WASHINGTON VACCINE ASSOCIATION

Vaccine Committee Meeting Minutes

May 19, 2011, 12:00 - 1:30 PM Location: Law Office of Ellis, Li & McKinstry

I. **Attendance** The following individuals participated in all or part of the meeting. Participants attended in person unless telephone participation is indicated by (T).

Committee &Consultants:
Dr. John Dunn
Jeff Duchin (T)
Joe Gifford, Regence
Dr. Ed Marcuse
Dr. Anthony Marfin
Laura McMillan
Chad Murphy (T)
Mary Kay O'Neill, Cigna
Janna Bardi
Fred Potter

Others:
Jan Hicks-Thomson, DOH
Margaret Lane
Sarah Michael, sanofi pasteur
John Goddard, GlaxoSmithKlein (GSK)
Several other representatives of vaccine manufacturers joined the meeting telephonically.

II. Actions Taken

1. Voted to approve the minutes from the Vaccine Committee meeting on January 20, 2011.
2. Directed that DOH work with non-responders and those providers choosing no vaccine preference who administered 100 or more doses of meningococcal vaccine in 2010 to urge they make a choice between meningococcal vaccines. Following that effort, non-responders will be provided the vaccine they used last year ; for those who chose no preference, 50% should be provided with the new entrant meningococcal vaccine and 50% with what they used last year.
3. Voted to make all the current combination vaccines part of every provider's order set, including Comvax and Kinrix.

III. Minutes

At 12:00 PM, a quorum having been established, Dr. Ed Marcuse, Chairman of the Vaccine Committee, opened the meeting. Jan Hicks-Thomson gave an update on the vaccine selection survey. As of May 18th, there was an 87% response rate. Over 1,000 providers have responded, including 18 large organizations with multiple sites. Jan asked the local health jurisdictions to follow up with organizations that have not responded. The goal is a 95% response. The selection process closed end of business on 5/18/2011. Jan noted that coordination was the key to the survey's success with e-mail prompts from different organizations during the process to raise awareness. As of the end of that week, 7% of the providers (94 sites) had no preference, and 13% had not responded. The 13% do not represent a large volume of vaccine. These results are phenomenal – and achieved the overall goal of provider preference driving vaccine choice in Washington State.

The Committee next addressed the vaccine selection process. The Vaccine Selection Work Group met telephonically on Monday and had three recommendations: 1. In future surveys, regardless of the methodology, we will no longer offer the "no-preference" option, and attempt to force providers to make a choice, which is easier via an electronic survey; 2. we should close the survey at this point. (This has already

been accomplished; and) 3. We would force provider choice via an electronic survey or linking the expression of a preference to receiving an order.

The committee moved on to the default order set recommendation. Dr. Marcuse summarized Option A and Option B. Default order sets involve two groups of people, non-responders and those selecting no-preference; both options treat them the same. Option A would give the two groups what they ordered the prior year. The rationale for this option is that we believe that supplying offices with the vaccines that they have received in the past is the least complex and safest. We recognize that this may be failing to treat a new vaccine equitably, but we believe that simplicity and safety concerns regarding (potential) negative implications of using an unfamiliar product outweigh attempts to achieve equity. Option B states that prior to taking the survey, we made a commitment to offer more than one default order set. While we are hesitant to assign market share to new entrant vaccines, we believe our goal of equitably allocating the vaccines among those receiving the default order set might be best served by providing the new entrant meningococcal vaccine, Menveo, to a portion of the vaccine orders for 2011-2012. We believe the additional complexity is relatively small and are not convinced that the substitution of one vaccine over another vaccine creates a safety concern.

Dr. Marcuse opened the floor up to discussion. The only vaccine in question was the meningococcal vaccine. One of the two types entered the market later than the other, and they are comparable regarding price, safety, and effectiveness. The later version was not available at selection time last year, so if we gave providers what they had last year, that brand is excluded. Any action favors someone. Regarding future precedents, the board intends for providers to make these decisions in the future, and not the board. This is a transition year. Regarding whether or not the two proposals were developed before the numbers of no preference were known, Dr. Marcuse said the options were developed on Monday when the percentage of no preference was thought to be 25-30%, which is no longer true. All available vaccines were chosen by some but the committee does not want to know the specifics of the survey. Only the DOH will know the survey results.

