2021 HOUSE HUMAN SERVICES

HB 1469

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1469
1/25/2021

Relating to exemptions from vaccine requirements before admission to school; and to provide an appropriation

Chairman Weisz opened the hearing at 6:07 p.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Inoculation exemptions
- Online vaccination education module

Rep Gretchen Dobervich, District 11 (6:07) introduced the bill, testified in favor, and submitted testimony #2848.

Courtney Koebele, Executive Director North Dakota Medical Association (6:14) testified in favor and submitted testimony #2443.

Kylie Hall, Fargo (6:15) testified in favor and submitted testimony #2616.

Travis Zablotney (6:19) testified in opposition.

Dr. Bob Zajac, New Kingdom Healthcare Eden Prairie, MN (6:21) testified in favor.

Kolette Kramer, Denbigh, ND (6:22) testified in favor.

Kari Roller (6:28) testified in opposition.

Alexis Wangler (6:28) testified in opposition.

Tara Dukart, Hazen (6:32) testified in opposition.

Brodi Alt (6:34) testified in opposition.

Christine Miller (6:36) testified in opposition.

Additional written testimony: #2235, #2337, #2338, #2349, #2351, #2365, #2444, #2453, #2463, #2470, #2475, #2478, #2482, #2508, #2518, #2531, #2540, #2559, #2576, #2587, #2595, #2601, #2607, #2614, #2653, #2668, #2669, #2671, #2674, #2675, #2689, #2691, #2694, #2701, #2702, #2739, #2759, #2762, #2767, #2772, #2794, #2799, #2802, #2825, #2828, #2853, #2869, #2909, #2916, #2920, #2939, #2942, #2947, #2963, #2966, #2973, #2975, #2982, #3014, #3027, #3029, #3035, #3039, #3054, #3061, #3104, #3114, #3136, #3148, #3170, #3228, #4249

Chairman Weisz adjourned at 6:39 p.m.

Tamara Krause, Committee Clerk

HB 1469 Testimony

Representative Gretchen Dobervich

January 25, 2021

Good Morning Chairman Weisz and Members of the House Human Services Committee. For the record my name is Representative Gretchen Dobervich and I represent District 11 in Fargo.

Rubella, a disease caused by a virus also known as German Measles, causes a red rash, fever, headache, swollen pink eyes, painful swollen lymph nodes, a heavy cough and nasal discharge. In severe cases Rubella can cause brain infections. [1]

"If an unvaccinated pregnant woman gets infected with rubella virus she can have a miscarriage, or her baby can die just after birth. Also, she can pass the virus to her developing baby who can develop serious birth defects such as— heart problems, loss of hearing and eyesight, intellectual disability, and liver or spleen damage. Serious birth defects are more common if a woman is infected early in her pregnancy, especially in the first trimester. These severe birth defects are known as congenital rubella syndrome (CRS)." [1]

About 25 to 50% of people infected with rubella will not experience any symptoms but are still infectious and can infect other unvaccinated adults and children. [1]

There is a vaccine for Rubella, it is part of the MMR vaccine (Measles, Mumps, Rubella). The vaccine is not given prior to age one, leaving children birth to 12 months at risk. The most common side effects of the vaccine include sore arm from the shot, low grade fever, and mild rash. Rare side effects include temporary swelling in the neck or cheeks, and temporary, non-life-threatening low blood platelet count. There is a very rare risk of febrile seizures, seizures caused by fever, the older a child is when they receive the MMR vaccine the greater the risk of febrile seizure.[2]

You have just been informed about what the Rubella virus is, the health impacts it has on children and women, vaccination available to prevent it, and known side effects associated with the vaccine. Having been given this information, informed consent for a Rubella vaccination or for an exemption to not receive it can best be made.

HB 1469 seeks to provide information for parents and guardians about common diseases and the immunizations for their prevention, to assure no matter the choice a parent or guardian makes, it is informed.

Currently, North Dakota has the most liberal vaccination exemption laws in the United States. There is no requirement that a parent or guardian be provided information about vaccinations or the illnesses they prevent when they sign an exemption form. There is no informed consent. If a parent or guardian seeks a religious, philosophical or moral exemption they can print out a form from the North Dakota Department of Health website, or obtain one from their child's school district, sign it and submit it. Medical exemptions in North Dakota do require an exemption form signed by a Medical Doctor or Doctor of Osteopathic Medicine.

HB 1469 would not remove the ability and ease at which an immunization medical exemption may be obtained in North Dakota. The bill expands the medical provider list of who may certify a medical exemption to include advance practice nurse practitioners and physician assistants.

HB 1469 would not take away North Dakota's liberal religious, philosophical, and moral exemptions. Instead, it would provide rigorously researched, scientific, evidence based information about diseases and the vaccinations for their prevention, including all known possible side effects in a 60 minute streaming video, which would be required to be watched by parents and guardians prior to signing a vaccination exemption form. This would assure that parents and guardians are providing informed consent when exempting their child from vaccination.

After watching the informed consent video, the parent or guardian will print out a certificate of completion and provide it with the vaccination exemption form. A $50,000 fiscal note is attached to this bill for the creation of the video. In comparison to the $2.3 million cost of Minnesota's most recent measles outbreak, this is a small amount to invest in the State's public health.

In 1964-1965 the United States experienced its last Rubella epidemic. In this epidemic, 12.5 million Americans were infected, it killed 2,000 babies and caused 11,000 miscarriages. Since 2012, only 15 cases of rubella have been reported in the United States.[3]

I chose Rubella as an example because when my sister was 6 months old, and too young to get the MMR vaccination, she was infected with Rubella and experienced severe symptoms. She and I were at an event where we were exposed by playing with children who had not been vaccinated and were infectious, but not yet symptomatic. I was old enough to have been vaccinated and was spared the agony of the disease, she was not. She survived and is a nurse who has cared for people hospitalized with and who have died from COVID-19.

No child in North Dakota is forced to be vaccinated without the consent of their parent or legal guardian. HB 1469 would not change this; it would expand the medical providers who may certify a medical exemption and provide information for informed consent of an exemption.

This concludes my testimony. Mr. Chairman and Members of the Committee I stand for questions.

Resources

1. https://www.cdc.gov/rubella/about/symptoms.html
2. https://www.cdc.gov/vaccinesafety/vaccines/mmr-vaccine.html
3. https://www.cdc.gov/vaccines/vac-gen/whatifstop.htm

House Human Services Committee
HB 1469
January 25, 2021

Chairman Weisz and Committee Members, I am Courtney Koebele, the executive director of the ND Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

NDMA stands in support to HB 1469.

Childhood vaccinations have proven to be one of the most effective public health strategies to control and prevent disease. Efforts by health care providers, as well as community- and government-based interventions to increase vaccine coverage, must continue to continue to reduce morbidity and mortality in children due to vaccine-preventable diseases.

Actions proposed in HB 1469 would strengthen efforts to educate the public on vaccines, that would present an unbiased view on immunizations. By providing evidence-based information about childhood vaccinations, the public will be provided with both potential harm information as well as vaccine benefits.

Since North Dakota citizens have freedom of choice on medical, religious and philosophical reasons to choose a childhood vaccine exemption, this bill has the potential to bring important science-based information to the public by providing an unbiased platform for vaccine education.

Thank you for the opportunity to testify today. I would be happy to answer any questions.

HB 1469 Testimony
Human Services Committee
January 25, 2021 2:30 p.m.

Good afternoon, Chairman Weisz and members of the Human Services Committee. My name is Kylie Hall, and I am here to testify in favor of this bill. I have a Master's Degree in Public Health and have worked at the North Dakota State University Center for Immunization Research and Education for the past 5 and 1/2 years. I would like to make clear that my comments today are not on behalf of NDSU.

I feel uniquely qualified to testify on this bill. In 2015 and 2016, I led a study in North Dakota that produced recommendations for how to improve school immunization rates. The study engaged nearly 200 immunization stakeholders in North Dakota, including healthcare providers, school administrators and staff, public health staff, legislators, and parents.

In 2015-2016, only 90% of children were up-to-date with school immunization requirements, approximately 3% had an exemption on file, and nearly 7% of students were non-compliant with school requirements. Children who are noncompliant with state immunization requirements are 1) not up-to-date with school required immunizations, 2) do not have an immunization record on file at the school, 3) are not immunized, and/or 4) do not have an exemption on file at the school.

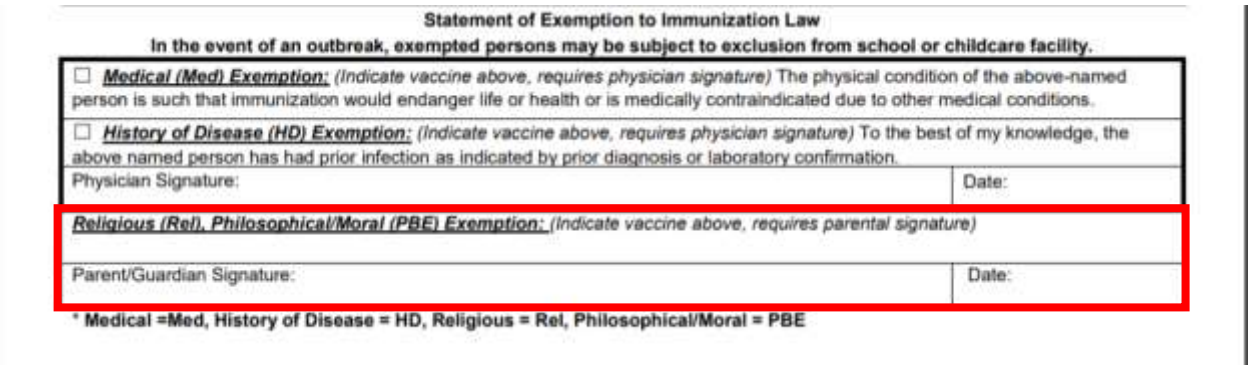
Because of ND's large noncompliant population, our final report said that school enforcement of immunization requirements had the greatest potential to increase immunization rates in North Dakota, as nearly 7% of kindergartners were non-compliant. However, we also said that North Dakota's steady increases in exemption rates should not be ignored, and a policy change may be needed if immunization rates do not meet goals and enforcement alone does not work.

So where are we today? The NDDoH has implemented many of the recommendations laid out in the report. North Dakota's preliminary MMR immunization rates for the '20-'21 school year are approximately 93.22%. While our rates have increased from the '15-'16 school year, this number is down from 94.75% last year. Our exemption rates have reached 4% this school year, and just under 3% of children are noncompliant. We still do not meet the goal of having 95% of children up-to-date with their immunizations, and I believe it is time for North Dakota to consider making changes to their immunization exemption policy.

I want to make clear that this discussion is not about removing any of the three exemptions currently available in North Dakota (medical, religious, personal belief).

There are some other things I would like to share that may aid in your acceptance of this bill.

As has already been stated, North Dakota has one of the most liberal vaccine exemption laws in the country. All parents have to do is sign the exemption form, which is readily available on the NDDoH website.



Statement of Exemption to Immunization Law

In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

☐ ***Medical (Med) Exemption:*** *(Indicate vaccine above, requires physician signature)* The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

☐ ***History of Disease (HD) Exemption:*** *(Indicate vaccine above, requires physician signature)* To the best of my knowledge, the above named person has had prior infection as indicated by prior diagnosis or laboratory confirmation.

Physician Signature:	Date:

Religious (Rel), Philosophical/Moral (PBE) Exemption: *(Indicate vaccine above, requires parental signature)*

Parent/Guardian Signature:	Date:

*** Medical =Med, History of Disease = HD, Religious = Rel, Philosophical/Moral = PBE**

During our study, we heard from many immunization stakeholders that we know parents are **abusing** our current exemption process. In North Dakota, we know that there are some schools that hand this form out to parents who need to be in compliance. Parents are also using the form out of convenience if they have children that may be partially immunized but are not up to date OR parents may not be able to get immunization records from their healthcare providers/other states so they file exemption forms. This is troublesome.

As we sit here in 2021, I think it is time for us to address our rising exemption rates and remove the convenience option for parents. North Dakota has tried so many things to try and boost rates. Enforcement. Resources to aid schools in determining compliance. Setting clear expectations and deadlines. While rates have improved, exemptions have also continued to increase. We are at-risk for outbreaks. County-level measles vaccination rates range from 75%-100%. School level measles vaccination rates range from 0%-100%. It's time for a change. As many of our stakeholders said during our study, "It should be harder to get the exemption than it is to get the vaccine."

So what would this bill do? It would make it a little bit harder to get an exemption. It means that parents can't just sign the form. It gives them one extra step. This bill will likely not change the minds of those with deep-held philosophical beliefs against vaccination. But if parents do have questions about vaccines, they deserve to receive evidence-based information in order to make an informed decision. Additionally, parents will no longer be able to sign the form out of convenience. It will encourage parents to obtain immunization records or get their kids in for their booster doses.

You might also be wondering: What have other states done when faced with similar challenges, and have they seen improvement? There are a few states that allow personal belief exemptions that have started to require an educational component for exemptions. Currently, 16 states allow exemptions for kindergarten entry. Only 15 of these states allow exemptions for MMR, Washington allows PBEs for all vaccines except MMR.

In 2009, Washington State required parents get a healthcare provider signature on their exemption form. After 18 months, exemption rates had decreased by 25%.

In Oregon in 2014, a new law required parents to receive education via healthcare provider or online module. In the first year: exemption rates decreased by 15% (from 7.1% to 6.0%).

In 2015, Michigan introduced a new law that required in-person education for parents wanting an exemption. In the first year, exemption rates decreased by 35%. Still today, exemption rates are 25% lower than they were in 2014.

Finally, I'd like to point out that outbreaks of vaccine-preventable diseases are costly to contain. In Minnesota in 2017, 79 cases of measles cost the state $2.3 million to contain. Increasing exemption rates and pockets of undervaccination are putting our state at risk. It's time to address our rising exemption rates and implement policies that increase immunization rates.

Link to full study:
https://www.ndhealth.gov/Immunize/Documents/Schools/ImmunizationandExemptionPoliciesandPracticesinNorthDakota_20160615.pdf

My name is Stephanie Hager, and I am a resident of Mandan, North Dakota. I am testifying in **OPPOSITION** to HB 1469. It is the choice of the parent/legal guardian as to whether to vaccinate their child/children. If one makes the decision to not vaccinate for ANY reason, there is absolutely no need for them to view a clearly biased education module. It is a waste of money. Again, I am in opposition of this bill. Thank you.

Kyle Small

Re: Sixty-seventh Legislative Assembly of North Dakota

House Bill No. 1469

The proposal is to require “A child's parent or guardian seeking a religious, philosophical, or moral exemption” to “view the state department of health's vaccination education module online.”

It is proposed that this vaccination education module will “provide scientific, evidence-based information about childhood vaccinations...”

Note: the exemptions listed are *religious, philosophical,* and *moral*. The reason that these exemptions have existed in current policy is due to the inappropriate and illegitimate nature of any law that would attempt to compel behavior from any constituent that would conflict with his/her own convictions on the matter. The nature of these convictions is clearly not based upon “scientific, evidence-based information.” It should be clear that these convictions have nothing to do at all with science, the safety, or even the efficacy of vaccination. These convictions would be based upon an individual’s understanding of how vaccination would relate to his/her own already-established moral, religious, or philosophical worldview.

The implication behind this proposal is offensive to individuals who hold to such convictions. Without stating so explicitly, the clear message behind this proposal is that *given the right amount of scientific information, religious, moral, or philosophical convictions can be altered.* **It is to say that such convictions are only held by the scientifically ignorant or uninformed.** That is, an individual with the right scientific information in-hand would certainly not take a religious exemption, while in truth the two categories are mutually exclusive.

This proposal would seek to use the power of the state to manipulate the moral, philosophical, and religious convictions of its constituents. This is an over-reach of power, and I implore the legislative body, as representatives of the rights of the people, to vote “no.”

Thank you,

Kyle Small

Chairman Weisz and the House Human Services Committee,

My name is Melyssa Howry and I respectfully submit testimony in STRONG OPPOSITION to HB1469, which would place requirements on parents who are claiming philosophical or religious vaccination exemptions for their children, regardless of where they attend school (public, private, or homeschool). My reasons for this are:

1) A religious or philosophical exemption is personal and private. The state of North Dakota, particularly the Department of Health, has no place stepping in and dictating how a parent uses such an exemption.

2) Homeschooling parents, such as myself, should not be required to submit vaccination status of their children in the first place. North Dakota is one of only five states in the US that require immunization records for homeschoolers. The other four are Minnesota, Louisiana, Pennsylvania, and Tennessee: (https://kidskonnect.com/articles/a-full-breakdown-of-the-homeschool-laws-by-state-what-do-you-need-to-be-aware-of/). In my opinion, Section 1, line 10 of this bill which states “or be supervised through home-based instruction” should be completely removed, in addition to all of the suggested changes that HB1469 presents. The fact that the form must be submitted for homeschoolers who aren’t even in contact with children in the public school setting is already a violation of privacy. This would take that one step further, by hindering a parent’s ability and right to freely discern which exemption they deem necessary and appropriate. Anytime the government takes away a parent’s right to decide what is best for their child, even in a seemingly small way, it is a step in the wrong direction.

3) The majority of parents who use philosophical or religious exemptions have a particular reason, and have done their research. Most people spend hours and hours already reading everything they can, on both sides of the issue. It is not a decision made lightly, by any means. Often, a child has already been vaccine-injured, and when parents cannot get a doctor to sign off on a medical exemption for that same child or younger siblings (this is

often the case), they resort to the other options for exemption.
State-produced online modules about vaccination will not be able to tell parents what they have not already heard many times before. It won't be effective, and will be a complete waste of energy, resources, and taxpayer dollars. These parents are essentially going to view this as a paid advertisement for the pharmaceutical industry, and nothing more.

4) If you do choose to recommend a "Do Pass" on this bill, which I sincerely hope does not happen, an informational video should be required to include ALL RISKS associated with vaccines. It should explain how vaccine clinical trials are conducted, how long safety studies last, and should include the package insert for each and every vaccine on the exemption form. This would be the only way to ensure true informed consent, something we all should be in favor of.

Again, I ask that you give a "Do Not Pass" recommendation on HB1469.
Thank you for reading!

Sincerely,
Melyssa Howry
District 4
New Town

Regarding Bills HB 1468, HB 1469, HB 1377
Where do I begin!?
Removing a child from school due to lack of vaccination is unthinkable. As a child I couldn't have vaccinations due to allergies. Should I have been held a pariah? By your standards, that is exactly what I would become, an outsider. And who gets to decide what is best for our children? The HEALTH DEPARTMENT, not the parents, but a bureaucratic agency who looks at numbers, not actual PEOPLE.
And the ND Health department is not infallible, as was evidenced by their mishandling and incompetent actions during COVID. Test numbers were grossly overestimated, non-professionals were allowed inside the labs to complete test results, and just last week a 'computer glitch' told everyone there were 88 people hospitalized for 2 weeks, when the actual number was 55.
This is a huge government overreach, I would applaud everyone who stands up and tells you to vote NO to this grab at our personal rights. It is up to parents to care for children themselves. YOU did not give birth to them, YOU do not house and feed them, and YOU won't give a damn if things go wrong and there are health repercussions from these vaccines. Unless you are confident enough to step up and allow for individuals to SUE YOU and the ND Health Department personally.
And as to requiring parents to watch an information video before ALLOWING them to get an exemption for their child? HOW DARE YOU! You automatically assume people are too STUPID to understand the value of vaccines, so you are going to make them jump through even MORE hoops to be able to live their lives without you telling them exactly how.
Stand down, and stay out of it.

Re: Testimony in opposition of HB 1469

Attn: Committee Members,

I, Todd Kjelland am writing in opposition to HB 1469.

The bill as written, with amendments, is blatant religious discrimination against a select group of people according to the civil rights laws enforced by the U.S. Department of Education's Office for Civil Rights (OCR) which protects all students, regardless of religious identity, from discrimination on the basis of race, color, national origin, sex, disability, and age. None of the laws that OCR enforces expressly address religious discrimination. However, Title VI of the Civil Rights Act of 1964 (Title VI) protects students of any religion from discrimination, including harassment, based on a student's actual or perceived.

