implement a policy specifying which vaccinations would be required for employees who provide direct patient care. These policies are to be in place by September 1st. The Texas Hospital Association along with the Texas Pediatric Society and the Texas Medical Association worked diligently to craft legislation that would be the most effective and encompass a majority of personnel without overly burdening hospital operations. These organizations also stressed strongly that immunizations from a vaccine preventable disease stance were a patient safety issue.

One of the ultimate goals of this policy, is to increase the percentage of Health Care Personnel who are vaccinated annually against the seasonal flu.

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Currently the rules are not final; however, THA has been working on sample policy documents which will help hospitals identify who would be covered, and new definitions of exemptions as alternatives to vaccination. Hospitals will have quite a bit of discretion as to who is considered covered, who needs what vaccines, to include contracted staff, students and non-patient personnel. It is expected and suggested that hospitals utilize the recommendations of the Advisory Committee on Immunization Practices ACIP and ensure the policy is in concert with the new requirements of the Texas Health and Safety Code, Section 224 .004(b).

A few additional points of interest include, policies development must include acknowledgement of Exemptions, such as reason of conscious or religious, which could be hospital specific. Medical exemptions however is required by law must indicate recognized contraindications and precautions according to the Centers for Disease Control and Prevention. Exemptions must be maintained on file, and may require individual signatures. Religious exemptions must include clergy signature. Acknowledgement of exemptions will allow facilities to reassign an individual not complying with policy; facilities can take disciplinary action against employees if they do not provide proper documentation for not getting the vaccines. According to developed policies it also let individuals know that they may not be allowed into certain work areas or may be required to wear/utilize special protective equipment for patient safety if not properly vaccinated according to policy. *Please see handout THA SB7 for additional information.*

Meningococcal Plan Post Discussion Update

Tony Aragon and Luis Valenzuela provided a joint presentation on the progress made since the last TISWG meeting on the Meningitis Action Plan. At the March meeting participants approached the Senate Bill 1107 vigorously on how to implement and engage various elements of the bill. SB1107 has passed and requires all students show evidence of vaccination upon entry into higher education institutions. This includes new and transfer student according to the bill. Only three exemptions are recognized at this time. These include exemptions for students attending on-line studies, students 30 years of age and above, the requesting exemptions for medical or reason of conscious. Since the bill was to be effective September 1, 2012, the number of requests for exemptions increased dramatically. The adult safety net for vaccinations was created to help these students obtain the vaccination.

Mr. Aragon reiterated that the Action Plan was developed with two main objectives in mind:

- To reach 16-18 years olds and to
- Ensure 19-20 year olds get the vaccine.

Mr. Valenzuela provided the updates and actions taken since the March TISWG meeting. He stated that DSHS has executed the communication plan with input from stakeholders focusing on provider education, education for students and families, and assisting institutions of higher education to incorporate the new bill requirements into policies.

DSHS has also launched the meningococcal microsite. You can find this site at <http://collegevaccinerequirements.com/>. The microsite includes information and resources for viewers on meningococcal vaccine requirements, obtaining the vaccine, and disease information. As of 05/18/2012, 2,500 visitors have accessed the site Mr. Valenzuela provided a demonstration of the microsite and highlighted features the site has to offer such as vaccine requirements, how to obtain the vaccine, requirements for proof of vaccination, and vaccination exemptions. Visitors' feedback commented that the microsite is user friendly and provided the necessary information timely. The DSHS Immunization Branch responded to these efforts by widely disseminating the resources and references to those in immediate need of access. In addition,

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DSHS created a one page fact sheet for distribution among health-care providers and entering college students. Mr. Valenzuela remarked on the input and commitments made by several stakeholders. These are included in the PowerPoint presentation attached.

Stakeholders Feedback Challenge

Dan Walters led the discussion on the working group's portion on the TISWG Participant Feedback and Suggestions Challenge. The purpose of this exercise is to gather planning information and determine the vitality of TISWG. He stated that the face of TISWG is changing and has evolved into a problem solving entity. Dan provided a summary of the TISWG Operational Charge in which the purpose and the method has not changed but the outcomes have. A few items noted that has changed since inception is as follows:

- The immunization target population has shifted from childhood vaccinations only, to include adolescents, adults and elders.
- Attendance has heavily increased from 20-30 regular attendees to over 80-90 participants per meeting to include first timers to more community stakeholders.
- TISWG shifted during H1N1 to a problem solving model and has remained in that state to a large degree.
- TISWG meetings have also shifted from quarterly to three meetings per year.
- Vaccine availability and the nature of immunization policy and delivery are changing due to healthcare reform.

Participants were also provided with the evolved agenda format for each meeting for review. Each meeting includes a series of universal updates, internal branch program updates, topic discussion on immunization specific information and hot topics, meeting follow up, stakeholder activities/ interventions, guest speakers and subject matter experts. Participants were invited to give written feedback on seven (7) categories either to provide identified problems, potential improvements or both. The categories were as follows: *Agenda Topics and Timing*, (20 responses) *Presentation Content*, (17) *Meeting Process and Discussion Format*, (15) *Committees and Workgroups*, (10) *Communications to Stakeholders by DSHS*, (12) *Communications from Stakeholders to DSHS*, (5) *Communications between stakeholders*. (12) All responses were collected and can be seen as "Stakeholder Feedback Analysis". *For more information, please see document attached.*

Closing Remarks

Jack Sims provided closing remarks. Mr. Sims thanked everyone for attending and contributing to today's meeting. Questions were asked of any updates of the required deputization for local health departments and officials to provide vaccination to the eligible children in underserved populations. By October 1st this requirement will be in place and be required to show proof of a formal recruitment of all providers. Mr. Sims stated we believe health departments and clinics are already providing documentation through TWICES. If we are not getting the adequate response we may need to focus closely on rural health clinics if there are gaps in the service area to cover eligible children.

Meeting adjourned at 3:07 pm.

The next TISWG meeting is scheduled for December 6th, 2012, at the Joe C. Thompson Conference Center.