State of Vermont
Vermont Department of Education
120 State Street
Montpelier, VT 05620-2501

Immunization Work Group for Protecting Immunocompromised Students
Meeting Minutes
November 27, 2012

Attendees: Breena Holmes, MD; Kate O'Neill; Jeff Francis (by phone), Barbara Frankowski, MD; William Raszka, MD; Brenda Perkins, RN
Guests: Lisa Boisvert McKenzie, Lucie Garand from Downs Rachlin Martin PLLC

Agenda Item	Discussion	Action
Update on Assignments from October meeting	• Dr. Raszka provided draft definition* (see below) of the term immunocompromised. It is difficult for us to study the feasibility of allowing students with special health needs to be considered in this category as this is a huge population of students with variable diseases (asthma, diabetes, cystic fibrosis, etc) • The student population of special health needs is hard to define in terms of physiologic response to vaccine preventable disease • Ms. O'Neill researched educational policy regarding moving students. Legislation 16 V.S.A. § 821 and 16 V.S.A. § 822 allows the movement of students when necessary school does not exist in district. Amendments to this legislation next year to allow for more secondary school choice with caps on numbers. This does not pertain to topic of moving students for the purposes of protecting immunocompromised students. • Ms. O'Neill referenced Unsafe School State Board Rule 4000 re: school movement. This does not pertain to topic of moving students for the purposes of protecting immunocompromised students.	

Discussion of Feasibility	• Immunocompromised students would comprise a very small group of students that might benefit from moving to school with higher immunization rates, provided there could be assurances of healthier environments in schools elsewhere.
	• There are other issues for children with special health needs when they get sick than just susceptibility to illness.
	• Moving a broader pool of students with special health needs becomes less feasible to consider school movement.
	• Limiting movement to "adjoining" districts does not make sense if the objective is to move immunocompromised students from a less safe environment to a safer environment.
	• Concerns about lack of ability to assess the safety of one school vs. another
	• Comparative risk analysis of whether one school is really healthier than another difficult.
	• Similar to statute (4000) "safe school" could be defined as:
	  o X% immunized,
	  o has not had an outbreak, or days missed,
	  o other pre-determined criteria
	However, imposing these rates in order to determine the relative safety of a school is arbitrary.
	• Absence of full time nurse in many schools creates barrier to determine best placement for immunocompromised students	

Discussion of necessity and practicability of requiring school personnel to be fully immunized	• Ms. Perkins confirmed that Vermont does not have health requirements for school personnel. NEA national research did not identify any requirements in other states. • Dr. Raszka shared Center for Disease Control and Prevention recommendations for prevention of transmission of infection to immunocompromised individuals but to protect immunocompromised require immunizations should be considered. • The work group would like to align requirements of school personnel with student immunization requirements, requiring same immunizations for school personnel as for students, and to allow for the same exemptions. • Recommend evidence of immunity/immunization for school personnel. • Practicability concern: There are other nonemployees in schools on a regular and consistent basis, so even requiring school personnel to be fully immunized may not improve the safety of the environment for students with special health needs.	

Public Comment (Lisa Boisvert McKenzie)	• Referenced *Vaccine History or Confirmed Pertussis Cases*** (see below) • Expressed concerns: o Small school populations and potential for unintended consequences due to such small numbers o Pertussis outbreaks occur in highly vaccinated children o Potential for workforce issues if school personnel are required to be immunized o Divisiveness for communities to label a school unsafe o Potential to not release sick children from school if Vermont used that illness as criteria for determining an unsafe school	
Finalize Recommendation and Plan for drafting report to legislature		Dr. Holmes will write first draft of legislative report and will circulate draft via email to working group members. Final report expected to be submitted to AHS by COB Friday December 14, 2012.

*Notes from Dr. William Raszka:

Action Plan 1 assigned to WVR
For the purpose of the working group, an immunocompromised child is one that has a chronic acquired or persistent genetic increased susceptibility to infection. While individuals may have temporary immunodeficiency do to medication use for an acute or temporary illness the goal of the working group is to protect children with profound immune deficiencies unlikely to resolve during the course of a single school year. Examples of such include a) hereditary immune deficiencies requiring prophylactic medication; b) infections such as HIV characterized by a CD4+ T-lymphocyte count less than 200/ml; c) chronic diseases such as chronic kidney disease requiring peritoneal or hemodialysis; d) medication induced immune deficiency such as that occurring in patients treated for malignancy, autologous transplantation, or autoimmune disease.

Action Plan 2 assigned to WVR
The Centers for Disease Control and Prevention recommends that all health care workers receive annual influenza shots and receive immunizations against measles, varicella zoster (chicken pox), mumps, rubella and pertussis. A specific rationale is to prevent transmission of infection to immunocompromised individuals. Using the same rationale, the working group recommends that all teachers receive yearly influenza immunizations and have evidence of immunity to measles, mumps, rubella, chicken pox, and pertussis.
Immunity to these infections is as follows:

1. Those born before January 1st, 1957 are exempt from submitting documentation for measles, mumps, rubella, and varicella zoster.

2. Measles (also known as Rubeola)

   A: Must have either: Two doses of live measles vaccine on or after the first birthday separate by at least 8 weeks
   OR Date & results for blood test (titer) for measles
   OR Date of physician positive diagnosed measles disease

3. Rubella (also known as German Measles)

   A: Must have either: two doses of live rubella vaccine on or after the first birthday separated by at least 8 weeks
   OR Date & a copy of lab results for positive blood test (titer) for rubella

4. Mumps

   A: Must have either: two dose of live mumps vaccine on or after the first birthday separated by at least 8 weeks
   OR Date and a copy of lab results of mumps blood test (titer)
   OR Date of physician positive diagnosed mumps disease
5. Varicella zoster

   A: Must have either: two doses of varicella zoster virus vaccine on after the first birthday and separate by at least 8 weeks

OR Date and a copy of lab results of varicella zoster blood test (titer)
OR Date of physician positive diagnosed varicella zoster disease

6. Pertussis

A: All teachers regardless of birth year must have either: a dose of pertussis containing vaccine in the past 10 years
OR: Date of physician positive diagnosed pertussis disease within the past five years

**Reference from Ms. Boisvert McKenzie:

Ben Truman
Health Policy & Web Program Coordinator
Vermont Department of Health

The vaccine history for the 252 confirmed cases through September 5th, 2012 is in the table below. The table indicates the number of doses of pertussis-containing vaccine at the time the case was confirmed, rather than an assessment of whether each individual was appropriately vaccinated.

Vaccine history[1] of confirmed pertussis cases aged 6 months to 18 years (n = 215), Vermont Jan 1 2012 – Sep 5 2012

Age	0 doses	1 – 2 doses	3 doses	4 doses	5 doses	6 doses
6 – 11mo	0	0	7	0	0	0
1 – 4 yr	3	1	4	17	2	0
5 – 6 yr	2	0	0	1	5	0
7 – 10 yr	3	0	0	0	51	3
11 – 18 yr	11	1	1	3	25	71
Total	19	2	12	21	83	74

[1]Number of doses missing in 4 patients

There were 6 confirmed cases who were less than 6 months old and 31 confirmed cases who were greater than 18 years old