This bill as written singles out people of faith to be re-educated to the beliefs of non-religious tenets set forth by advocates of science. This constitutes an act of exclusion and harassment and advocates for State supported religion.

The bill fails to show equality by NOT forcing parents who choose to vaccinate to watch State approved propaganda which is based on only one point of view, which due to separation of church and state, cannot be of religious nature.

So essentially, non-believers of religious principles are given a different set of standards to attend public schools.

Article Six of the United States Constitution specifies that "no religious Test shall ever be required as a Qualification to any Office or public Trust under the United States."

If this is the requirement to hold public office, it should equally be that no TEST *(Section 3b of HB 1469 states…" exemption views the state department of health's vaccination education module online; prints, saves, or takes a screenshot or photograph of the* ***vaccine education certificate*** *upon completion; and submits this* ***verification*** *to the institution authorities."* shall be required to attend a State supported school.

North Dakota House Bill No. 1469 not only takes parental rights away, but if passed, needs to include verbiage that the State MUST include in their "educational modules" information about VAERS (https://vaers.hhs.gov/) and the Supreme Court Case 1:18-cv-03215-JMF Document 18 Filed 07/09/18 (https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/168629)

This was a Freedom of Information lawsuit requesting the documentation of the Safety Testing that HHS is supposed to be doing periodically. No documents could be provided because no testing was ever done for Safety in 32 years.

Don't allow State censorship through sponsored education modules to run interference for Big Pharma lobbyists by allowing omission of history-based information about childhood vaccinations.

Vote NO on House Bill 1469! Which could prevent a State sponsored religion, called Science.

Todd Kjelland

701-31-2956

emocoach@live.com

Members of the House Human Services Committee,

I would like to express my opposition to HB 1469.

My name is Ashley Bruner. I am a mom of 4 children, ages 6, 4, and 1 year old twins. Seven years ago, when pregnant with our first born, the journey to finding the truth of vaccines began for me. Like many first-time moms, I spent countless hours reading and researching every stage of pregnancy and baby development, and every option and choice that we, as that precious baby's parents, had to make in her first days of life.

Being curious and usually someone to challenge the status quo, I think the most common question I've asked throughout my life, is simply, "Why?". And so, when it came to vaccines for my tiny day-old baby, I asked that question. "Why are we giving these vaccines, and furthermore, what if we don't?"

While in graduate school, I was taught to research, to be objective, and to be a critical thinker. And so, as I posed these questions, I dug in and began researching every single vaccine on the recommended list of vaccinations for children. I researched every disease these vaccines are said to protect us from; we weighed the risks versus benefits for each one. This research has never ended, even after our 4th baby has been born, as it's a topic of continual education, to often review the risks versus benefits, for all things regarding our children.

In other words, as a highly educated person, and more importantly, as our children's' parent, I have already spent literally days upon days doing my research regarding vaccines. These are not decisions we are making regarding the health of our children on a whim, or because someone told us to. I know a large number of parents with the same background, same thought process, same questions, and same research done; quite frankly, a biased Department of Health video will not change our minds on the decisions we've chosen for OUR children.

Save the state funding for these "Vaccination Education Modules", or better yet, use it to educate parents who have not done their own research, weighing the true risks and benefits of vaccinations for their children.

I strongly oppose HB 1469 and encourage you to cast a Do Not Pass vote from this committee.

Thank you for your time and consideration!

Ashley Bruner

Drake, District 6

I am writing to express my opposition to proposed changes to the state vaccine exemptions in House Bill 1469. As a parent of young school age children, I find myself in the position of having to fight harder and harder for medical freedom and the ability to make medical choices for myself and my family without interference from the government. All medical decisions should be a discussion between our Doctor and our family. Not between our Doctor, our family, and the state of ND. And our decisions should be respected, regardless of whether a family fully vaccinates on schedule, uses a delayed schedule, or chooses not to vaccinate at all. Once the state puts itself in the position of removing medical freedom from its constituents, you are no longer in the position of being our representatives, you have now made yourselves our dictators.

The fight against medical freedom is something we should all be concerned about. Medical freedom is the right to true informed consent. Receiving full knowledge of risks and benefits and the ability to participate or decline without being bullied, manipulated, or coerced. And make no mistake, not allowing children to participate in society, (ie, schools, daycare, head start, etc.) without first having a medical procedure done is coercion, not informed consent.

If your decision is to force parents and guardians to take a class in order to be able to decline vaccines, I think you will discover that the reality is we are probably more informed than you would like us to be. Nothing is more important to me than the health and wellbeing of my children and I have spent countless hours researching what will keep them safe. The ongoing narrative is how safe and effective vaccines are, but the reality is, unlike all other pharmaceutical medications, vaccines have never gone through inert placebo safety studies. And the "tracking" done to watch for adverse reactions was so minimal that it is ridiculous. A matter of days, is not enough time to find long term side effects.

Target Disease	Product Name (Manufacturer)	Duration of Safety Review After Injection	
		Solicited Reactions	Unsolicited Reactions
Hepatitis B	Recombivax HB (Merck)[118]	5 days	5 days
	Engerix-B (GSK)[119]	4 days	4 days
Hib	ActHIB (Sanofi)[120]	3 days	30 days
	PedvaxHIB (Merck)[121]	3 days	3 days
	Hiberix (GSK)[122]	4 days	31 days
DTaP	Infanrix (GSK)[123]	8 days	28 days
	Daptacel (Sanofi)[124]	14 days	6 months
Poliovirus	Ipol (Sanofi)[125]	3 days	3 days
Pneumococcal	Prevnar 13 (Wyeth)[126]	7 days	6 months
Combination Vaccines	Pediarix (GSK)[127]	8 days	30 days + phone call at 6 months
	Pentacel (Sanofi)[128]	7 days	60 days + phone call at 6 months

https://childrenshealthdefense.org/wp-content/uploads/ican-reply-december-31-2018.pdf

Logically with all the advancements in medicine one would conclude that our children should be getting healthier. Speak with any teacher, doctor, parent, or anyone that works with children and you will know that is not the case. Our children's mental and physical health is on a steep decline. Our youth are plagued with allergies, autoimmune disorders, and learning disabilities amongst other problems. A staggering 54.1% of our nation's children now suffer from 1 of 20 different chronic health conditions. Is this only a problem because of vaccines? No, we live in a toxic world with many variables, but are we really going to rule out a product that most children are injected with even though the scientific studies have never been done? Are you going to bank your children's or grandchildren's health on the say so of the pharmaceutical companies

who stands to make billions of dollars from vaccines? Are you willing to bank my children's health on a complete lack of data? And more to the point, why do you think you should have any say in the medical decisions of my family?

But the chances of having a problem are only one in a million, right? Unfortunately, that is simply not the case, but don't take my word for it, take the word of Harvard Medical School. The Federal Agency for Health Care Research (AHCR) and the US Department of Health and Human Services commissioned Harvard Medical School to do a study and create an automated system for reporting adverse reactions to vaccines. They were given $995,000 to create such a system and they did. And what were their findings? Less than 1% of adverse reactions were reported. During the study, there was on average 1.3 adverse events per clinician per month. Way more than one in a million. This is big news, right? Except after they sent their findings to the CDC, Harvard was completely ignored and they never heard back from the CDC again. Something doesn't seem right there, does it?

https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

The bottom line is, if you are going to create an online class for families to complete before they can refuse vaccinations for their children, make sure you include all the facts not just the ones approved by organizations that get much of their funding from pharmaceutical companies. True informed consent means knowing the risks and benefits without fear of being bullied, manipulated, or coerced. Where there is risk, conflict of interest, profits to be made, no inert placebo studies, no safety follow through, and a rise in disease, there must be choice.

Andrea Lenertz

My name is Sarah Lepp and I am in opposition of HB 1469. I strongly discourage giving any organization or board team or committee the authority to use any pandemic or emergency status to vaccinate children or adults as they deem fit. It should be solely up to the person(s) for themselves and or their dependents whether they be a child or elder. I say this as a board member does not know the person's history or beliefs on why they choose not to vaccinate. This is removing their individual rights as a human. There should also be no, what I'm calling it, "re-education" on vaccinations for claiming exemptions due to any belief or personal preference. There would be no need for re-education if there was information openly given at the doctor's office beforehand explaining what the risks/benefits or ingredients and statistics are. Also, to deny a child education for not being vaccinated is against the constitution for the right of education. We shouldn't have choose between vaccinating or education. We have a constitutional guarantee for our children to education no matter their sex, race, religious background, ethnic background, rich or poor, or even citizen or non citizen. NDCC 23-07-17.1(3) grants our rights to claim these exemptions at a local level. To also deny any child care services is cause for discrimination cases throughout North Dakota. Again, I strongly urge a DO NOT PASS for this bill as it takes away our personal rights and exemptions.

Vaccine Management Plan

North Dakota Department of Health

Scope

This plan represents a complete revision and consolidation of prior NDDoH plans related to vaccine management. Because a moderate or severe influenza pandemic puts the greatest stress on vaccine management, that will be the base scenario for development of this plan. Other scenarios to which this plan may apply are bioterrorism (anthrax, smallpox), community-based vaccination for a localized outbreak (e.g., meningitis) and seasonal influenza in which vaccine shortages are substantially impacting vaccine coverage of the population.

Response Goals for Pandemic Vaccination

- To maximize uptake of vaccine by the population;
- To ensure that those persons determined to be at highest priority for vaccination are vaccinated first;
- To ensure that specific population subgroups (e.g., age) receive the correct, FDA approved vaccine;
- To minimize the amount of time from receipt of vaccine in the state to administration;
- To maximize second dose administration as soon as possible after completion of the required interval after the first dose;
- To maintain the cold chain and security of the vaccine;
- To have vaccine allocation which is ethical and transparent;
- To ensure that adverse events associated with vaccine administration are captured and investigated as indicated;
- To minimize disease transmission which will arise from aggregating persons in vaccination clinics during a pandemic.

Assumptions For Pandemic Influenza Vaccination

- Vaccine for pandemic influenza will be administered to the entire population that accepts it.
- Vaccine which is specific to the pandemic strain will not be available until many months after the pandemic is identified, and once it becomes available, quantities will not be initially available to vaccinate all persons.
- Pandemic vaccine will be prioritized either to 1) high risk groups first, or 2) to high risk groups and critical infrastructure, depending on the nature of the pandemic.
- Receipt of vaccine into the state will be in proportion to the state population (about 0.2% of the US population), but may not take into account persons crossing over into North Dakota from other states.
- Initial vaccine dose will provide little, if any, protection against infection[1];
- Influenza is contagious during the 24 hours prior to symptom onset (making exclusion of all contagious individuals from vaccination clinics impossible) and vaccination clinics potentially have a strong anti-social distancing effect which, if not neutralized, may increase morbidity and mortality;
    - Anti-social distancing effect will be minimized by vaccination between waves.

[1] This assumption was not true for the H1N1 pandemic because the population already had some inherent immunity to H1N1, but it will remain as a planning assumption for most pandemics since it is likely to be true for many potential influenza pandemics (H5N1).

    - Some types of clinics (e.g., drive-through) are expected to minimize any anti-social distancing effect.
    - For indoor clinics, infection control procedures (screening for ill, cough hygiene, distancing between families) will be needed to minimize disease transmission.
- If vaccine for mass vaccination arrives during the first wave, rapid administration of the vaccine may not be possible in the face of high absenteeism among public health and health care staff.
- Second dose vaccination, if needed to secure immunity, will, in almost all circumstances, take precedence over first dose administration. That is, completion of immunity which is protective is more important than initiating immunity which is not protective. However, doses will not be held from a shipment to provide the second dose to persons who are not yet eligible to receive the second dose.
- Within NDDoH, the lead role for vaccine management policy will be taken by the Immunization Program of the Division of Disease Control. The Immunization Program will function as part of incident command under the Operations Section of the DOC, but will not be relocated to the DOC.
- The roles for the Immunization Program and the DOC in vaccination management will be different.
    - Immunization Program roles will include provider registration, vaccine ordering, allocation to registered sites, management and analysis of NDIIS, vaccine adverse events coordination, and communication with CDC Immunization Program.
    - DOC roles will be logistical management (including vaccine receipt, cold chain and distribution), public information and policy.
- In a moderate or severe pandemic for which vaccine is perceived as lifesaving, the vaccine may pose a security risk.

Refer to planning documents relevant to specific diseases (e.g., anthrax, smallpox) for assumptions for those conditions.

Background

Many factors that cannot be known prior to a major event will potentially affect vaccine management. These include the nature of the event (severity, public reaction to the pandemic and to the vaccine, impact on infrastructure), the characteristics of the vaccine (quantity available, timing, release rate, doses required, adjuvant required, toxicity, mode of administration, cold chain requirements and FDA approvals) and the response of the health care system. Each of these factors is discussed below.

Nature of the Event

In a pandemic setting, it is assumed that the entire population will be at risk and that the intent of the vaccine delivery process will be to reach every person with the vaccine. In an anthrax, smallpox or meningitis scenario, it is assumed that the vaccine will be targeted toward a much narrower part of the population actually at risk for illness; however, public and political pressure may result in broader use of the vaccine than is actually indicated (and broader adverse consequences). During a pandemic, the amount of public fear of the illness will likely be the strongest factor determining the extent of public uptake of the vaccine and the amount of political pressure.

In an influenza pandemic, it is expected that several months will elapse from the time the specific organism (clade) is typed to the time that vaccine becomes available, and all vaccine will not become available at the same time. This will result in prioritization of the vaccine. In the event of small impact on the national infrastructure, the vaccine will be targeted toward risk groups at highest risk of adverse outcome (e.g., pregnant women). If the pandemic is causing serious impacts on infrastructure, substantial portions of the vaccine will be directed toward persons responsible for maintaining the infrastructure. CDC plans call for this infrastructure allocation to extend to all critical sectors of the economy (e.g., transportation, energy production, communications) and not just the health care or emergency response sector. (See Attachment C.)

In a moderate or severe pandemic, timing of mass vaccine delivery would logically be impacted by concerns about the anti-social distancing effect of vaccination clinics. Mass vaccination during a pandemic wave, particularly for a vaccine which requires two doses to be protective, may actually increase the mortality rate. That is, providing the initial, non-protective dose in an anti-social distancing environment may increase illness rates while providing no protection. In some pandemic settings, waiting until after the wave is over to begin vaccination may be the best option for improving outcome, albeit an option of questionable political viability. Some regions of the state are prepared to deliver vaccine by drive-through clinics to minimize the anti-social distancing impact, but it is not clear that this could be done on a scale large enough for rapid vaccination of most of the population, and some regions have never exercised this approach[2].

Vaccine Characteristics

In an influenza pandemic, it is likely that two doses will be needed to achieve adequate protective antibodies. This might be altered by the use of an adjuvant. If a chemical (adjuvant) can be added to the vaccine when administered to increase the body's immunological reaction to the disease agent, less vaccine or fewer injections may be required. Mixing and matching of antigen and adjuvant at point of care may be required. Matching an antigen and adjuvant type from the first dose at the time the second dose is given may be needed. The exact combination of antigen and adjuvant administered for the first dose may also be needed for administration of the second dose. Introduction of adjuvants may cause public distrust of the vaccine since adjuvants have not previously been used in this country.

Influenza vaccine is currently being developed primarily using chicken embryos as the cell culture medium. This process is slow. During the H1N1 pandemic, the vaccine was released late and in a trickle. By the time substantial amounts of the vaccine were available, much of the public appeared to be "over it," particularly since the pandemic was mild and the initial wave was on the decline in many states. Cell culture-produced vaccine is now appearing

[2] It is not clear what the relative throughputs for drive through clinics and walk-in clinics are. However, an additional barrier is availability of venues for drive-through vaccination which are protected from the weather, have sufficient space and flow for many lanes and can safely handle vehicle exhaust.

which could decrease the wait time after the identification of a pandemic to vaccine availability, although it still may take several months to produce vaccine.

A transition to intradermal vaccination may result in improved vaccine coverage when quantities of the antigen are limited, since intradermal vaccination requires less antigen to achieve the same level of immune response now seen with intramuscular vaccination. Some vaccine for intradermal is now available but represents only a small fraction of the influenza vaccine in use.

If the influenza subtype is known in advance of the pandemic (e.g. H5N1), the U.S. government may have developed vaccine to the subtype which is not clade specific. That is, the vaccine would not offer substantial protection to the recipient, but may be quite adequate as a priming dose to improve response to the clade-specific vaccine. It is unlikely that generic subtype vaccine would be available to vaccinate a large percentage of the population, but may be sufficient to start the vaccination sequence for certain high risk subgroups or for infrastructure personnel.

Vaccines vary substantially in risk of adverse events. Influenza vaccine is very safe, but if given to millions of people, a few serious adverse events are inevitable. Some persons take this information and miscalculate their relative risk of receiving the vaccine versus not receiving the vaccine and refuse vaccination. Alternately, smallpox carries a higher risk of adverse events of the available vaccines. For this reason, and because smallpox spread can be quite effectively controlled using ring vaccination techniques, the preference of public health will be to avoid mass vaccination. However, fear of smallpox with political pressure to vaccinate everyone may make this impossible. People will tend to overestimate their risk of illness relative to the risk of the vaccine and demand vaccination[3]. This is not likely to be as big a problem with anthrax since the disease is not contagious, but a larger group than is actually exposed may demand prophylaxis. In the case of both smallpox and anthrax, unlike pandemic influenza, sufficient vaccine should be available immediately for all persons who need it.

Another characteristic of influenza vaccine that makes mass vaccination complicated is the number of different manufacturers and formulations with varying FDA approvals. Some products will be approved for infants, toddlers, pregnant women, immunocompromised persons, persons with egg allergy or persons over 65; however, a typical product will be approved for some of these categories but not for all. During H1N1, as vaccine trickled in, the specific products had to be allocated to specific providers according to the type and number of patients they expected to vaccinate who were eligible to be vaccinated with the vaccine that was available. This not only made allocation complicated, but was confusing to

[3] Just because people demand vaccination is not sufficient reason to provide it, any more than people demanding a narcotic should be given a prescription in the absence of a medical indication for treatment with a narcotic. Political mandates can alter public health action by taking the decision to vaccinate or withhold vaccination away from public health.

providers[4]. To the degree possible, Disease Control tried not to give many different vaccines to the same provider over time.

During H1N1, vaccine came in a variety of package formats including multi-dose vials, single dose pre-filled syringes and single dose nasal vaccine. The pharmaceutical industry has increasingly moved toward single dose formats due to higher safety. The primary impact of the dosage form on vaccine management is the amount of cold chain space required to store and transport the vaccine since single dose packaging is much bulkier. A marked increase in the amount of vaccine received in single dose containers could pose a storage problem at some local sites; however, the NDDoH warehouse is expected to have sufficient space to maintain the vaccine that it receives for re-distribution.

Health Care System Response

The health care system currently provides the vast majority of vaccinations; for influenza this is estimated at around 80%[5] of the doses given (exact number is pending). However, during seasonal influenza, a large percentage of the population does not request influenza vaccination. During the 2012 – 2013 flu season, only 48.9% of North Dakotans were vaccinated[6]. During a pandemic, more people will be requesting vaccine, more doses will be needed and the health care system may be overwhelmed by clinical care. Not only may the private health care system be unwilling to pick up the large number of extra vaccinations which need to be provided, they may not even have the resources to vaccinate the patients they would have vaccinated during a normal influenza season. What vaccine is not administered by the private health care sector will need to be administered by public health, pharmacies, long term care facilities or other non-traditional vaccine providers (e.g., contract vaccinators, employee-based clinics).