Overall, “no-response” represented about 8,600 doses of meningococcal vaccine, which averaged out to a little less than 10 doses a month. Several of the clinics were very low dosage, maybe 0-10 in one year. The “no preference” represented 2,000 doses with very few higher volume providers. This estimate is based on the former recommended allotment of 1 on hand, which has doubled to having 2 on hand. Overall then, we are talking about roughly between 10,000 and 20,000 doses of the vaccine.

One suggestion was to treat non-responders one way and no-preference responders differently. If you did not respond, you should get the vaccine types you had previously received, and if you said no-preference, then you should get the new vaccine. From a public health perspective, this is not significant. Though, from the health of the vaccine system perspective, many judge that having multiple providers of vaccines is in the public interest. Mr. Potter brought to the attention of the committee, the need to make some changes in wording. Mr. Potter wanted to remove any language of market share, and Dr. Marcuse agreed.

Following discussion, Dr. Marcuse articulated the following proposal: With regard to the non-responders, a two-step process is proposed: 1. Reach out to non-responders to obtain a choice from those providing more than 100 doses per year. 2. For those providing fewer than 100 doses, give them what they received last year. With regard to those who indicated no-preference: 1. Work to obtain a choice for those providing more than 100 doses per year. 2. For those providing fewer than 100 doses, give 50% of them the new meningococcal vaccine. Dr. Marcuse and Margaret will work on final wording. The committee expressed unanimous support

for this option to direct DOH to work with non-responders and those providers choosing no vaccine preference who administered 100 or more doses of meningococcal vaccine in 2010 to urge they make a choice between meningococcal vaccines. Following that effort, non-responders should be provided the vaccine they used last year; for those who chose no preference, 50% should be provided with the new entrant meningococcal vaccine and 50% with what they used last year.

Dr. Marcuse then directed discussion to combination vaccines. Janna stated the issue: currently, what is made available through the DOH formulary are 3 of 5 combination vaccines. The two currently excluded are Comvax and Kinrix. The committee decided that all the current combination vaccines would be part of every provider's order set. Each combination vaccine is unique as it has different components that are administered to different age groups. The combination vaccines include multiple vaccines in one, so there are fewer "sticks." In the past, the state vaccine advisory committee has weighed in during preliminary discussions. Timing restrained consultation this year. Dr. Marcuse's recommendation is that we include both vaccines. However, as new combination vaccines come along, the WVA would like the input of the Washington State Vaccine Advisory Committee. The committee expressed unanimous support for proceeding in this way.

Upon motions duly made and seconded, it was unanimously

VOTED:

To approve the minutes from the Vaccine Committee on January 20, 2011.

Dr. Marcuse did not set any meeting dates but will be periodically sending out information for review. The next cycle would be how to operationalize forced choice.

There being no further business for the Committee, the meeting was adjourned at 12:50 PM.

WASHINGTON VACCINE ASSOCIATION

What:	WVA Vaccine Committee Meeting
Date and Time:	May 19, 2011, / 12:00 – 1:30 AM
Place of Meeting:	Law office of Ellis, Li & McKinstry, PLLC, Market Place Tower, PH-A, 2025 First Avenue, Seattle
Call in Numbers:	(local) 206.925.3583; (long distance/toll-free) 877.826.6967; Part code: 1981457183#

AGENDA for Vaccine Committee Meeting in Person

Approximate Time	Topic/Anticipated Action	Presented by
12:00 – 12:05	1. Welcome a. Purpose of Meeting b. Approval of minutes from Feb. 17, 2011	E. Marcuse
12:05 - 12:20	2. Update on Provider Vaccine Selection Tool a. Update on survey implementation and results b. Provider response: information on respondents	J. Hicks-Thomson
12:20 –12:55	3. Vaccine Selection Process Recommendations a. Preliminary recommendations on Vaccine Selection Process: 1. In future surveys, do not offer "no preference" as an option to select. 2. Close the provider survey on vaccine selection on 5/20/11 3. When feasible, force provider choice of vaccine either via an electronic survey or by linking an expressed preference to the vaccine order system. b. Develop Default Order Set recommendation for WVA Board	E. Marcuse
12:55 – 1:10	4. Closing Section a. Public comment b. Committee charge and schedule for next meeting	E. Marcuse