Physical Vaccine Management and Cold Chain

For a bioterrorism related outbreak, vaccine would likely come to the state via the SNS. For all other circumstances, NDDoH would request and receive vaccine through CDC's authorized contractor which in recent years has been [redacted] for North Dakota shipments). During H1N1, CDC authorized the direct shipment of full cases (100-dose increments) to providers authorized by the state to receive that much vaccine at one time. Because vaccine was released slowly, relatively few providers could be allocated full cases. Consequently, a high percentage of the vaccine had to be received by the NDDoH warehouse and re-apportioned into smaller quantities for shipment to specific sites. During the H1N1

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[4] For example, a provider needing to vaccinate a seven year old child may have been able to do so with vaccine provided to his or her office one week but not with vaccine provided the following week with vaccine only approved for children eight and older. Keeping track of which vaccine can be given to which people and which vaccine the clinic has could be very difficult. During a normal influenza season the provider would have ordered only vaccine that he or she was familiar with.

[5] The percentage of H1N1 vaccine provided by various provider types has not been calculated, but it is believed that LPH provided a substantially larger percentage of the H1N1 vaccine than it normally provides of seasonal influenza vaccine.

[6] CDC Fluvax View: http://www.cdc.gov/flu/fluvaxview/reports/reporti1213/reporti/index.htm

pandemic, shipments of vaccine went to well over 100 public and private destinations, although not all these destinations would receive vaccine from every shipment.

Most vaccines, including influenza, are expected to be received as liquid that must be stored between 35º and 46º Fahrenheit (2º – 8º Celsius)[7]. Vaccines for some conditions (e.g.., smallpox) have traditionally shipped frozen and need to remain frozen. Mass shipment of influenza vaccine during winter months proved to be difficult due to the need to protect the vaccine from moderate warmth and severe cold[8]. The only methods proven to be reliable by trial and error were shipping in controlled temperature environments (i.e., portable refrigeration units in temperature controlled vehicles) and certified shippers, which had a small payload for the shipping weight making them an expensive and inefficient distribution option except in select circumstances (e.g., sites a long distance from Bismarck).

During H1N1, NDDoH had concern about the [redacted] shipments that it received. The shipments were packed in large Styrofoam containers which did not have thick walls. No temperature loggers were included in the shipments. NDDoH found that even containers with much thicker walls could not reliably prevent freezing during harsh winter conditions for the lengths of time which commercial shipping companies kept the vaccine containers out of doors[9]. In the event that forecasted temperatures dropped so low that [redacted] refused to ship, NDDoH developed plans for retrieval of vaccine from [redacted] directly using a temperature controlled aircraft. It never became necessary to implement this plan during H1N1. Substantial changes in federal shipment practices could occur for the next pandemic, but are not expected at this time.

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[7] Vaccine removed from refrigeration to a warm environment does not instantly reach ambient temperature and 46º is not a firm number above which the vaccine loses potency. Vaccine can likely tolerate periods (days to weeks) of moderate temperatures above 46º without substantial loss of potency (the warmer the temperature, the faster it will degrade), but this varies by vaccine and the temperature stabilizers added to the vaccine. At least one study found insignificant degradation of influenza vaccine after two weeks at room temperature (see abstract at http://www.ncbi.nlm.nih.gov/pubmed/16150515). Another study found no loss of influenza vaccine potency for live attenuated vaccine after three freeze-thaw cycles (see abstract at http://www.ncbi.nlm.nih.gov/pubmed/22341195). However, even if vaccine can stand freezing, it is typically packed with rubber stoppered bottles of diluent (e.g., sterile water). If the bottle diluent freezes, the stopper is forced part way or entirely out of the bottle so that it is no longer guaranteed to be sterile and must be discarded.

[8] Vaccine leaving the warehouse by commercial shipper during the winter would be packed in a warm room, be picked up by the commercial carrier where it might remain outside in an unheated truck overnight, be transferred to the cargo hold of a plane (variable temperature), again spend time on a truck, go to a warehouse belonging to the shipping agent, go back into a plane, go back on a truck and finally arrive at its destination where it may or may not be moved immediately to a refrigerator.

[9] It is not clear that this concern has been fully addressed at the federal level. Although NDDoH never proved that any Xxxxxxxx material froze, temperature monitoring was not present in the periphery of the containers near the walls.

Provider Recruitment

During H1N1

The first step in the vaccination process during H1N1 was provider recruitment. This was initiated upon CDC instructing to the states to begin; CDC also provided most of the language for enrollment documents. NDDoH held a series of video/webcast sessions to educate providers, including pharmacies, clinics, long term care facilities, hospitals and local public health. This was followed by a memo sent through multiple communication channels (e.g., email, HAN contacts, professional associations) providing information about the enrollment process. Since enrollment was the only means for providers to acquire the vaccine, it is thought that nearly all eligible vaccine providers chose to enroll. Enrollment occurred over a website; a paper enrollment option was not provided in order to eliminate data entry.

Enrollment was by vaccine delivery site. This meant for large health systems, which make up the bulk of health care providers in North Dakota, multiple enrollments would be necessary, one for each delivery point. Specific information required for shipping was collected at the time of enrollment and populated into a lookup table in the CDC vaccine ordering software. This information was used by both [redacted], to ship directly to providers, and by the warehouse for direct delivery. The registration site also provided a contact who could be called to ensure that someone would receive the vaccine when it arrived at the door.

Another action initiated by enrollment was ensuring providers where signed up and prepared to use NDIIS. Upon receipt of an enrollment request, the Immunization Program looked up the provider site in NDIIS to ensure that that site was using NDIIS. If not, the practice was contacted and required to enroll in NDIIS before they could become a vaccine recipient site.

The final action initiated by enrollment was a request to providers to estimate the number of each risk group that they believed they could vaccinate, so this information could be used as part of allocation. This is discussed below under allocation. To help providers make this estimate, they were provided with information from orders made during regular flu vaccination seasons.

No specific guidance was given to providers about accounting for out-of-state residents coming to North Dakota to get vaccinated. For Grand Forks, Fargo, Wahpeton and the western edge of North Dakota substantial numbers of people flow into the state for health care services. That is, the number of doses provided to out-of-state residents by North Dakota would substantially exceed the number of North Dakota residents who got their vaccination out of state. (No allocation adjustment was made by CDC for this during H1N1.)

The vaccine was provided free of charge, but vaccine providers were permitted to charge an administration fee up to a maximum set by CDC. The administration fee could be collected from insurance or out of pocket from the recipient, but providers were not allowed to turn anyone away for inability to pay[10]. Additional requirements set by CDC for vaccine eligibility

[10] No mechanisms were in place during H1N1 to ensure that non-pay patients weren't turned away, but anecdotal reports of this were not received by the state so attempting to monitor this is not needed unless a problem becomes evident.

included agreement to meet vaccine storage requirements (which may include continuous monitoring[11]), and agreement to abide by the prioritization of vaccine to the specified high risk groups CDC specified. The NDDoH required use of the NDIIS for vaccine administration documentation.

During H1N1 in two regions of the state, the local public health unit was allowed to become the local vaccine recipient and redistribution point for vaccine within that regional area. This was done at the request of those local public health units. While it had the advantage of decreasing the number of distribution points for NDDoH, it also created a substantial number of problems including provider complaints (e.g., unfair allocation, lack of transparency, excessive control, increased delay), primarily from one of the two areas. Having an additional drop-off and redistribution point, also created another opportunity for a break in cold chain.

Provider Recruitment for Future Pandemic

The process used for provider recruitment during H1N1 worked well. No substantial change is anticipated in the method unless changes imposed by CDC require it. It was not necessary during H1N1 to recruit additional providers after the initial enrollment due to the large percentage of providers who chose to enroll. In a future pandemic, if insufficient numbers of providers of specific types (e.g., pediatricians, obstetricians) are initially enrolled, these needed groups will be targeted specifically with enrollment messages. An enrollment cutoff date would be stated to try to get all providers on-board and trained before mass vaccination was needed, but in practice, enforcement of the cut-off date would be unlikely.

Non-traditional vaccinators (e.g., pharmacies, other private vaccination groups) received their allocations relatively late during H1N1. This was due to an incident command decision to preferentially direct vaccine toward providers providing longitudinal care of patients, and due to greater numbers of persons in clinics with influenza risk factors. If a future pandemic is more severe, the anticipated large gap in vaccination by clinic-based vaccination providers would have to be filled by public health and non-traditional vaccinators. Current law allows pharmacists to vaccinate against influenza down to age five. The greater need for vaccinators during a more severe pandemic may make an executive order allowing pharmacists to vaccinate young children advisable.

Future policy related to local redistribution will default to a strong no; however, it is possible that some compromise might have to be reached. If that becomes necessary it is proposed that LPH must:

- Obtain the consent of all provider recipients in the area; and,
- Develop and provide to NDDoH for approval a vaccine allocation and redistribution plan which addresses:
    - Communications;
    - Allocation algorithm including fairness and optimal use of vaccine;
    - Security;
    - Cold chain and storage;

[11] Many providers who have implemented continuous monitoring are finding substantial problems with vaccine storage which is necessitating replacing vaccine storage equipment.

- Timeliness;
- Transportation;
- Documentation (NDIIS); and,
- Transparency.

If these criteria could not be met, the vaccine would be distributed directly to providers by NDDoH.

Procedures for Vaccine Ordering by the State

During H1N1

A set amount of vaccine was allocated to the state by CDC as the vaccine became available; however, the state still had to order the vaccine. A computer program provided by CDC used for the ordering process during periods of non-pandemic was also used during H1N1. To complete the ordering process, the Immunization Program had to:

1) Populate the recipient lookup table which included the names and addresses of all registered vaccination sites eligible to receive vaccine (i.e., registered). This information was obtained from the data generated by the registration website, but had to be manually transferred into the ordering software.
2) Examine the specific vaccine (how supplied, manufacturer, quantity) which had been allocated to the state (provided daily by spreadsheet from CDC, even if no new vaccine was allocated during the previous 24 hours). From this information, the specific amounts of each vaccine to go to each provider were input into an excel spreadsheet.
3) Adjust quantities to try to reach full boxes for those destinations near that level, so that vaccine at least would not have to be repackaged and shipped from the NDDoH warehouse. This adjustment had to be done in a manner which was not unfair to smaller volume vaccinators who would never get enough vaccine at one time to make a full carton.
4) Orders were then entered into CDC's vaccine ordering system on behalf of providers. Orders had to be in 100-dose increments by vaccine type. Orders for providers receiving less than 100 doses by vaccine type were aggregated and ordered to be sent to the NDDoH warehouse for redistribution.
5) Update the allocation information into NDIIS (manual entry) and generate a packing slip for the warehouse in NDIIS which would describe the specific vaccine, quantity and destination. These packing slips were then sent to the warehouse by email or fax.
6) Populate a website where providers could look up how much of each vaccine they had been allocated.
7) For those sites which used a local regional health broker, the warehouse shipping point was ultimately different from the data in NDIIS (i.e., actual provider who administered the vaccine), so that information had to be corrected.

Vaccine Ordering for Future Pandemic

CDC is now using new vaccine ordering software, VTrcks, which should allow direct uploading of spreadsheets rather than manual entry. Additionally, NDIIS now has a vaccine ordering system where providers can enter orders for vaccine directly and then the orders are reviewed by Immunization Program staff, and if approved, electronically uploaded to VTrcks. The Immunization Program will be responsible for training providers as to how to use the NDIIS vaccine ordering system. During a pandemic, Immunization Program staff may have to

enter orders into the NDIIS on behalf of providers. A substantial burden of data entry would be expected, so Disease Control would work with the DOC to pre-plan additional assistance in the Immunization Program. Whether these needs would be filled by existing NDDoH staff redirected to emergency response or whether by temporary employees would be determined at the time.

One option for ordering in a pandemic would be to tell the local provider how much vaccine their site was allowed to order, but require the provider to go in and order the vaccine. The ordering system allows all vaccine orders from within the state to be reviewed and approved by NDDoH before the order goes to CDC for processing. The state would need to ensure that providers did not order a greater quantity of vaccine from the state allocation or order a different type of vaccine then they were told they could have. Vaccine orders in excess of the state allocation would mean that someone at the federal level would determine who would or would not receive vaccine in the state. To avoid this, the state will need to stay within its allocation limit.

An additional change that would streamline the ordering process would be a modification to NDIIS to improve its handling of spreadsheet data without manual re-entry of information. However, this would take a financial investment that is not available at this time.

The NDIIS ordering system does give providers a vaccine shipment tracking number, so they are able to track vaccine shipments, however, providers receiving vaccine from the NDDoH warehouse would not receive this tracking number. Also, if orders are directly entered into VTrcks, providers would not see this tracking number in NDIIS. A method would need to be developed to notify providers of vaccine shipments.

Vaccine Prioritization and Allocation

During H1N1

Prioritization of vaccine during H1N1 followed CDC guidelines; however, NDDoH did attempt to sub-prioritize CDC authorized risk groups to ensure that those at very highest risk were vaccinated first. This created some confusion on the part of the public re: who was eligible be vaccinated, and inconsistency between local sites with some vaccine providers moving on to vaccinate other sub-groups while others were still waiting for sufficient vaccine to reach the highest priority groups. Because the H1N1 pandemic did not threaten infrastructure, no infrastructure allocation was necessary other than the targeting of health care workers.

The allocation process during H1N1 was awkward and time consuming. Disease Control would determine number of vaccine doses of what type had been allocated to the state and assign each dose to a provider based on the best estimate of population need and provider ability to reach high risk groups. This would be input into the ordering system. When the vaccine arrived, Disease Control would use the NDIIS to generate a packing slip in NDIIS and transmit this to the warehouse by fax or email where it would be used to pack the right amounts and types of vaccine for each destination.

For allocation, Disease Control relied heavily on provider estimates of how many people in each risk group the site could vaccinate. After Disease Control received the vaccine quantity request, the amounts sometimes required adjustment. For instance, if the sum of providers serving a catchment area were ordering quantities believed to exceed likely ability to reach

persons needing vaccine, estimates were adjusted down. One local public health broker site that ordered enough vaccine for the entire population in their region had their allocation adjusted down, since this would not be achieved and was substantially out of line with estimates from other sites. (Sites estimating high tended to receive vaccine faster relative to the population size than sites which estimated low.)

As each provider was allocated vaccine, this was tracked on a cumulative basis with calculation of expected vaccine coverage in that area. Adjustments were made to the allocation of vaccine based on these estimates. Even with these adjustments, substantial unevenness in vaccine availability across the state appeared to exist. To some extent this was unavoidable, but better methods for determining how much vaccine to allocate to each provider were needed.

As vaccine come in which was suitable for specific risk groups, it was allocated to all providers who reporting being able to vaccinate that risk group. One problem with this was that it meant a provider might have to deal with many different vaccines with different approved indications rather than vaccines the provider was familiar with.

Priority Vaccination

The current plans for prioritization of vaccine are dependent on the severity of the pandemic and the potential for the pandemic to impact infrastructure. CDC has provided some planning guidance for covering critical infrastructure sectors including health care, transportation, energy production, community utility, community services (e.g., grocers) and others. The prioritization would not ignore high risk groups like pregnant women, but a substantial quantity of the early vaccine would be directed away from adverse outcome-based allocation to cover infrastructure. This would not happen in a milder pandemic in which damage to infrastructure was not expected to be substantial. DES has maintained lists of critical infrastructure which could be used to help make the allocation.

For the health care and public health sector, NDDoH has also planned for within sector prioritization. Hospitals especially would determine internally who received vaccine first in order to preserve its internal infrastructure. Generally ER and ICU personnel would be highest priority followed by other direct care providers, but portions of the support infrastructure (e.g., dietary, housekeeping, maintenance) would have be vaccinated reasonably early. For guidance on how within sector prioritization would occur and be documented, refer to the pandemic influenza plan re: prioritization and to attachments A and B.

Entities which received vaccine which required population prioritization (e.g., hospitals) would need to document how each dose was allocated. Since during a pandemic, people would be expected to become seriously ill or die due to vaccine shortage, the entities allocating vaccine within their system would need to be able to defend the appropriate use of the vaccine at a later date (e.g.., vaccine was not diverted away from high priority groups to lower priority group with more authority).

During priority vaccination only, a local vaccine broker may be used. A vaccine broker is a partner institution at the local level which has agreed to receive vaccine and administer it

according to state and federal guidance. Only local public health units (LPHU) and hospitals are designated as eligible vaccine brokers in current plans[12]. Only a vaccine broker would be designated as a ship-to site during priority vaccination.

The roles of the vaccine broker include:

- Receipt and storage of vaccine, including maintenance of cold chain;
- Security of the vaccine;
- Administration of the vaccine to those authorized to receive it;
- Maintaining documentation of administration and reason for vaccination priority, and providing that documentation on request;
- Ensuring that persons given their initial dose receive an appropriately timed second dose;
- Allocation of vaccine to end user organizations (duty of LPHU only);
- Establishing clinics or PODs for mass vaccination (duty of LPHU only), and;
- Splitting vials of vaccine among priority recipient groups (duty of LPHU only).

For additional details related to roles during priority vaccination, see Attachment C.

Vaccine Prioritization and Allocation during a Future Pandemic

The NDIIS can calculate where (provider) people routinely go to get vaccinated. This could provide a reasonable estimate of how much each destination should expect to receive, but would still have to be modified by provider input since the percentage of the vaccination burden that will be left to LPH or other vaccinators may vary from provider to provider. For instance, Hettinger Clinic would need to plan to vaccinate substantial portions of Bowman, Slope, Hettinger, Grant and Adams Counties, and could receive an allocation based on the percentage of people it normally vaccinated from each county in its catchment area. This might result in a substantially better algorithm than that based on provider estimates of coverage alone. An allocation module in the registry would have the potential to improve the allocation process, but creating it would likely be expensive and no funds have been identified for this at this time. Another possible resource is SAS code written in Tennessee intended to assist with the allocation process. This software has not been evaluated in North Dakota to date.

[12] One problem that has developed since the H1N1 vaccinations is the rapid population growth in Western North Dakota and shortfall in health and public health services for the population. In this area of the state at least, it may be necessary to encourage employers to register to receive and administer vaccination, if they have the capability to do that. Employer-based vaccination would still be required to follow risk-group prioritization requirements and would need to provide estimates of how many of each risk group they could vaccinate. Estimates from NDIIS would not be available to help allocate vaccine to employers.

To the extent possible, Disease Control would attempt to provide the same vaccine to a provider consistently rather than giving them whatever vaccine is available. If providers must track the indications of many different vaccines, they are likely to make errors and deliver vaccine to individuals for which the vaccine available is not approved. This effort to create some consistency for providers would have to be balanced with the need to fairly distribute vaccine to the entire population. That is, if no shipment of the vaccine which the provider previously received is expected soon, they would be allocated a different vaccine so that the patients served by that site could have access to vaccine.

The use of adjuvant would provide a new challenge to vaccine management. It will not be known whether one or more adjuvants will be used or how they will be managed or administered until the event. Some additional training will be required for providers, but that is not expected to pose a substantial problem. NDIIS is being setup to manage data related to adjuvant. This is discussed further in the section allocation of vaccine for second vaccination.

During H1N1, traditional vaccination providers (clinic-based) providing longitudinal care and local public health were given allocation priority over pharmacies or contract vaccine providers in the allocation process. Although this was felt to be advantageous at that time, it would be less likely to be advantageous in a situation in which outpatient care was being overwhelmed with sick patients. This would remain an incident command decision during a future pandemic. Allocation will also need to consider special destinations like state penitentiary and other custodial care institutions and cross border vaccinees in how vaccine will be allocated. Consideration may rest heavily on the epidemiology of the virus (e.g., susceptibility to serious disease outcomes). For instance, H1H1 has not had a propensity to cause epidemic illness in long term care facilities, so allocation to LTC was less urgent during the last pandemic. See section on vaccination of vulnerable population for additional discussion.

Example:
In county X with a population of 5,000 of which 1,000 are children, 50% of adults (2,500) and 50% of the child population (500) usually get an annual influenza vaccine, of which 30% of the vaccinations provided to children in the county are done by Clinic A (150), 50% by Clinic B (250), and 20% by LPH (100). For adults 50% are provided by Clinic B (1,250), 10% by Clinic C (250) and 40% by LPH (1,000). If Clinic A reports that it will attempt to vaccinate any children presenting for vaccination (guess maybe 40% of child population or 400 children) and Clinics B and C expect to only vaccinate the number of people they would normally vaccinate in a typical influenza season, that is B (250 + 1,250) and C (250 adults). If 90% of the population is expected to be vaccinated with pandemic vaccine, that leaves 250 children ((1,000*0.9) – 650=250) and 2,100 adults ((4,000*0.9)-2,500=2,100) that LPH or other non-traditional vaccinators would vaccinate in that county. If two doses are required, the total allocation to that provider for that county would be double the number of people that they would expect to vaccinate. Each provider would also receive an allocation for each of the other counties they served.

Communication to the Public and to Providers

During H1N1

On a single instance early in the vaccine delivery process, part of a shipment of vaccine was thought to have possibly frozen. The vaccine was administered before a determination was made that it should be discarded. NDDoH decided to report the vaccine loss in the media and ask that those who received the vaccine be re-vaccinated. Other states also froze some vaccine but NDDoH was the only one known to have reported it to the media. The NDDoH response was consistent with DOC policy of media transparency during a disaster.

Information about influenza and vaccination were communicated through the media by weekly press conferences, radio and TV ads. This was in addition to information which was coming from CDC through the media. The hotline was open and received calls, but many callers were looking for clinical information (e.g., about care of an individual) that the hotline was not able to provide.

Although the amount of information flowing to the public was large, misinformation remained a problem. For example, as the pandemic progressed it became increasingly difficult for the state to give a uniform message about who was eligible for vaccination. Initially all local providers were targeting the same high risk groups, and it was intended that local areas not progress to vaccinating new groups until the DOC notified them that the entire state would begin to vaccinate the same new groups. In part because vaccine availability and demand were uneven, some local areas began to run out of eligible and willing vaccinees before they ran out of vaccine, so they moved to new target groups without consulting the DOC. Rumors about low vaccine safety were also common nationwide although the extent to which that impacted vaccine uptake was not known.

Communicating local vaccine availability to the public during H1N1 was a challenge that was never fully solved. The vaccine delivered to a particular provider could be provided by NDDoH because NDDoH made the allocation decision, but local clinic-specific information which the public needed to know to seek out vaccination could not be updated by the state. This included eligibility, how many doses the clinic had for what age or risk groups and when vaccination clinics were being held. Although local providers (e.g., LPHU) may have used methods specific to their area, the primary method used by the state was the Flu-Finder website.

The intent was that each provider or clinic would update this information in Flu-Finder as the information changed, but this was not done consistently. The only incentive offered to providers was the ability to get information to their patients and to decrease the number of phone calls to the office. Substantial pressure was applied by the federal government to the states related to this issue, but that did nothing to alleviate the problem[13]. The website was adequate, but the updating was not, and NDDoH did not control the updating.

Communication during a Future Pandemic

[13] DHHS went so far as to call state governors to complain about problems with up-to-date vaccination information in Flu Finder without first consulting with state health agencies. This created a firestorm of protest.

The communication of general information about the pandemic and vaccine worked reasonably well, particularly with federal investments in nationwide education, and is unlikely to be greatly different in a future pandemic. However, communication about the specifics of vaccine availability at local sites needs to improve (see below).

During a moderate or severe pandemic, some issues will be difficult to communicate to the public such as declining quality of care and allocation of ventilators. Priority vaccination may be one of these issues since it may be viewed as inherently unfair by some persons. Priority vaccination is about valuing the protection of some people over others. This not likely to be as much a problem for vaccination of high risk group as it will be for vaccination of priority infrastructure, particularly those outside of health care. Since the recommendation for priority infrastructure vaccination will come from the federal level, the federal level is also likely to take the lead in justifying it to the public.

A couple of methods may be useful for getting provider offices to update the Flu-Finder website. A requirement to update Flu-Finder can be included in the initial registration agreement signed by the provider as a condition of receiving vaccine, as well as requiring contact information for one or more persons in each office who were assigned the responsibility for updating. Incentives may be helpful but have not been identified. Yet, as long as it is left to the providers' initiative to update this information, gaps will occur.

A more reliable approach would be for NDDoH to assume responsibility for updating the website. This would require incident command to collect this information from provider offices, probably by daily or every other day phone calls to all registered provider offices. This information would then be posted by NDDoH to the Flu-Finder website. Taking on this task would require additional personnel time, either by using additional NDDoH non-EPR staff in the response or by hiring temporary employees. In a moderate or severe pandemic, additional personnel time to make phone calls to provider offices may not be available due to high absentee rates.

Heavy dependence on a website to communicate the needed information may tend to limit access for some people to this information; however, the information is complex and changes often, so other easily accessible statewide alternatives are not apparent. Some alternatives include reverse 911, mass text messages through Amber Alert, large clinic reverse 911 systems or National Weather Service alerts. Problems with these systems include 1) triggering the use of several of these would require that the information had a substantially higher urgency than was the case in H1N1, and 2) complex information which is locally specific and changing frequently would be a barrier for these methods. Social media use may be successful but would have similar limitations to the Flu-Finder website. Local communications (newspaper, public access channels) can reach local populations with provider specific messages about availability and may be the best option, but one better employed by local public information providers. Local public health could be asked to be responsible for collecting and communicating vaccine availability within their jurisdiction, but many local public health units are small and may have very thin staff due absenteeism. Complete loss of public health services in some local jurisdictions is possible due to absenteeism since staff depth is so small.

No mechanism was in place to evaluate the success of communication systems in H1N1, but anecdotal information suggests a substantial problem. In a future pandemic, it would be helpful to determine if alternative communication strategies being employed were meeting the information need. Although not without bias, one simple approach would be the addition of a pop-up survey on the Flu-Finder website and questions asked of callers to the hotline. The BRFSS could be used with less bias, but is more difficult to alter and would have a substantial delay (e.g., one or more months until prior months data became available).

Warehouse Vaccine Processing

During H1N1

During H1N1, the warehouse received cases of vaccine which had to be split among multiple delivery points. These arrived in large Styrofoam containers delivered by commercial carrier. The vaccine was transferred into alarm-monitored, walk-in refrigerators. Allocation schedules were received as packing slips produced by NDIIS prior to actual receipt of the vaccine and faxed or emailed to the warehouse by Disease Control. All the designated sites were plotted on a map and eight cluster routes were defined for delivery[14]. The vaccine was sorted by provider and route and routing sheets were created. Vaccine for each route was put into a holding container (basket) in the refrigerator for loading at 6:00 am the next morning.

The next morning, all the vaccine in a single container was placed in a portable refrigerator, a glycerin thermometer with lead wire was placed among the vaccine and the lead wire was attached to the external temperature display of the thermometer. One route sheet was put on a clipboard with route instructions and another route sheet was attached to the top of the portable refrigerator. Each refrigerator was numbered and the number was added to the routing sheets.

The drivers would leave the warehouse in time to arrive at their first destination after the site had opened to receive it (usually 8:00am). The route driver called the recipient contact for each site a few minutes before arrival. If the contact could not be reached, the driver called the DOC and requested the DOC to make contact with the destination. On arrival at the site, all the vaccine for that site was removed from the refrigerator to a Styrofoam cooler and carried into the building, where it was transferred into the refrigerator. If the site had any coolers or shippers to return the warehouse, these were picked up by the driver. Routes were intended to be no longer than 12 hours. To keep the length of the routes down, far distant destinations (e.g., Divide County) received their allocation by certified shipper shipped by commercial carrier. The vaccine recipient shipped the certified shippers back to the warehouse once emptied.

It was not intended that the driver stay overnight with any vaccine, but return to the warehouse to report-in that same afternoon. If a driver had to stay overnight, the driver would take the vaccine refrigerator into the hotel room and plug it in. If the driver was unable to deliver all the vaccine (e.g., the recipient site refused the vaccine because they

[14] In large rural areas like North Dakota, cluster routing in which routes look like lollipops on a stick are more efficient that loop routes that look like a horseshoe.

had all they wanted), the vaccine was returned to the warehouse and reallocated for the next shipment.

Several problems had to be overcome (during and after the pandemic) until final procedures were established. These included:

- Non-certified shippers could not always maintain temperature during extreme weather. Shipping switched to controlled temperature refrigerators in temperature controlled vehicle cabins, and certified shippers.
- Refrigerators initially used were hard to set and did not reliably hold temperature. The refrigerator could be plugged into the cigarette lighter, but did not have battery backup. They were replaced with vaccine refrigerators with battery backup.
- Drivers were not initially instructed to carry vaccine into the destination building in coolers. This upset some recipients so procedures were changed.
- Attempts to use SNS software called TourSolver v. 2 were not successful. The faster way to route was by hand which proved to be quite adequate for this state. Many iterations of TourSolver have been released since then, but it may not be valuable for this purpose in this state.
- Disposable temperature monitors were not found to be reliable enough and could not be externally monitored. The disposable thermometers had a plus or minus two degree margin of error. Glycerin thermometers had a plus or minus one degree margin of error and could be externally monitored.
- DOT drivers "wore out" over the course the outbreak. The DOC switched to a contract service to transport the vaccine to its destination. This worked well.
- Certified shippers needed to be pre-cooled before loading to help them maintain the correct temperature. This resulted in a procedure change.
- Although no frozen vaccine was used during H1N1, it was used in other vaccination projects. Vaccine refrigerators can manage frozen vaccine. Packing frozen vaccine in shippers is problematic since there is no reliable source of dry ice in Bismarck.
- Two vaccine refrigerators can be run off the cigarette lighter of a truck, but not in a smaller vehicle due to insufficient amperage.
- If a refrigerator is unable to keep temperature and the time to route completion lengthy, the vaccine can be dropped off at a LPHU (if so directed by the DOC) until the problem is solved. I reality, the vaccine is not so sensitive to a modest temperature rise that that should be necessary, but the freeze-thaw threshold for that vaccine should not be crossed.

Communications between the warehouse, the DOC and Disease Control evolved over the course of the pandemic and seemed to work well during most of the course of the response. Communication from providers to the DOC or Disease Control did not always work as well. Often the first indication NDDoH got that a particular provider had all the vaccine that that clinic wanted was when the vaccine was refused at the door. Most clinics would make provisions to receive vaccine after hours if they were notified to expect it. After hour delivery was an occasional problem for private providers, but a bigger problem for some small local public health units. Communications from NDDoH to providers improved over the course of the H1N1 response. The next allocation of vaccine was posted on the FluFinder website for each provider including when to expect delivery. The only place substantial problems remained was in one of the areas which was managing vaccine allocation for its region. Substantial provider complaints were received from that region.

Warehouse Vaccine Processing during Future Pandemics

A future pandemic would follow the procedures outlined above except:

- Data loggers (with probe in glycol) which can be externally monitored and have an alarm (different from the refrigerator alarm) have replaced glycerin thermometers. These are periodically re-calibrated.
- Vaccine refrigerators do not need to be plugged in unless there is an overnight stay. They will hold temperature over the course of the delivery route. Batteries will re-charge overnight.
- During H1N1, NDDoH attempted to receive, route, pack and deliver vaccine it received within 24 hours of receiving it. Although the policy prevented vaccine from sitting in the warehouse when it was needed by vaccine providers, it placed considerable strain on resources both in Disease Control and the warehouse. Whether to continue this policy would be an incident command decisions. In a serious pandemic when personnel resources become stretched and tired, this may be unreasonable.
- Additional contacts other than the primary contact for each destination are held in NDIIS; this information needs to be transmitted to the DOC.
- For shipped vaccine, recipients have had a hard time learning how to read the temperature log. More training is required and is being undertaken by Disease Control. Recipients must look at the logger at the time of vaccine receipt to ensure the vaccine is still good.
- Transportation capacity may be impaired in a severe pandemic. This may result in less frequent shipments and possible use of a greater combination of transportation resources to move vaccine.
- Higher volume of vaccine may cause a problem for certified shippers, but portable vaccine refrigerator capacity should not be taxed.
- Having all vaccine for a single destination inside a single, breathable container (e.g., laundry mesh bag) inside the refrigerator would prevent driver errors in selecting vaccine for each destination. This was not perceived to be a serious problem during H1N1, but occasionally errors were made.
- Destination will sign for the vaccine when they receive it.
- Sites which may have difficulty having someone available after hours to receive the vaccine need to make arrangements with an alternate recipient such as hospital or LTC facility which would be able to store the vaccine until it could be picked up by the vaccine provider.

Vaccine Documentation

During H1N1

Data from the vaccine recipient (vaccinee) was collected at the clinic site on a form designed for that purpose. The form could be scanned using an appropriate fax machine which would upload it into NDIIS.

- Persons completing the form often made little effort to write into the designated scannable boxes on the form.
- The program reading the forms did not perform adequately. This lead to data being dropped or scanned in as gibberish, including some critical information.
- Information required before the data could go into NDIIS was often unreadable or unavailable. There was no way to ensure that all the information needed was collected

at the time of the encounter. Mandatory fields had to be removed in order for the data to go in.
- Form scanning was often delayed.
- It was not possible for the person scanning the form to know of the form had been successfully transmitted or not.
- Data going into the registry often duplicated individuals rather than merging with existing individuals, mostly due to the poor data quality from the scan.

Eventually data was redirected to the DOC where manual data correction occurred.

Vaccine Documentation during Future Pandemics

Collection of all vaccine administration data during a pandemic will be important, and data needs to be available as soon as possible to permit assessment of coverage and reminder recalls for second dose administration. Consequently, all providers must agree to submit the data into NDIIS if they wish to become vaccine providers. The Immunization Program will be responsible for training providers as to how to use the NDIIS.

With the adoption of electronic health records (EHRs) by many health systems, data from the EHR can automatically document the vaccine record in NDIIS in real time. As of the time of this writing, about 60% of records were going into NDIIS electronically by EHRs. One of the limitations of EHR is inflexibility of the systems that generate the data for NDIIS. That is, if a new field is wanted in NDIIS, the EHR cannot easily be altered to capture the information. Pharmacies and local public health account for most of the remaining vaccine that is not transferred by EHR. Few vaccinations given in LTC facilities are currently being entered into NDIIS so that data is being lost (a new grant has been received to bring LTC into NDIIS). Additionally, IHS is not yet electronically submitting immunization data to the NDIIS.

It is assumed that all or nearly all mass vaccination records will need to be collected on paper forms for later entry into NDIIS, and a very substantial portion of the vaccines given in a pandemic could take place in mass clinics. Those forms blanks would be created by Disease Control at the time of the pandemic with content adjusted to the specific pandemic situation. To encourage getting data into NDIIS, the proposed policy is not to ship additional vaccine to a site which does not account in NDIIS for administration of all the doses previously sent (that is, every dose is accounted for by administration to a specific individual). Failure to enter data into NDIIS would limit ability of that provider to receive more vaccine; the assumption will be if the data is not in NDIIS, the vaccine dose has not been delivered. This is already being done with Vaccines For Children (VFC) vaccine. (Whether this could actually be enforced during a pandemic would depend on the circumstances.) Another alternative to ensure timely entry of data into NDIIS would be for the paper records to be sent to NDDoH for entry here. Substantial numbers of temporary staff would be needed to accomplish this. Forms would be destroyed once the data is entered.

Entry of data into NDIIS from a paper record has not proven to be problematic; matching to the correct person for data updating appears to be quite good. Time requirements for data entry into NDDoH for persons without existing records is not expected to be a serious problem since about 80% of all North Dakotans already have a record in the system.

NDIIS can generate recall reminders for persons who received the initial dose of pandemic vaccine once the required time between doses had elapsed. The system can produce line lists to upload to an autodialer which could deliver a generic message to persons needing to return to the clinic[15]. A more specific message would be better, especially if it is determined that to be important that a person's second dose be exactly the same vaccine (e.g., type, manufacturer) as the first dose, or at least the same adjuvant. In that case, just because sufficient time had elapse for the person to receive the second dose would not mean the specific vaccine would be available in the community. It might prove difficult for the patient to show up at the right place and time to get the correct vaccine, even if they knew what vaccine and adjuvant they needed. A reminder letter could be generated when the vaccine the person needed was available to them locally, but this would be labor intensive and expensive, and likely impractical during a pandemic when hundreds of thousands of persons were receiving two doses of vaccine. Furthermore, by the time the letter was received, the vaccine the person needed might already have been used.

Adverse Event Reporting

Influenza vaccines are rarely associated with serious side effects, but any vaccine or drug given to enough people will cause serious adverse reactions in rare instances. The addition of adjuvant to the vaccine, even if very safe, will increase the risk of adverse reactions, although the risk profile of the vaccine will depend on specific adjuvant used with it. The NDDoH currently recommends that providers directly report adverse events using an on-line form to VAERS (www.vaers.org). Previously, providers reported adverse events using the NDIIS. Since these events are not able to be electronically submitted to VAERS, the immunization program changed this process. During a pandemic, VAERS reporting in NDIIS could be turned back on. During H1N1, CDC pushed states to receive adverse events and investigate those that were unexplained and serious. CDC is likely to do this again during the next pandemic. Not all vaccines are quite as safe as influenza vaccine, and some are substantially less safe.

Wasted and Recalled Vaccine

Some wastage of vaccine is inevitable. Currently this is reported to NDDoH through the NDIIS. The Immunization Program is responsible for training providers on how to use the NDIIS vaccine return/waste system. If vaccine is recalled, NDIIS will be able track who received the specific vaccine that was recalled in order to make contact with the provider to quit using the vaccine.

Security

In the event of a serious pandemic in which many otherwise healthy persons are dying because insufficient vaccine is available to protect them, vaccine security may become a substantial problem. In that event, security will be handled as outlined in the SNS for other types of materials distribution.

Mass Vaccination Clinics

Medical Waste

[15] Use of autodialers in North Dakota is currently against the law; however, this could be altered during a pandemic by executive order.

NDDoH has acquired the materials needed for safe containment of large amounts of medical waste. Individual public health units have their own local arrangements with providers of services for disposal or destruction of the waste material. During a pandemic it is expected that there will be some problems with managing large amounts of sharps generated by mass vaccination within the capacities of existing disposal companies. If necessary, LPHU will store the waste in sealed containers in locked rooms until the capacity of disposal companies is sufficient to receive and destroy the excess medical waste material.

Infection Control and Social Distancing

Public health workers routinely administer vaccines, including influenza, and are trained in universal and bloodborne pathogen precautions. It is possible that a public health worker shortage might lead to vaccine administration by some workers who are not normally allowed to administer vaccine, but could do so under circumstances of a Governor-declared disaster. Ensuring that these employees are adequately trained in infection control will be the responsibility of the vaccinating entity.

Prevention of transmission of influenza during a pandemic vaccination clinic is a serious concern, since presence in a pandemic vaccine clinic may increase the risk of exposure but receiving the vaccine will not provide immediate protection against disease. In other words, a vaccination clinic will have a potentially powerful anti-social distancing effect. There are several approaches that may be used to minimize the adverse social distancing:

- Universal covering of the nose and mouth – Masking appears to be at least somewhat effective a limiting the droplet spread of a person who is sneezing or coughing, even if its effectiveness at preventing another person from inhaling the droplets is less clear. Although sufficient surgical masks may not be available to put on every person, clinics may need to require every person to have their nose and mouth covered with a mask or a cloth at all times.
- Education – Continuous education of those who enter the clinic regarding respiratory etiquette, avoiding touching surfaces, frequent hand washing, not touching the face with one's hands, and maintaining a distance between families of at least three feet may be needed.
- Use of outdoor space or drive through clinics – Not all local sites have exercised drive through clinics which should more effectively limit spread between families, but many of the large jurisdictions in the state have exercised it. Throughput would likely be a problem for large scale vaccination is needed quickly.
- Clinic intensity – Lower clinic throughput may decrease the risk of transmission; if is not likely that if this will be known although if it permits greater distance between families coming in for vaccination, it should be partially effective. Lower than expected throughputs may also be necessary if an acute shortage of public health workers makes staffing large clinics impossible.

Logistics

Vaccination at the LPHU may be logistically easier than POD-based vaccination when the number of doses to be administered remains small. It will be the option of LPHU to determine when the number of doses is so large that transition to POD-based vaccination would be more efficient. The details of POD-based operations are contained within local POD planning documents which are part of the SNS documentation at the local level.

Local POD plans[16] encompass both drug distribution and mass vaccination. Initial plans were developed for antibiotic prophylaxis, but have been modified to address vaccine specific issues. Issues unique to vaccination, when compared to mass dispensing of oral medication include:

- Workforce vaccinators and person drawing up vaccine/adjuvant– Even though an executive order by the Governor made under the state disaster act would provide opportunity to use providers to give vaccines who don't normally give vaccinations, the availability of providers who will be capable of administering an injection will be limited. In addition the greater physical demand of the work compared to pill dispensing will place more limitation on the number of hours a vaccinator can work without rest.
- Cold chain – Mass vaccination sites may have limited refrigeration capacity which will require LPHU to transport the vaccine from the storage site to the mass vaccination site and maintain the vaccine within temperature at the clinic site. Requirement for cold chain maintenance may limit the amount of vaccine that can be brought to the vaccination site at any one time.
- Number of persons to be treated – Unlike antibiotic dispensing which provides multiple courses of medication to the head of household, vaccination clinic will have to reach all persons.

Vaccination of Special and Dependent Populations

The approach to vaccination of special and dependent populations will vary from one LPHU to another, but is similar to plans developed for SNS drug distribution.

- Homebound – Vaccination of homebound will take place after mass vaccination clinics have largely completed general population vaccination. This reflects the somewhat lower risk of infection of persons who are not mobile, but more especially the low efficiency of reaching the population compared to mass clinics. In most LPHU, this will involve home visits by public health personnel.
- Outreach to custodial institutions – Delivery of vaccine to institutions which have custodial responsibility for the health of their population, when health care personnel are not on-staff to provide the vaccine, will require a visit by public health vaccine providers. Generally, public health personnel will be dispatched to go on-site after mass vaccination is completed, but institutions may be prioritized for earlier vaccination based on risk assessment. Some institutions will be able to vaccinate their own residents. These would include hospitals and clinics, long term care, some schools (if operational at that time), state penitentiaries.
- Language barriers - North Dakota has a low percentage of non-English speaking persons generally, but substantially higher in some areas. Approaches vary depending on the percentage of the population which is not English speaking. In areas with relatively higher numbers of non-English speakers (e.g., Fargo area), interpreters will be available within clinics for common languages. For areas with low numbers of non-English speakers (as well as for languages which are spoken by few persons in all parts of the state) telephone-based interpretative services will be provided with the help of designated persons assigned to assist those with special needs in the clinic.

<u>Vaccination of Reservation Populations</u>

Some reservations have PODs which may be able to vaccinate. Otherwise, persons on reservation will need to seek vaccination at the nearest public venue off reservation. For both Spirit Lake and Turtle Mountain reservations, these venues are likely to be close. Fort

[16] Each of the 62 local POD plans includes an MOU and points of contact for both site command structure and building access including multiple access numbers. The plans are located in the secure document library of NDDoH.

Berthold is likely to be able to vaccinate locally since they have had the most stable POD structure. Standing Rock has not been able to sustain a POD in the past across changes in tribal leadership. Because of the large distance to the nearest substantial city (Mandan), and accessory transportation plan has been drafted and may need to be activated. Standing Rock is trying to re-establish a POD at this time. The NDIIS should provide the ability to track vaccine coverage among American Indians.

Emergency Use Authorization Vaccination

The provisions of an EUA requires that persons receiving the vaccine know that the vaccine has not completed full approval, but that it is being offered due to an emergency. Potential recipients would need to know the risks and benefits of receiving the vaccine or of refusing the vaccine, any alternatives that they have to the vaccine, and an assurance of their right to refuse the vaccine. In the event that NDDoH needed to administer vaccine under an EUA, the agency would expect to receive substantial information from DHHS detailing the following:

- Target recipients;
- FDA conditions for use;
- Information regarding risk and benefit of use;
- Additional information to be collected (in addition to contact information and information collected as part of the vaccination process for a non-EUA vaccine);
- Guidance regarding enhancements to adverse event reporting and case investigation which would need to implemented as additional safeguards.

NDDoH would provide training of all persons who would be administering vaccine under an EUA. Training would be provided using video conferencing over Stagenet and BTWAN (hospital network), as well as by web-casting if needed to reach additional entities not tied into the videoconferencing system.

Investigational New Drug Protocol

IND protocols require specific information collection, especially related to adverse events, a detailed consent signed by each recipient and patient follow-up. Because of its high burden of documentation, investigational new drug protocols would be impossible to implement on a mass scale; however, implementation within a narrowly targeted population could be feasible. Should IND vaccine use be necessary, NDDoH will look for additional guidance specific to the vaccine being used under IND including vaccine recipients to be targeted, additional documentation requirements and reporting. The NDDoH IRB would be prepared to review the protocol on a priority basis. Prior to use of the IND protocol, NDDoH would ensure that it had:

- FDA site approval for administration;
- IRB approval by the NDDoH IRB (or a CDC IRB which NDDoH has recognized as a substitute IRB);
- A designated principal investigator. Since the vaccine would be administered under the authority of NDDoH, the State Health Officer would likely be the PI.
- A research protocol which incorporated FDA requirements for data collection and patient follow-up and to which no changes would be made without IRB review and approval.
- A reporting pathway defined for adverse event communication back to DHHS.
- State training of all persons who would be administering vaccine under an IND protocol including informed consent requirements, record keeping and reporting. Training would be provided using video conference over the Stagenet (IT backbone for state) and BTWAN (hospital network), as well as by web-casting if needed to reach additional entities not

tied into the videoconferencing system. State software used to register for and track training would be used to confirm participation in training for each site before the IND protocol could be used.

Until the time of the event, it will not be known what the extent of the utilization of a vaccine would be under an IND protocol. Once this is known, vaccine would be allocated to specific sites and duplicated consent form/protocols (duplicated through central duplication services of the state) would be distributed through the SNS system along with POD materials for clinic setup.

ATTACHMENT A
HOSPITAL PREPAREDNESS PROPOSAL FOR PANDEMIC INFLUENZA VACCINE DISTRIBUTION PRIORITIES

At this time, NDDoH is expecting that direct care providers in hospitals will be first line recipients of pandemic influenza vaccine. It is likely that initial vaccine shipments will not be sufficient to vaccinate all direct care providers; consequently, establishing a priority system for vaccination pre-event is necessary. At this time, no guidance is available for development of such a system.

Hospital preparedness representatives to the four regional HPP meetings were asked to describe a priority system for allocating the expected small numbers of vaccine doses which would initially be available to distribute to health care workers. Prioritization does not include other personnel who may be assigned vaccine outside the health care sector such as critical community infrastructure and public health.

To divide health care personnel into priority groups, the hospital planning committees were asked to only consider prioritization based on their perceptions of the approach that would save the most lives. In keeping with that overarching goal, it was recommended that they consider 1) whether the person had specialized skills which were necessary for patient care and difficult to replace (e.g., ventilator management); and 2) the level of exposure that the employee would likely have to persons infected with the pandemic strain. Since in smaller hospitals, many of the staff serve multiple roles, it was decided that the prioritization level of any individual would be based upon their highest level of priority. For example, a nurse covering both the floor and the ER would be considered ER for purposes of prioritization, since it was at a higher priority level.

PRIORITIZATION RECOMMENDATION

The following prioritization schedule represents a consensus of the hospital preparedness representatives. Tier 1 is numerically ordered with each numerical group being completed with two doses before starting the next numerical group. Lower tiers are not subdivided. If insufficient doses are available to vaccinate an entire tier (e.g., Tier 2A) or category (Tier 1 Category 1) that was eligible for vaccination, it would be up to the health care institution to decide who within the tier or category would receive the vaccine. It is expected that facilities would attempt to vaccinate some persons from across the categories represented within a tier in order to maintain all functions to the degree possible.

Tier 1

1. Critical Care Staff [ICU, ER, and Specialty Physicians (ICU, ER, and Infectious Disease)
2. Hospital designated urgent care staff (walk-in/triage area to minimize traffic in ER)
3. Primary Care Nursing Staff (RN, LPN, CNA)
4. Emergency Medical Services staff
5. Incident Commanders
6. Radiology Staff
7. Respiratory Therapy staff
8. Primary care physicians
9. General Surgeons

10. Laboratory/phlebotomy staff
11. Anesthesia
12. Inpatient pharmacy

Tier 2A

- All other physicians, nurses, CNAs
- Admitting staff
- Housekeeping
- Bio-medical staff
- Dietary staff
- Laundry staff
- Incident Command staff
- Chaplain staff

Tier 2B

- Medical records staff/ward clerks
- Central Supply staff
- Long term care staff
- Home health staff
- Social Workers/Discharge/Case managers
- Psychiatry staff/mental health providers
- General Incident Command Staff
- Security staff

Tier 3

- Purchasing staff
- Maintenance staff
- Information technology staff
- Rehab Therapy
- Admin Support
- Finance staff

Tier 4

- Any other staff without direct patient contact
- Family members of Tier 1 hospital staff

ALLOCATION

It is expected that when NDDoH receives the first shipment of vaccine, the Department Operation Center (DOC) would determine the percentage of vaccine that would go to several different domains (e.g., local public health, state public health, health care, first responders, municipal workers, and disaster management). The relative allocations between these groups will be an incident command decision guided by the situation in the state when the initial vaccine is made available and any CDC requirements. It is expected that the vast majority of doses would be allocated to health care. Based on the number of doses of vaccine available for allocation to that domain, recipient institutions would be asked to supply the number of persons who fall into each Tier 1 category. Incident command would designate which categories were eligible for vaccination, and recipients would have to agree to abide by these eligibility criteria in order to receive vaccine. For the purposes of this discussion, community

health care staff (within minimum care facilities) will be considered for vaccination based on their assigned role, as if they were hospital staff.

The available doses would be divided proportionate to the number of personnel in each of the categories that could be covered. It is the intent of NDDoH that the vaccine would be sent to destinations within 24 hours of receipt by the state. Facilities receiving vaccine would be asked to provide the vaccine to staff within 24 hours of receipt, keeping careful records of who received the vaccine and why. The receiving facility would need to provide for the security and storage of the vaccine including maintenance of cold chain.

If insufficient vaccine is available to vaccinate an entire priority group (e.g., ICU and ER), the hospital would need to decide how to allocate the vaccine. The decision needs to be logical and ethical. It could be by lottery, epidemiological risk (e.g., age), professional risk (e.g., assignment to care for pandemic patients specifically), availability to work through the pandemic or any other defensible method. The method chosen should be documented and as each person is vaccinated, it should be documented why that person was vaccinated and not someone else. These records would be made available to NDDoH on request, which would only be likely if questions were raised about ethical allocation. Given that vaccine receipt may determine whether certain persons live or die, public inquiry may occur after the pandemic.

PUBLIC HEALTH PANDEMIC INFLUENZA VACCINE PRIORITIZATION

Once the world enters into pandemic influenza, an effective vaccine is not expected to be available for several months. Although it is not possible to know how the situation will unfold, we are expecting that as vaccine is produced, it will be released to states in small quantities, and into the public sector (NDDoH) rather than the private sector. Past experience suggests that it will be up to states to determine how the vaccine will be allocated within their states within broad guidelines supplied by CDC. At this time, it is anticipated that two doses would be required by each vaccine recipient in order to acquire any protective immunity. Persons who had received one dose would be given a second dose (assuming sufficient time had elapsed) before an unvaccinated person was given their first dose.

It is expected that when NDDoH receives the first shipment of vaccine, the Department Operation Center (DOC) would determine the percentage of vaccine that would go to each of six domains as follows: local public health, state public health, health care, first responders, municipal workers, and disaster managers (listed in no particular order) in addition to any risk categories designated as high priority by CDC. The relative allocations between these groups will be guided by the situation in the state when the initial vaccine is made available. That is, different shipments of vaccine might be divided among the domains differently based on the situational assessment. It is anticipated that the largest quantity of vaccine in each shipment would be allocated to the health care domain.

The NDDoH Department Operation Center would designate which categories were eligible for vaccination and potential recipient institutions would be asked to supply the number of persons who fall into each specific eligible category. Recipients would have to agree to abide by these eligibility criteria in order to receive vaccine.

Priority
The tier table below represents the recommendation of local public health for vaccine prioritization. The final decision on eligible categories would be made by the NDDoH Department Operation. In the recommendation below, each tier and each numbered category within each tier below represents a higher priority level than the tiers or categories below it. Vaccination would be completed in the highest level tier or category before moving on to a lower category or tier. Regardless of category or tier, provision of second dose to those already having received their first dose takes precedence over provision of any first dose, assuming sufficient time as elapsed since the first dose was given.

<u>TIER 1:</u>

1. Nursing Staff
2. Public Health Officer (with direct patient contact)
3. Field Surveillance Workers

<u>TIER 2:</u>

1. PH staff at-risk of exposure*
2. Incident Command Staff

- Incident Commander
- Business Manager
- PIO
- Community members filling these functions
- EPR Coordinators

4. IT Staff

TIER 3:

1. Program Staff
2. Janitor
3. Board of Health Members
4. Primary and secondary POD people/managers
5. Families of Tier 1

* Persons having direct patient contact other than those listed above.

Local Vaccine Brokers

A local vaccine broker is a partner institution at the local level, typically a local public health unit or hospital, which has agreed to receive vaccine and administer according to state guidance and federal guidance. The role of the vaccine broker would include:

- Receipt and storage of vaccine including maintenance of cold chain;
- Security of the vaccine;
- Administration of the vaccine;
- Allocation of vaccine to end user organizations;
- Maintaining documentation of administration and reason for vaccination priority and providing that documentation on request;
- Ensuring persons receiving their initial dose receive an appropriately timed second dose, and;
- Setting clinics or PODs for mass vaccination.

Only a vaccine broker would be eligible to receive and administer the vaccine for priority vaccination of infrastructure. This would not be true of priority vaccine for demographic risk groups. All domains which were allocated doses would have to report to the vaccine broker in order to have the vaccine administered. If both a hospital and local public health unit were designated vaccine brokers, it is expected that in most cases, the local public health unit would be the primary broker responsible for splitting vials among domains and administering those doses.

ATTACHMENT C

Vaccine Management and Administration Roles During Priority Vaccination

Local Public Health Roles

By its nature, vaccination is considered to be primarily a local public health function. Local public health assumes this duty under legislative mandate and contract with NDDoH. The following are the anticipated roles of local public health:

- Receiving vaccine and signing for receipt (chain of custody)[17];
- Administering vaccine to all non-hospital priority recipients;
- Ensuring that vials which need to be split between two different groups are appropriately divided. This includes splitting vials for hospital employees when only part of the vial is allocated to hospital personnel. Those hospital employees receiving vaccine from a split vial will need to go to the LPHU to be vaccinated, unless other arrangements have been made with the LPHU.
- Ensuring that vaccinees receive their second dose as soon as possible after they become eligible for the second dose;
- Maintaining records for all priority recipients which include the reason why the person was selected for priority vaccination;
- Providing whole vials to institutions which agree to 1) perform self-administration and 2) maintain required vaccination records. (See section on custodial care.)
- Maintaining the vaccine between 35°and 46° at all times, and provide documentation of cold chain records;
- Maintaining refrigeration space in excess of daily, non-pandemic requirements sufficient to hold a local allocation equivalent to one dose per person – Given the uncertainty of potency of the vaccine and hence the number of vials of vaccine which might be received at any time, it is difficult to know with certainty the amount of refrigeration space required.
- Maintaining cold chain transportation from vaccine storage sites to public health operated clinics. That is, vaccine will be received at the LPHU; however, POD sites, one or more per region, may be at a different location. This will require transporting the vaccine from the LPHU to the vaccination site and storage of the vaccine at the site. (Vaccine which is released to other institutions for self-vaccination will also have to be kept cool, but this is the responsibility of the receiving institution. LPH would need to take care that it does not release vaccine to an entity which is packaging it for cold chain transport;
- Setting up and operating vaccine clinics of sufficient capacity to administer expeditiously the quantity of vaccine ready for administration. When vaccine quantities are small, vaccinations will occur at LPHU offices with transition to POD sites for large volume administration. The point of transition from office to POD will be at the discretion of local public health;
- Establishing hotlines which can receive reports of vaccine adverse events and forwarding adverse event reports to NDDoH;
- Entering data into the North Dakota Immunization Information System (NDIIS);
- Providing public communication in cooperation with regional and state public information officers.

Hospital Roles

[17] The receiving agent for vaccine within each local public health unit is the designee of the incident commander for the institution. NDDoH will make direct contact with the agency operations center for notification of vaccine shipments and signing custody transfer forms.

- Receiving shipments of vaccine from manufacturer or shipping agent and maintaining security and cold chain[18];
- Administering vaccine to own employees and volunteers, unless arrangements have been made specifically with local public health to complete this;
- Selecting individuals for priority vaccine within the guidelines provided by the state;
- Ensuring that employees due a second dose receive it in a timely manner;
- Maintaining records for all employees given priority vaccination including the reason why the person was selected for priority vaccination;
- Entering data into the North Dakota Immunization Information System (NDIIS);
- Receiving reports of adverse reactions caused by the vaccine and reporting that to NDDoH.

NDDoH Roles

- Designating the priority recipient groups based on pre-determined state and federal guidelines provided (responsibility of incident command in the DOC);
- Determining shipment allocations;
- Providing to the federal shipping agent the list of ship-to sites and the quantities to be shipped to each destination for each shipment;
- Receiving shipments from the manufacturer or their shipping agents and re-packaging vaccine for shipment to smaller geographic areas as necessary.
- Approving redistribution of vaccine if indicated -- If all persons within the approved priority groups in the jurisdiction of a LPHU have been vaccinated, but vaccine remains, the LPHU will call the Department Operations Center (DOC) of NDDoH which will determine whether to permit use at the local site or to re-allocate vaccine to another LPHU jurisdiction for use with priority designees in the approved groups (unlikely unless quantity of vaccine remaining unused is large). NDDoH will coordinate the transfer of the vaccine between the public health units if this becomes necessary.
- Reviewing adverse reactions to identify those of high severity or of an unusual nature which require investigation to assess the likelihood that the reaction was vaccine-related, or identify any reasons why reaction occurred (e.g., presence of a relative contraindication or absolute contraindication to vaccination). See section on adverse event reporting for additional detail.
- Providing aggregate reports to CDC in the manner requested by CDC. NOTE: In some circumstances, shipment sites will differ from administration sites (e.g., multiple PODs within the jurisdiction of a single health unit);
- Providing oversight to the NDIIS system and coordinating system changes with Noridian (Blue Cross/Blue Shield of North Dakota) which administers the software;
- Analyzing results from the NDIIS system to provide estimates of coverage, identification of local areas which appear to be experiencing barriers to rapid completion of vaccination, identification of individuals substantially overdue for second dose vaccination and identification of number of persons ready for second dose vaccination (for purposes of vaccine allocation);
- Taking the lead in working with the PIO for public communications about priority vaccination. It is expected that not all persons will willingly understand why they or their family members were not selected for priority vaccination. NDDoH will attempt to provide transparency to the process through media messages.
- Ensuring staff at the state level who are to receive priority vaccination are vaccinated. (State personnel prioritized for vaccination will be vaccinated through their local public health unit in the same way as priority vaccinees of other infrastructure institutions.)

[18] The receiving agent for vaccine within each hospital is the designee of the incident commander of the institution. NDDoH will make direct contact with the agency operations center for notification of vaccine shipments and signing custody transfer forms.

ATTACHMENT D

Prioritization of Infrastructure

Summarizing information for critical infrastructure recommendations other than the above from The Prioritization of Critical Infrastructure for a Pandemic Outbreak in the United States Working Group

www.dhs.gov/xlibrary/assets/niac/niac-**pandemic**-wg_v8-011707.pdf.

:

Tier 1	Law enforcement personnel Fire services personnel Key government leaders
Tier 2	Electricity sector personnel Natural gas personnel Communications personnel Water sector personnel Critical government personnel Community suppt. & emergency mgt. (e.g. Red Cross
Tier 3	Transportation sector personnel Food and agriculture sector personnel Banking and finance personnel Pharmaceutical sector personnel Chemical sector personnel Oil sector personnel Postal and shipping personnel Other important government personnel

Sector	**Tier 1 Functions**	**Tier 2 Functions**	**Tier 3 Functions**
Financial	• Federal funds, foreign exchange, and commercial paper; • U.S. Government and agency securities; • Corporate debt and equity securities. • Sufficient critical personnel to operate and maintain minimum cash availability to the public through the ATM network (1 ATM per bank branch office).	• Obtain cash on a broader basis through the ATM network • Maintain electronic payment systems (checking, wire transfer, ACH, retail lockbox, credit/debit card) throughout a pandemic.	

Chemical	50% of critical • Production and plant first-line management; • Production, plant and system assemblers and operators; • Material recording, scheduling, dispatching, and distributing; • Industrial machinery mechanics and machinery maintenance workers; • Transportation and material moving workers; and • Healthcare and safety and occupational health providers	Other 50% of critical personnel	
Commercial facilities	50% of the most critical • Lodging • Real estate • Retail maintenance • Media	Other 50% of critical personnel	
Communications	% of criticals • Wireless service providers; • Wireline service providers; • Other communications service providers; • Manufacturers, suppliers and vendors; • Networking companies; • Information Technology companies that characterize themselves as having a communications infrastructure or provider-related role; • Communications-related system integrators; • Owners/operators of infrastructure used within the sector including cable systems, other operators and broadcasters; • Trade and other associations representing sector members; • Infrastructure owners who have national assets used in the Emergency Alerting Systems		
Emergency Services	• Fire • EMS • Law Enforcement • Emergency Management • Local Jail/Corrections Officers • Dispatch		

Electricity	• Transmission System Operators • Distribution System Operators • Power Plant Operators • Outage Response Line Mechanics • Substation Operators • Substation Technicians • SCADA Technicians	• Maintenance Line Mechanics • Power Plant Maintenance Mechanics • Customer Service Representatives • Substation Maintenance Mechanics • Material Handlers, Management, Finance and Accounting • Regulatory Affairs, Engineers	• All remaining power plant personnel • Line mechanics • Substation mechanics • Dispatchers • Supply chain • Customer service • Finance • Accounting
Oil and Natural Gas	Mission criticals for: • Oil and Natural Gas Extraction • Petroleum Manufacturing • Petroleum Merchant Wholesalers • Gasoline Stations • Pipeline Transportation (Natural Gas)	Business criticals for: • Oil and Natural Gas Extraction • Petroleum Manufacturing • Petroleum Merchant Wholesalers • Gasoline Stations • Pipeline Transportation (Natural Gas)	
Food and Agriculture	None identified		
Health Care	See Above		
IT	Those providing onsite presence to customer support.		
Nuclear			
Postal and Shipping (Public sector)	10% of critical employees in • Field processing • Movement and delivery	20% of criticals for maintenance of service	
Postal and Shipping (Private sector)	5% of criticals in • Aviation • Truck delivery • Warehouse and material management	15% of warehouse and management	

Transportation	Criticals in • Aviation air traffic controllers and critical specialty commercial pilots; • 50 percent of maritime crew members and the most critical port workers, such as crane operators; • Some critical skilled maintenance workers • 50 percent of the most critical railroad locomotive engineers, operators, and maintenance workers; • 50 percent of total drivers and support personnel for critical specialty cargos and vehicle types.	Remaining 50% of criticals	
Water and Waste Water	Not defined		

Opposing HB1469

Exemptions are available for a reason. Inserts for vaccinations state that there is no guarantee of immunity from said infections. Even if a child is not vaccinated for an infection does not mean they are more susceptible. Exemptions should not be conditional.

The education module mentioned in subsection 3B should include possible risks as well as possible benefits and be available to all parents, not just those seeking an exemption. It should rely on facts and not sway parents one way or the other.

Amanda Saueressig

01/24/2021

My name is Diane Kadrmas and I am in opposition of HB 1469. I feel that the parents should make the decision for their children and no amount of "vaccination education module videos" is going to change the minds. Many parents, grandparents, or guardians have done extensive research themselves and have made an informed decision on why they choose not to vaccinate. Also, there are instances where the person themselves have been vaccine injured or know someone who has been vaccine injured which is where they started to look furter into vaccines and risks. I feel that we, as a people, have the right to choose what is put into our bodies without government meddling in interference. No one person knows what is right for another person better than the person themselves. We should not have any medical professional, DoH persons, or outside source force someone into something they do not agree with even if we are under "emergency status." Individual responsibilty needs to be taken. As a grandmother of 3 very special children, I am also concerned that they will not be able to get an education due to religious beliefs we hold stong to. This is a discriminatory bill against our beliefs.

Greetings, my name is Jessica Kuntz, and I am submitting testimony in STRONG OPPOSITION to HB1469, which would place requirements on parents who are claiming philosophical or religious vaccination exemptions for their children, regardless of where they attend school (public, private, or homeschool). My reasons for this are:

A religious or philosophical exemption is personal and private. The state of North Dakota, particularly the Department of Health, has no place stepping in and dictating how a parent uses such an exemption.

Homeschooling parents, such as myself, should not be required to submit vaccination status of their children in the first place. Many parents who have filed for such exemptions have done so after exhaustive research. The decision to vaccinate or not vaccinate our children based on the research we have done should be left up to the parents. The government does not belong in my medical, religious, or philosophical decisions.

State-produced online modules about vaccination will not be able to tell parents what they have not already heard many times before. It will not be effective, and will be a complete waste of energy, resources, and taxpayer dollars. These parents are essentially going to view this as a paid advertisement for the pharmaceutical industry, and nothing more.

Again, I ask that you give a "Do Not Pass" recommendation on HB1469. Thank you for reading!

01/24/2021

My name is Curtis Kadrmas and I am in opposition of HB 1469. I feel that the parents should make the decision for their children and no amount of "vaccination education module videos" is going to change our minds. Many parents, grandparents, or guardians have done extensive research themselves and have made an informed decision on why they choose not to vaccinate. Also, there are instances where the person themselves have been vaccine injured or know someone who has been vaccine injured which is why we started to look furter into vaccines and risks.
I feel that we, as a people, have the right to choose what is put into our bodies and not government. No one person knows what is right for another person better than the person themselves. We should not have any biased medical professional, DoH persons, or outside source force someone into something they do not agree with even if we are under "emergency status." Individual responsibility needs to be taken. As a grandfather of 3 very special children, I am also concerned that they will not be able to get an education due to religious beliefs we hold strong to. This is a discriminatory bill against our beliefs.

HB 1469 – HFND

STRONGLY OPPOSE – Please do NOT support this bill as it will force parents of school age children to take a ND Dept. of Health “Vaccination Education Module” before the are able to use a personal or religious exemption. As a parent, to make this choice comes with much personal research and is never done lightly. It is an educated health decision that parents are fully capable of doing on their own. To force or tie parents hands or make them jump through hoops to make a personal health decision for their family is wrong. Please oppose this bill.

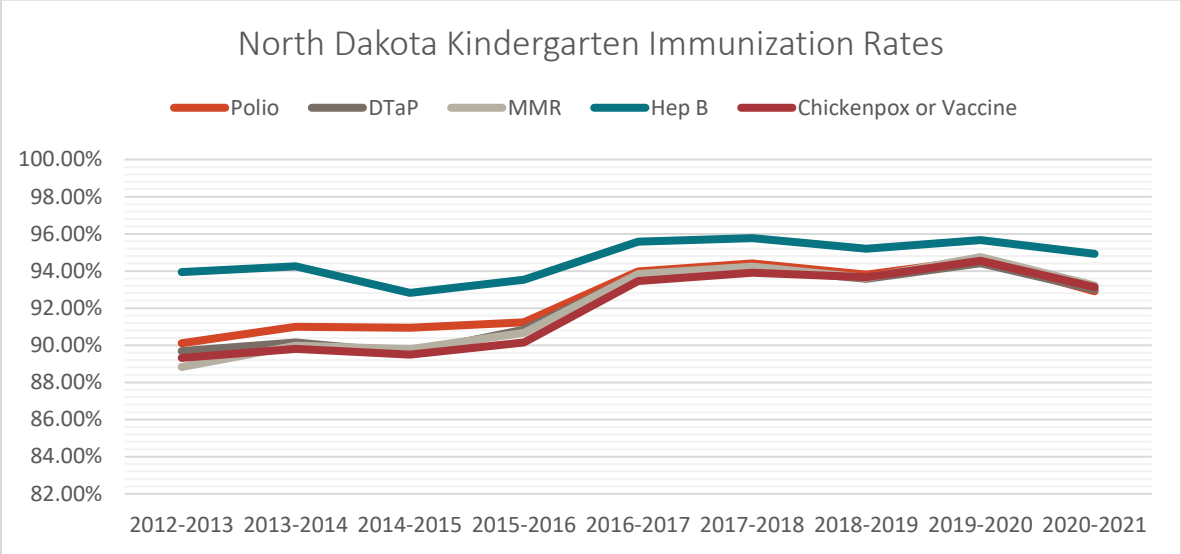
I am strongly in opposition to HB1469. We have three vaccine exemptions in ND and that's how it should stay. I don't need or want the Dept of Health's input on this matter. Any questions I may have, I can ask my children's pediatrician directly. My children's health decisions are my own. May God guide you to do the right thing and may He bless you all!

NORTH Dakota | Health
Be Legendary.™

House Bill 1469
Human Services Committee
January 25, 2021, 2:15 p.m.

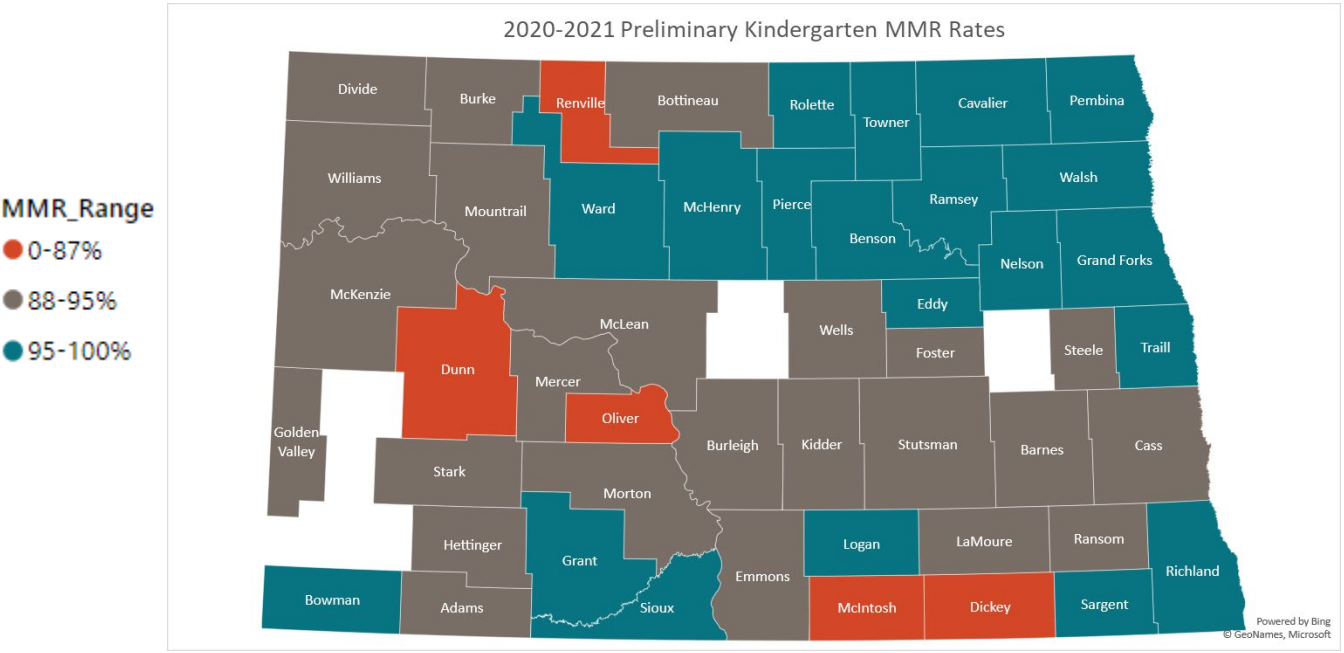
Good afternoon Chairman Weisz and members of the House Human Services Committee. My name is Molly Howell and I am the Immunization Director of for the North Dakota Department of Health. I do not have testimony for HB 1469 but wanted to let you know I am available virtually to answer questions if needed. If passed, the North Dakota Department of Health Division of Immunizations could use federal funding to develop the educational module described in HB 1469. Below is information about kindergarten immunization rates in North Dakota. Thank You.

Preliminary school immunization entry rates from this past school year show that 93.22% of kindergarten students were up-to-date for measles, mumps and rubella (MMR) vaccine. This is a decline from the previous school year, where the rate was 94.75%. Likely due to the COVID-19 pandemic, 48 schools haven't reported school immunization rates (down from last year) and many struggled with enforcement. Please see the chart below for historical kindergarten immunization rates in North Dakota. To achieve community (herd) immunity to measles, which is highly contagious, experts recommend a 95% vaccination rate. According to the Centers for Disease Control and Prevention, North Dakota ranked 21st in the nation for school MMR rates for the 2019-2020 school year.[1]

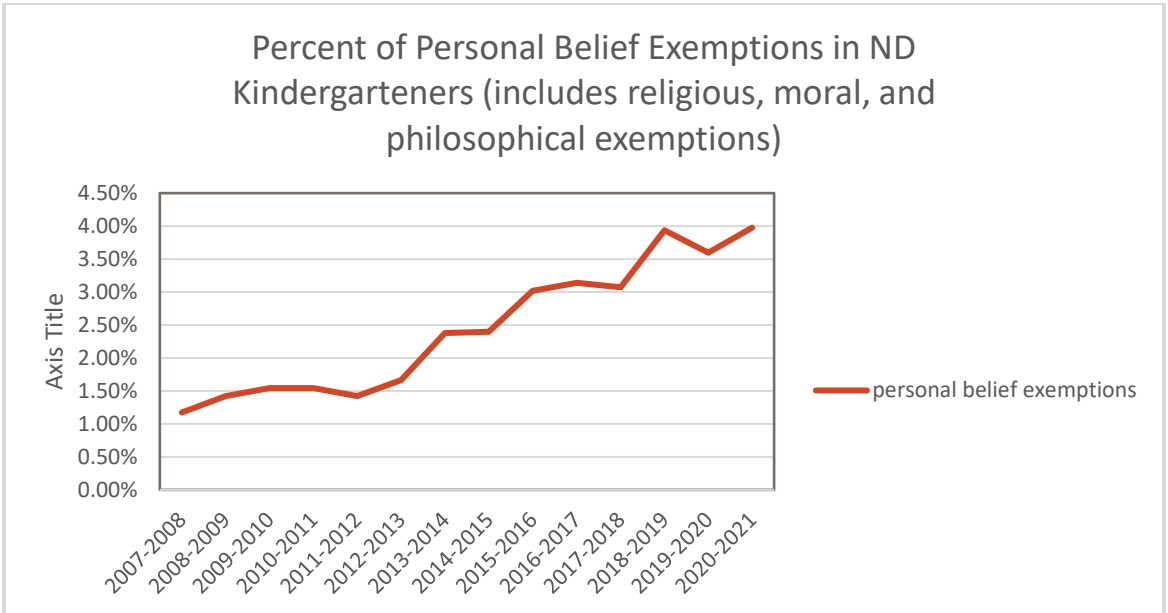


[1] SchoolVaxView School Vaccination Coverage | CDC

County MMR coverage rates range from 75% to 100%. School-level MMR rates range from 0% to 100%.



North Dakota kindergarten exemption rates have increased most years. This past school year, personal belief (philosophical, religious) exemption rates were 3.91% (395 children), up from 3.60% the previous year. Since the 2007-2008 school year, a 240% increase in exemptions has been reported in North Dakota. Please see the graph below for historical exemption rates.



Committee members, my name is Jocelyn Backman and I am writing IN OPPOSITION TO HB 1469 relating to exemptions from Vaccine requirements before admission to school; and to provide an appropriation.

My testimony on this bill will be short, it's already difficult for families to gain any exemption that we currently have (personal, religious, medical). Also, the people that do ask for exemption use for their children typically already have a Vaccine injured child or know of someone that has been Vaccine injured. Families that seek out an exemption to not vaccinate their children are extremely knowledgeable when it comes to Vaccines, which is why they know that they don't want their children to have them. If for any reason you decide to pass this bill, please make sure to include the other side in the education as well. If there is information to push vaccines, there also needs to be information from the other side (statistics of vaccine injury based on the vaccine being questioned, the last time there was an outbreak for the virus being vaccinated for, the symptoms of the virus that they are being vaccinated against {risks/benefits}, VAER's data on how to file a claim if there is an injury.

Please render a DO NOT PASS on HB1468.

Thank you for your leadership and service to our state.

HB 1469:

The public is bombarded with NDDOH biased advertising everywhere. It is on billboards, in social media, on the news, all over the schools, etc. Vaccination and inoculation should be a discussion between individuals and their medical providers who are knowledgeable about the benefits and the risks. Schools are responsible for educating children on FACTS and not OPINIONS and PROPAGANDA. Society is being damaged by these advertisements and NDDOH, there is absolutely no need to force individuals to be "re-educate" individuals. First because the video will only be presenting the reasons why NDDOH wants individuals to be vaccinated and it will not address all the risks and will not fully disclose the exemption options. The video is indoctrination and not education if it is not presenting ALL aspects.

I oppose HB 1469 As citizens of our fine state we should have the freedom to chose what is put in our bodies.

This bill is doesn’t provide for alternative action. For example, viewing a clip or video showing the negative possibilities of a vaccine as an alternative action.

Dear Chair and Committee members

Please support a do NOT pass on HB 1469

Thank you,

Bea Streifel

Not interested in watching a propaganda video based on false information.

Amy Thom

6480 Flickertail Drive

Bismarck, ND 58503

1/24/21

Representatives Dobervich, Buffalo, Guggisberg, Mock, Schneider

Senator Hogan

HOUSE BILL NO. 1469

To Whom it May Concern,
I am providing written testimony in opposition to this presented bill. We as parents are already pressured and often manipulated when it comes to vaccines. Risks are often not presented nor are inserts.
Thank you for your time.

Sincerely,
Amy Thom

January 24, 2021

This is my written testimony for HB 1469. I am asking you to vote No that will make parent watch a vaccine educational module, before we are able to get a personal or religious exemption. As a parent we should not have to have an extra step just to say no, especially when you as a parent know your children better than anyone, what they should not have that may cause harm.

Thank You,
Rosemary Ames

I am writing to ask for a NO vote on HB 1469. This bill requires you to watch a propaganda video put together by the NDDOH to "reeducate/indoctrinate" you before you can get an exemption for you or your children. We are already excessively pressured and manipulated by the NDDOH with their biased advertising which is completely void of the risks. Why is alright to give completely biased information to try to convince you to do something you have already spent time researching? This feels like peer pressure. This is just one more steps parents will have to jump through when this should always be a parents choice and never have to be pressured to do something to their child. This is an over reach, VOTE NO on HB 1469!

Dear Committee Member,

Please **reject** HB 1469 relating to exemptions from vaccine requirements before admission to school. This bill would unfairly discriminate against a child's parent or guardian making an informed medical decision of their own accord. Exemptions represent a natural right of a person to make an informed medical choice. Exemptions are ***not*** a civil right or status that can be granted by a local or state entity. It is the sole right of a parent or guardian to claim an exemption on behalf of their child.

I also believe that this bill sets forth the tone that a parent or guardian who has chosen to forego any vaccine has not received adequate education on the subject of vaccines and must participate in the education module set forth by the state. An education module could be offered but should not be required.

This bill also would also unfairly set forth discriminatory conditions on a child's *access to free and public education*.

Please uphold North Dakota's citizens' freedom of medical choice and submit HB 1469 with a **DO NOT PASS** recommendation.

Thank you for your consideration.

Austin Dvirnak

1120 Alder Avenue

Dickinson, ND 58601

HB 1469 I strongly urge you to “OPPOSE” this bill.

I have four children and have chosen to carry out their schooling at home. This is just one of the things that I have chosen for my children because, as their mother, I know what is best for them. I have ***never*** entertained the idea that a health care provider, or public health dept, cared about my children as much as I do. I sacrifice for them, I pray for them, and I make their health decisions because they are my children. Our practice of religion and living out our values is what makes my family mine.

Why have I told you all of this? Because I want you to know that my choosing to not vaccinate myself or my children is none of your concern, and I assure you that my decision is an informed one. Not the type of information that will surely be pushed in a $50,000 public health “Vaccination Education Module,” but real information.

Information about the billions paid out for medications that cause injury (knowingly) by the same companies that make vaccines.

Information about the millions of people who have been injured or killed by vaccines, though because of the passive system of reporting injuries to the Vaccine Adverse Events Reporting System (VAERS), even more go unreported.

Information about how vaccines can negatively affect health so that now **54% of US *children* have chronic health conditions**. It’s actually not surprisingly given our ramped-up use of vaccines since 1986 (in 1984 liability was taken away from pharmaceutical companies) when the number of “necessary” vaccines increased dramatically.

Information about vaccines lowering the immune response so that the body is more susceptible to illness. Many are deemed ineffective to prevent illness anyway.

Information about vaccines being grown in and tested on fetal cell lines from aborted babies and containing cell lines and retroviruses from various animal cells.

Information about the adjuvants and preservatives in vaccines that are known to be cancer-causing and toxic to the body and brain.

I have made decisions, educated decisions, to not vaccinate. I appreciate being able to claim medical, philosophical, or religious exemptions (though I’d like very much to not need to report this information at all). I don’t need public health to try and re-educate my way of thinking, nor do I trust their views regarding religion and values. I, like everyone else that I know who has chosen not to vaccinate, makes this choice because that is what is best for them and their family. I strongly disagree with this ploy of adding an “educational” requirement to make it more difficult for me to make that choice. You will likely hear from health providers claiming little risk, but they aren’t yet aware. Where there is risk, there must be choice, and I have made mine. Please <u>do not pass</u> this addendum of overreach.
Erin McSparron

Lisa Pulkrabek
4795 Co Rd 82
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Dear Human Services Committee Members,

I am writing to you today about HB 1469 Relating to exemptions from vaccine requirements before admission to school; and to provide an appropriation. I am NOT in FAVOR of this bill. I am urging a NO VOTE on HB 1469.

I do not feel that it is right to force parents to view a vaccine educational module before they are "allowed" to choose a religious or philosophical exemption for vaccination. It is fine to offer information to people, but forcing them to view or read it is unnecessary and unacceptable.

Parents of children under the age 18 who refuse vaccines for their children and patients who refuse vaccines for themselves, do so because they are informed and educated about vaccines far more than those who are blindly taking the vaccines just because the doctor's office and the government says that they should.

Again, I am urging a DO NOT PASS HB 1469.
THanks for your time!
Lisa Pulkrabek

Dear Chairman and committee members,

I am writing to you today in opposition of House Bill No. 1469.

Is education required for a patient who declines cortisone injections? Is education required for a patient who declines a hysterectomy? Is education required for a patient who declines a root canal? Is education required for a patient who declines an antibiotic? No. So why, in the “land of the free” would education be required to decline a vaccination? Why would we separate this intervention from the thousands of other available interventions?

Federal law specifically protects individuals from many forms of discrimination in the provision of healthcare services. Why should the patient’s right to choose not be protected in this instance?

The overreach included in the language of this bill opposes everything I was taught to protect as a Registered Nurse. My duty is to advocate for patients and honor their choices. If this education is required by North Dakota law, is my duty as a patient advocate abolished?

Thank you.

Brodi Alt, RN

Watford City, ND

January 24, 2021

RE: OPPOSE - (HB 1469 - A BILL for an Act to amend and reenact section 23-07-17.1 of the North Dakota Century Code, relating to exemptions from vaccine requirements before admission to school; and to provide an appropriation.)

Dear Chairman Weisz and Committee Members: My name is Jennifer Kadrmas and I am a North Dakota resident who resides in district 7.

I am in OPPOSE for HB1469

1. It is the use of coercion (Coercion is the practice of forcing another party to act in an involuntary manner by use of threats or force. It involves a set of various types of forceful actions that violate the free will of an individual to induce a desired response) by forcing a parent to watch a video provided by the state health department before they can be exempted due to reasons parents already had decided on their own.
2. Parents have the right to choose what is best for their family. They have either decided to choose the risk/benefit to not choose to vaccinate or due to ingredients being against their religious beliefs.
3. This is not informed consent as this video's goal is to increase vaccination rates, as this video will be like any other video and increase fear of the said disease and parrot the soundbites of safe and effective.
4. Per the documents **Immunization and Exemption Policies and Practices in North Dakota A Comprehensive Review and Recommendations for Improvement**, page 3 it states "Stakeholders overwhelmingly agreed that the process of obtaining an immunization exemption in the state of North Dakota is **too easy** and should be **strengthened**. The most common recommendation to strengthen the current policy was to require science-based immunization education from a healthcare provider or public health nurse for parents requesting a religious or personal belief exemption. This is **COERCION!!!** The whole basis of the Review is to increase vaccine uptake, which is not providing individual family choices. Vaccines can cause injury/death and an individual must have freedom to choose and not be bullied, coerced or pressured.

I hope you have a DO NOT PASS on this bill as it is a direct threat to the parental rights to choose what is best for families.

Sincerely,

Jennifer Kadrmas
District 7 resident

North Dakota State University Center for Immunization Research and Education

Immunization and Exemption Policies and Practices in North Dakota

A Comprehensive Review and Recommendations for Improvement

Kylie Hall, MPH, Danielle Pinnick, MPH, Nathan Fix, Rick Jansen, PhD, Abby Gold, PhD, Paul Carson, MD
6-13-2016

Executive Summary

North Dakota has experienced more than a decade of declining immunization rates. In 2000, 95% of North Dakota's kindergartners were fully immunized against diphtheria, tetanus, pertussis, measles, mumps, rubella, and varicella. During the 2014-2015 school year, North Dakota ranked as one of the five lowest states for kindergarten immunization rates, with only 89% of kindergartners fully immunized against these diseases. During the 2015-2016 school year, approximately 91% of kindergartners had received all of the recommended vaccinations.

These rates are well below the Healthy People 2020 goals of having 95% of kindergarteners fully immunized. This threshold is important to achieve herd immunity, which occurs when a critical percentage of the population is vaccinated against a disease. When herd immunity is achieved, outbreaks are prevented by limiting the spread of disease.

In addition to declining immunization rates, the state has seen a six-fold increase in the number of parents filing immunization exemptions. More than 3% of kindergartners had an immunization exemption on file during the 2015-2016 school year, whereas only 0.5% of kindergartners had an exemption in 2000. In private schools, the average rate of exemption is nearly twice the rate that is seen in public schools.

Furthermore, nearly 7% of kindergartners were unaccounted for in the school immunization survey data in 2015-2016. These students may be fully immunized without an immunization record on file at their school, they may be partially immunized, or they may not be immunized.

In North Dakota, children are required to show proof of immunization before entry into child care, school, or home-based instruction. Schools and child care centers are responsible for the collection of immunization records and exemption forms and the enforcement of state immunization requirements. Children who are not fully immunized according to state requirements have 30 days to receive any missing immunizations or they must be excluded from school.

North Dakota allows three types of immunization exemptions: medical, religious, and personal belief (philosophic/moral). North Dakota has been classified as one of the easiest states to obtain an immunization exemption; a physician's signature is required to obtain a medical exemption, but only a parent/guardian signature is required to claim a religious or personal belief exemption.

To better understand North Dakota's decreasing immunization rates, increasing exemption rates, and the large number of students with an unknown immunization status, the North Dakota Department of Health (NDDoH) engaged the North Dakota State University (NDSU) Center for Immunization Research and Education (CIRE) to study immunization policies and practices in the state. The CIRE was tasked with surveying immunization stakeholders about their beliefs regarding school and child care immunizations and exemptions in North Dakota. The CIRE was also tasked with researching other states' school and child care immunization enforcement and exemption laws and policies.

The stakeholder engagement process was done for three reasons:

1) To gain an understanding of the current state of immunization and exemption attitudes and opinions in North Dakota,
2) To facilitate meaningful participation in in-depth discussions on current immunization and exemption policies and practices in North Dakota, and
3) To make recommendations for potential policy, rule, or practice/process changes to the current immunization and exemption system in North Dakota.

The CIRE surveyed immunization stakeholders across the state by conducting focus groups and one-on-one interviews. Participating stakeholders included healthcare providers, public health employees, school officials, parents, legislators, and state government employees. The CIRE also reviewed and analyzed data, created a survey for North Dakota chiropractors, and compared immunization rates in enforcing and non-enforcing schools.

Stakeholders overwhelmingly agreed that the process of obtaining an immunization exemption in the state of North Dakota is too easy and should be strengthened. The most common recommendation to strengthen the current policy was to require science-based immunization education from a healthcare provider or public health nurse for parents requesting a religious or personal belief exemption.

Most schools around the state are not enforcing immunization requirements to the extent of excluding children who are noncompliant with immunization requirements. Many school administrators expressed displeasure that the enforcement of immunization requirements was a responsibility of the school system, and that excluding children from school presented a philosophical conflict for them as educators. School administrators from schools annually enforcing immunization requirements believed that immunization compliance was part of a safe and healthy school environment. Regardless of philosophy, many administrators understood why the school system is tasked with enforcement and agreed that partnerships with local public health units could help alleviate many of the barriers to full immunization compliance.

One important event happened after the commencement of the project that had an impact on results and recommendations. In October 2015, the Assistant Attorney General of North Dakota addressed school superintendents and reviewed North Dakota's immunization policies. This presentation called attention to the ability of the North Dakota Department of Public Instruction (NDDPI) to withhold funds from schools that were allowing children who were noncompliant with immunization requirements to attend school. The legal liability of non-enforcing schools in the event of an outbreak was also discussed.

Historically, very few in schools in North Dakota have strictly enforced immunization requirements. After the presentation, some schools and school districts decided to more strictly enforce immunization requirements, resulting in a study opportunity to evaluate the impact of enforcement in real time.

Immunization rates were compared in schools that enforced and did not enforce immunization requirements at the beginning of the 2015-2016 school year. Results showed that schools enforcing immunization requirements had significantly higher immunization rates than schools that did not enforce.

Immunization rates were also compared in three types of school districts from fall 2015 and spring 2016: 1) a school district that has annually enforced immunization requirements, 2) two school districts that began enforcing immunization requirements during the 2015-2016 school year, and 3) a school district that did not enforce immunization requirements to the extent of excluding noncompliant children during the 2015-2016 school year. The school district that regularly enforced immunization requirements did not see a significant difference in immunization rates, having met the Healthy People 2020 goal of 95% of kindergartners being immunized at both time points. The school district that did not enforce immunization requirements did see a small increase in immunization rates after making some efforts to improve immunization compliance, but they did not meet Healthy People 2020 goals. The largest increase in immunization rates came from the school districts enforcing immunization requirements for the first time in 2015-2016. Significant increases in immunization rates were observed, with enforcing schools meeting the Healthy People 2020 Goals for kindergarten immunization rates.

Overall, school enforcement of immunization requirements has the greatest potential to increase immunization rates in North Dakota. With 7% of students unaccounted for in school immunization data, bringing those students up-to-date with requirements or collecting records for those students could increase immunization rates above 95% in many areas of the state, as seen in two large school districts that began enforcing immunization requirements during the 2015-2016 school year. Even if the exemption process is made more difficult, decreasing the current immunization exemption rate of 3% will have much less impact on immunization rates compared to stricter school enforcement of immunization requirements. Nonetheless, the steady increase in exemption rates should not be ignored, and a policy change may be needed.

To improve immunization rates in North Dakota, the CIRE recommends the following changes, which are organized by policy, rule, and practice/process. Policy changes need legislative approval; rule changes need approval from the state health council; and practice/process changes are activities needed to increase immunization rates..

Policy Changes

- North Dakota should require parents and guardians to obtain the signature of a healthcare provider (physician, nurse practitioner, or physician's assistant) or public health nurse to receive a nonmedical exemption to immunization.
- The North Dakota Century Code language should be changed; specifically, moral and philosophic exemptions should be combined and jointly called "personal belief" exemptions.

Rule Changes

- North Dakota Administrative Rules state that the tetanus, diphtheria, and acellular pertussis (Tdap) booster and meningococcal conjugate (MCV4) vaccines are required for seventh grade entry. The rules should be changed to include the next higher grade each subsequent year to ensure that students who were not vaccinated at seventh grade or who are transferring to a North Dakota school are included in the requirement.

Practice/Process Changes

- The NDDPI, working closely with the NDDoH, should mandate the enforcement of school immunization requirements.
- If the policy change requiring the signature of a healthcare provider or public health nurse on the nonmedical exemption form is not deemed feasible or advisable, the NDDoH should limit access to the immunization exemption form. The immunization exemption form would only be available by request from the NDDoH. The form should not be readily available at schools or on the internet.
- The NDDoH should create a new immunization exemption form, which is separate from the Certificate of Immunization.
- The NDDoH and the NDDPI should modify the state immunization manual. The updated manual should include sample documents, current requirements, best practices, and frequently asked questions. This should be distributed and/or promoted among schools and local public health units.
- The NDDoH should provide more guidance to schools on the management of immunization compliance and exclusion for homeschooled children. In the school immunization survey, homeschool data should be collected separately.
- The NDDPI should incorporate immunization training opportunities for school administrators and staff to learn how to best incorporate immunization policies and practices into their schools.
- The NDDPI and school administrators should review the processes for determining average daily membership and the distribution of foundation aid to assure that schools are not financially penalized if children are absent from school because of noncompliance with state immunization requirements.
- The NDDPI and NDDoH should encourage all schools to track immunization status and compliance through the use of an electronic system.
- The NDDPI and NDDoH should better market the resources they have for schools regarding immunization compliance and the completion of the school immunization survey.
- The NDDoH should develop and target educational strategies for schools with persistently high immunization exemption rates, particularly private schools.
- All schools should follow the 30-day grace period outlined in the North Dakota Century Code (N.D.C.C.), and should exclude noncompliant students 30 days after the start of the school year or 30 days after enrolling in a school system.
- All schools should work closely with local public health units to improve immunization rates and compliance.
- Local public health units should create a memorandum of understanding with local schools so they can assist with immunization requirements and reporting.
- Local public health units should attend school registration events to provide and interpret immunization records, answer parent questions, and give missing immunizations.
- Schools should work with local public health units to enter out-of-state immunization records into the North Dakota Immunization Information System (NDIIS).
- Schools should consider hosting immunization clinics to achieve high immunization rates and full immunization compliance.

- Schools must follow-up with students who are in the process of receiving a series of immunizations every 30 days to ensure students are making progress towards full immunization compliance.
- The NDDoH should continue to work with other states on data sharing agreements to ease the process of accessing immunization records from out-of-state children.
- Local immunization stakeholders should meet yearly to discuss best practices, immunization clinics, potential collaborations, and concerns.
- The NDDoH should work closely with Lutheran Social Services, New Americans, healthcare centers providing care to New Americans, translators, and local public health units to develop culturally competent immunization materials and practices for New Americans to increase knowledge and help them overcome barriers to achieve immunization compliance.

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Introduction

Immunizations have been acknowledged as one of the 10 greatest public health achievements of the 20th Century.[1] They have helped eradicate smallpox from the globe and eliminate diseases such as polio and measles from many parts of the world.[1,2] Today, vaccines are routinely given to people of all ages in the United States for 17 infectious diseases.[i]

History of Vaccine Requirements and Exemptions in the United States

School vaccination laws have played a key role in the prevention and control of vaccine preventable diseases in the United States. In 1827, Boston was the first city in the United States to require a smallpox vaccination for children attending public school, and the state of Massachusetts was the first state to require smallpox immunization for school entry in 1855.[3,4] Other cities and states followed suit and adopted laws requiring immunizations for school entry. Today, all states have immunization requirements for school children, and school requirements have helped the United States achieve high vaccination rates.[3]

Immunization mandates have been contested within the United States court system. The United States Supreme Court has upheld immunization mandates on two separate occasions. In 1905 in *Jacobson v. Massachusetts*, the U.S. Supreme Court ruled that individual states could enforce compulsory vaccination laws in order to protect the public's health and safety. In 1922's *Zucht v. King*, the U.S. Supreme Court upheld a San Antonio, Texas city ordinance that prohibited children from attending school without a certificate of immunization for the smallpox vaccination.[4]

For those unable or unwilling to be vaccinated, immunization exemptions are available in each state. Individual states determine the exemptions available and the process by which exemptions are obtained. Exemptions can be categorized as either medical or nonmedical, and nonmedical exemptions can be further categorized as religious or personal belief exemptions. Personal belief exemptions are also known as philosophical, moral, and/or conscientious exemptions, and will be called "personal belief exemptions" from this point forward. Each state allows medical exemptions to immunization.[5] Two states, Mississippi and West Virginia, only allow medical exemptions for school children; California will only allow medical exemptions starting in July 2016. Other states allow nonmedical exemptions; in July 2016, 47[ii] states will allow religious exemptions, and 17[iii] states will allow personal belief exemptions in addition to medical and religious exemptions for school aged-children.[5,6] (Figure 1)

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[i] Diphtheria, Hepatitis A, Hepatitis B, Haemophilus influenza type b (Hib), Human Papillomavirus (HPV), Influenza, Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Poliomyelitis, Rotavirus, Rubella, Shingles, Tetanus, Varicella

[ii] As of July 2016, all states will allow religious exemptions for school entry except CA, MS, and WV

[iii] The following states will allow personal belief exemptions for school entry as of July 2016: AZ, AR, CO, ID, LA, ME, MI, MN, ND, OH, OK, OR, PA, TX, UT, WA, WI

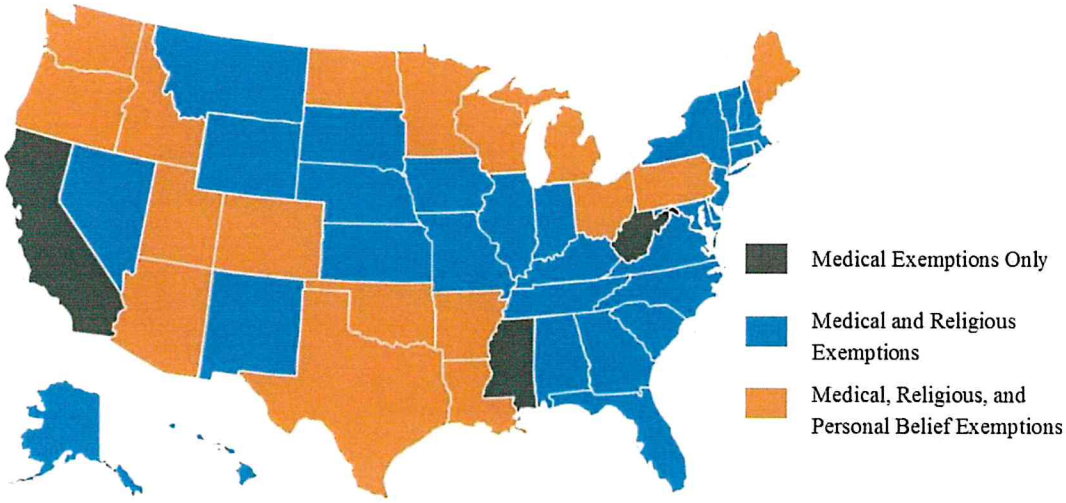

Figure 1. Immunization Exemptions Available by State, School-Aged Children, July 2016
Source: Centers for Disease Control and Prevention Public Health Law Center: State School and Childcare Vaccination Laws and Morbidity and Mortality Weekly Report: Vaccination Coverage among Children in Kindergarten – United States, 2014-2015 School Year

North Dakota's Immunization Policy

The North Dakota Century Code (N.D.C.C.) and Administrative Rules contain North Dakota's immunization policies and requirements. (Appendix A) The N.D.C.C. states "A child may not be admitted to any public, private, or parochial school, or day care center, child care facility, head start program, or nursery school operating in this state or be supervised through home-based instruction unless the child's parent or guardian presents to the institution authorities a certification from a licensed physician or authorized representative of the state department of health that the child has received age-appropriate immunizations..."[7]

North Dakota law allows children to be enrolled in school if they have not completed the immunization requirements but are in the process of receiving any remaining immunizations. Children who are not fully immunized before the start of school have 30 days to begin receiving the required immunizations, or they are to be excluded from school.[8]

The state allows for three types of immunization exemptions: medical, religious, and moral/philosophical (personal belief). Additionally, North Dakota allows a "history of disease" exemption for children with a reliable history of varicella (chickenpox). A physician's signature is required to obtain a medical exemption in North Dakota. A parent's signature is required for religious and personal belief exemptions. A physician or parent signature is required for a history of disease exemption, which can be filed for students with a reliable history of varicella. All exemption forms must be turned into a child's school before he/she can be admitted.[8] In the

event of an epidemic or outbreak of a vaccine-preventable disease in the state, unimmunized children may be removed from school for an extended period of time.[7]

In North Dakota, the Certificate of Immunization can be found online and must be filled out and signed by a healthcare provider or nurse. The Certificate of Immunization may also be printed by a healthcare provider or nurse from the NDIIS. In addition, this certificate serves as the state's Immunization Exemption Form. (Appendix B) Parents must submit the Certificate of Immunization or another immunization record to their child's school before a child can be admitted.[7]

The N.D.C.C. requires schools to enforce state immunization requirements. Schools must determine if children are compliant with school immunization requirements, notify the parents of children who are not, and after a 30-day grace period, exclude children not meeting school immunization requirements.[8] N.D.C.C. states that funding can be withheld from schools for allowing children to attend who do not meet state immunization requirements.[9,10] Children are deemed compliant with state immunization requirements if they are 1) fully immunized, 2) have an immunization exemption on file, or 3) are in the process of receiving missing immunizations. Children who are noncompliant with state immunization requirements are 1) not up-to-date with school required immunizations, 2) do not have an immunization record on file at the school, 3) are not immunized, and/or 4) do not have an exemption on file at the school.

In North Dakota, immunizations were first required for school entry at the start of the 1975-1976 school year. That year, required immunizations were diphtheria, tetanus, pertussis, polio, measles, mumps, and rubella. At the start of the 2000-2001 school year, religious and personal belief exemptions were added, along with the requirement for immunization against hepatitis B. During the 2004-2005 school year, a vaccination requirement for varicella was added to the school requirements along with a history of disease exemption for chickenpox disease. In 2008, a tetanus, diphtheria, and acellular pertussis booster and meningococcal vaccines were made a requirement for middle school entry. These two vaccines are now required for entry into seventh grade.[8,11]

Schools and child care centers are responsible for the collection of immunization records and immunization exemption forms. The enforcement of immunization requirements is the responsibility of the "institutional authority"; the institutional authority can be anyone designated by the governing body of an institution.[8] Most often, the institutional authority of a school is a superintendent.

Enforcement of school immunization requirements can impact federal and state funding for schools. N.D.C.C. states that "the superintendent of each school district shall ensure that schools comply with all health, safety, and sanitation requirements."[10,12] If a school district violates this requirement and does not take necessary corrective action, the NDDPI can impose sanctions.[9] The sanctions may result in a fine of one thousand dollars per occurrence.[12]

Because state and federal funding are partially based on school attendance, schools may be financially impacted by the exclusion of noncompliant children. Currently, federal education law states that schools must meet adequate yearly progress (AYP), which is measured by

standardized test scores and attendance for children in grades kindergarten through eighth grade and test scores and graduation rates of children in grades nine through twelve. If a certain percentage of students do not attend school for a certain number of days, the school does not meet AYP. When this occurs for two consecutive years, schools can lose discretionary funds and some authority when determining how to spend federal dollars.[13] Additionally, state funding for school districts is based on average daily membership: the total number of school days all children were enrolled in a school divided by the number of school days.[14] Therefore, when children are excluded from school for being noncompliant with immunization requirements, it has the potential to impact school funding.

To collect immunization data, North Dakota uses the NDIIS and the school immunization survey. The NDIIS is a statewide database that collects vaccination data in North Dakota, as N.D.C.C. requires childhood immunizations given in the state to be entered into the NDIIS.[15] It provides up-to-date information on immunization rates, consolidates vaccination records of children from multiple healthcare providers, generates reminder and recall vaccination notices for children, and provides vaccination forms.[16]. School staff are able to access the NDIIS, which assists with the collection of immunization records.

The school immunization survey is another data collection tool and is completed by each school in the fall for the NDDoH. The school survey collects aggregate data from each school on the number of children enrolled by grade, the number of children in each grade immunized against specific diseases, and the number of children that have medical, religious, or personal belief exemptions to immunization by grade. School survey data is sent to the Centers for Disease Control and Prevention (CDC) to compare immunization rates by state.

Project Background

During the 2014-2015 school year, North Dakota ranked as one of the five lowest states for kindergarten immunization rates, with only 89% of kindergartners immunized against diphtheria, tetanus, pertussis, measles, mumps, rubella, and varicella.[6,17] (Figure 2) During the 2015-2016 school year, the percentage of North Dakota kindergarteners fully vaccinated against the same was 91%.[17] In 2000, approximately 95% of North Dakota kindergarteners were fully immunized against the same diseases. These rates represent more than a decade of steadily decreasing immunization rates among children in North Dakota. (Figure 3)

In addition to declining immunization rates, North Dakota has seen a six-fold increase in the number of parents claiming an exemption to immunization. In 2000, only 0.5% of kindergartners had an exemption to immunization. In 2015-2016, 3.3% of kindergartners had an exemption to immunization, 73% of which were reported as a personal belief exemption.[6,17] (Figure 3)

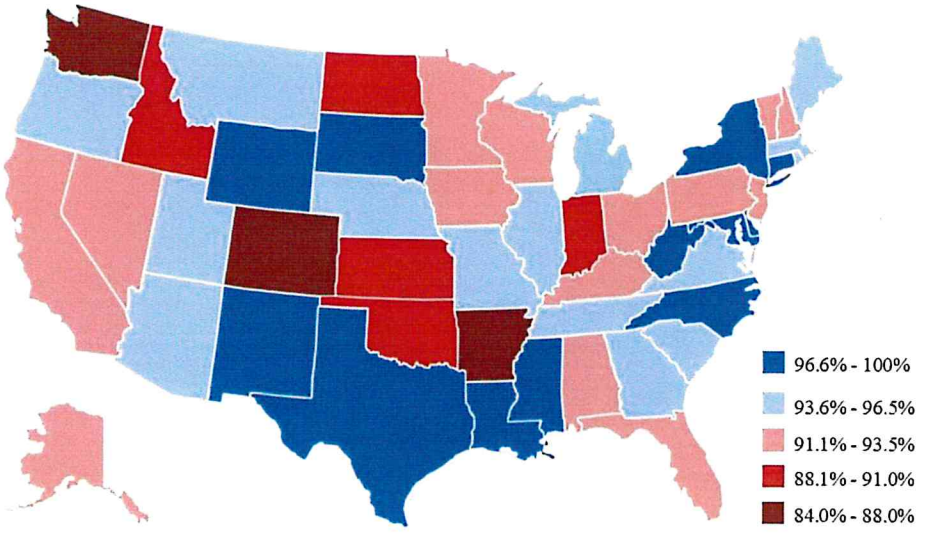

Figure 2. Average Kindergarten Immunization Rates by State for DTaP, MMR, and Varicella (where applicable), 2014-2015 (Hawaii Data Not Available)
Source: Centers for Disease Control and Prevention

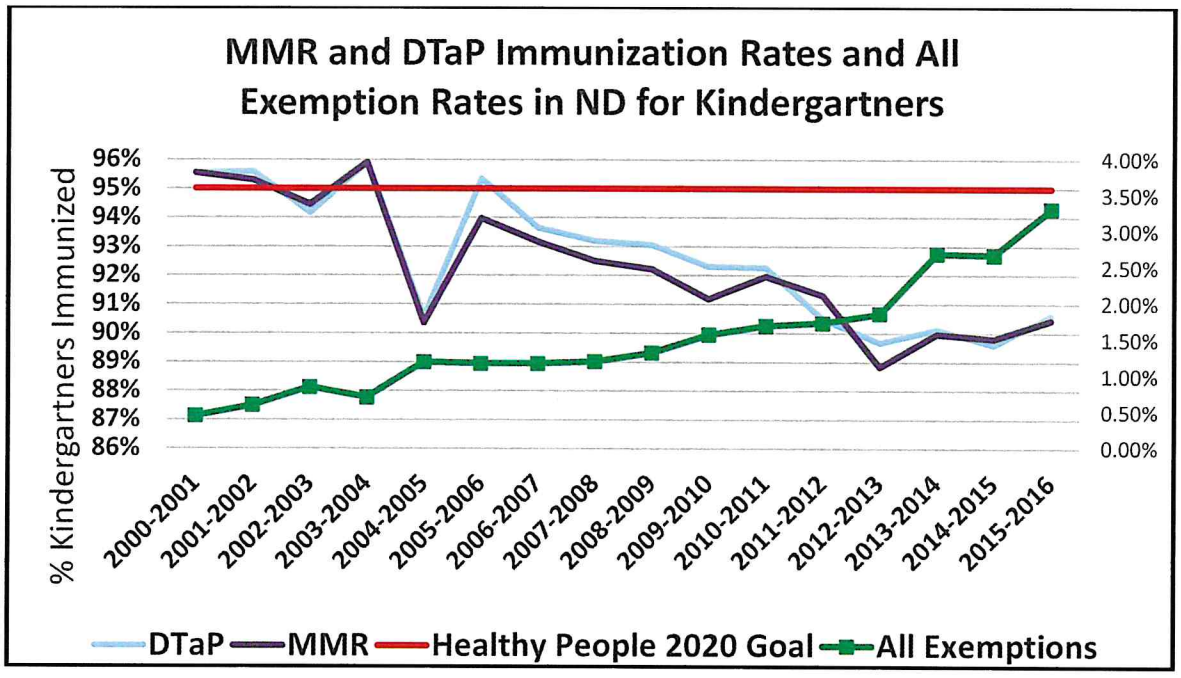

Figure 3. Kindergarten Immunization and Exemption Rates, 2000-2015; Includes Data for Medical, Religious, and Moral/Philosophic Exemptions
Source: North Dakota Department of Health, Centers for Disease Control and Prevention
**Graph updated with revised data on May 18, 2016.*

North Dakota's low immunization rates and higher than average exemption rates are not reflective of the entire kindergarten population or problem. During the 2015-2016 school year, nearly 7% of kindergartners were unaccounted for in the school immunization survey data. These students all have an unknown immunization status; 2% of kindergartners do not have immunization records on file at their schools, while the remaining students may be partially immunized or unimmunized. Regardless of their true immunization status, this population of North Dakota's kindergartners is reported as not up-to-date in the school immunization survey until their record is provided to their school or they receive their missing immunizations.

North Dakota has also recently experienced a large increase in state population. According to the United States Census Bureau, North Dakota ranks as this decade's fastest growing state.[18] Much of the population increase can be attributed to an oil boom in the western part of the state. This has filled many schools to capacity, increased the number of students entering school systems from out-of-state, and made the collection of immunization records and the enforcement of school immunization requirements difficult to complete.

Because of falling school immunization rates, increasing exemption rates, and a large percentage of students having unknown immunization status, the NDDoH engaged the NDSU CIRE to study North Dakota's immunization policies and practices and make recommendations for potential policy, process, and rule changes in the state. Specifically, the NDDoH asked the CIRE to survey immunization stakeholders as to their beliefs regarding school and child care immunizations and exemptions in North Dakota. The CIRE was also tasked with researching other states' school and child care immunization enforcement and exemption laws and policies.

The stakeholder engagement process was done for three reasons:

1) To gain an understanding of the current state of immunization and exemption attitudes and opinions in North Dakota,
2) To facilitate meaningful participation in in-depth discussions on current immunization and exemption policies and practices in North Dakota, and
3) To make recommendations for potential policy, process, and/or rule changes to the current immunization and exemption system in North Dakota.

Finally, the following event happened after the commencement of the project. It was not done in conjunction or as part of the project, but it had an impact on project results and recommendations and is worth mentioning.

In October 2015, the Assistant Attorney General of North Dakota addressed North Dakota's school superintendents at the annual North Dakota School Boards Association Conference to review North Dakota's immunization laws and rules for schools. The Assistant Attorney General reviewed state immunization requirements listed in the N.D.C.C. with school superintendents, calling attention to the ability of the NDDPI to withhold foundation aid from schools allowing children who are noncompliant with state immunization requirements to attend school. The legal liability of non-enforcing schools in the event of an outbreak was also discussed.

Historically, very few schools in North Dakota have enforced state immunization requirements to the extent of excluding children who are noncompliant with state law. Following the meeting,

some schools and school districts decided to more strictly enforce immunization requirements. This resulted in a study opportunity to evaluate the impact of enforcement on immunization rates, exemption rates, absenteeism rates and duration for noncompliant children, and workforce demands in some of these school districts.

Methodology

Data Collection

Immunization data was collected and analyzed from the NDDoH, CDC, and the Association of Immunization Managers (AIM). This included data from the North Dakota school immunization survey, data from the NDIIS, CDC Morbidity and Mortality Weekly Reports, and AIM surveys.

Immunization rates in North Dakota were analyzed by school district, school, and county. Epi Info™ was used to map kindergarten immunization rates by county for the 2015-2016 school year. Immunization rates for each county were calculated by averaging the immunization rate of diphtheria, tetanus, and pertussis (DTaP); measles, mumps, and rubella (MMR); and varicella in each county.

Evaluating the Effect of School Enforcement Policy on Immunization Rates

During focus groups, school administrators and staff shared their varying immunization and enforcement practices. Using the information gathered in focus groups, the CIRE classified schools and school districts based on enforcement practices. Then, immunization rates were compared between 1) schools from two large school districts annually enforcing immunization requirements and 2) schools from five large school districts not enforcing immunization requirements. The CIRE hypothesized that schools enforcing immunization requirements at the beginning of the 2015-2016 school year would have higher kindergarten immunization rates than schools not enforcing immunization requirements. Kindergarten immunization rates reported in the school immunization survey were provided by the NDDoH.

Kindergarten immunization rates were compared for polio; diphtheria, tetanus, and pertussis; measles, mumps, and rubella; hepatitis B; and varicella in 60 schools using a t-test comparing weighted least squares means with a Tukey-Kramer adjustment for multiple comparisons (statistically significant cutoff p-value = 0.05).

Evaluating Immunization Rates Before and After Enforcement

As previously mentioned, following the school superintendents' meeting with North Dakota's Assistant Attorney General at the annual School Boards Association Conference, some school districts decided to more strictly enforce immunization requirements. The CIRE hypothesized that school districts deciding to enforce immunization requirements during the middle of the 2015-2016 school year would see a significant increase in immunization rates after the enforcement of school immunization requirements and the exclusion of noncompliant children.

The CIRE also hypothesized that enforcement of immunization requirements could increase the number of parents filing for nonmedical exemptions.

To test the hypothesis, the CIRE reached out to four, large school districts and asked if they would repeat the school immunization survey in the spring of 2016 and report their updated immunization rates post-enforcement. Three types of school districts were selected: 1) a school district that has regularly enforced immunization requirements, 2) school districts that began enforcing immunization requirements during the 2015-2016 school year, and 3) a school district that increased its efforts toward compliance but did not enforce immunization requirements to the extent of excluding noncompliant children. School districts were classified according to enforcement policies disclosed in school focus groups.

School-reported rates from the school immunization survey completed in November of 2015 were used as a comparison, and data was aggregated by district. School nurses, secretaries, and staff provided the updated immunization rates and exemption rates.

A t-test comparing weighted least squares means with a Tukey-Kramer adjustment for multiple comparisons was used to determine if changes in immunization rates were significant (statistically significant cutoff p-value = 0.05).

Review of Literature and Other States' Policies and Procedures

Because each state determines its immunization requirements, available exemptions, and practices, state policies and practices are extremely variable. Each state's immunization policies and practices were examined to understand immunizations requirements, types of exemptions allowed and the process for obtaining exemptions, who enforces immunization requirements and how they're enforced, how immunization rates are collected and reported, and other practices.

To gather this information, many resources were used, including the CDC's Kindergarten Vaccination Coverage Reports and the CDC's Public Health Law Program's compilation of school immunization requirements. To gather specific components of individual state's school immunization requirements and exemption policies, the CIRE reviewed state policies obtained from each state's department of health website. In addition, national surveys on state immunization enforcement practices were reviewed. Lastly, if state laws, policies, and practices were still unclear, each state's immunization management division was contacted through email or phone to seek clarification and information.

To better understand the correlation between immunization policies and practices and immunization and exemption rates, a systematic review of the literature was conducted using PubMed and the NDSU Library Herd Search application. Specifically, literature was found by searching for the term "vaccine exemption" and refining the search to include "exemption(s)" and "health policy" from 2010-present. The role personal belief exemptions have played in the increase of vaccine preventable diseases in the United States was reviewed, as well as the financial impacts, clustering of those individuals seeking exemptions, effects of policy change, and availability of personal belief exemptions.

Stakeholder Engagement: Focus Groups and One-on-one Interviews

Sector-specific focus groups were conducted throughout the state in seven of North Dakota's largest cities: Fargo, Grand Forks, Bismarck, Mandan, Minot, Dickinson, and Williston. The following immunization stakeholder groups were targeted for participation: family medicine and pediatric healthcare providers, including doctors, physician's assistants, nurse practitioners, nurses and clinic staff; public health employees, including public health nurses and staff; school administrators, nurses and staff; parents; and state government employees from the NDDoH, NDDPI, North Dakota Attorney General's Office, and the North Dakota Governor's Office.

To recruit participants for focus groups, an immunization stakeholder was contacted for each stakeholder group in each city. This stakeholder often held the position of a lead physician, director of nursing, vaccine coordinator, school administrator, or another similar title. Once contacted about the project and having expressed their willingness to participate, the CIRE Project Manager and each local stakeholder worked together to schedule focus groups and determine invite lists of appropriate stakeholders in the region.

At the beginning of each focus group, participants were shown a brief presentation on the current state of immunizations in North Dakota and informed about the state's immunization policies and practices. (Appendix C) Stakeholders were then asked a series of sector-specific questions regarding immunization attitudes, beliefs, policies, and current practices. Lastly, they were asked for their opinions on potential immunization policy changes in the state. (Appendix D) Questions were written or selected in conjunction with the NDDoH; questions were selected because of their relationship to project objectives and by reviewing pertinent literature.

Telephone interviews were conducted with state legislators, those unable to attend focus groups, and others recommended as immunization stakeholders during focus groups and interviews. Interviewees were asked to review the aforementioned presentation before the interview. Interviewees represented various stakeholder groups from both urban and rural areas of the state.

Chiropractor Survey

Many stakeholders shared that there are several anecdotal cases of chiropractors in the state sharing misleading information about vaccinations to their clientele, and one chiropractor was holding seminars to "inform" people about vaccinations. The CIRE believed it was important to have a sample of North Dakota chiropractors' attitudes, beliefs and practices regarding immunizations, and a survey was created for North Dakota's chiropractors based on previous chiropractic surveys and also based on input from the NDDoH and the North Dakota Chiropractic Association (NDCA). (Appendix E)

The CIRE worked with the NDCA to distribute the electronic survey link through their membership listserv in their bi-monthly newsletter. There are approximately 250 NDCA members in the state out of approximately 400 total chiropractors.

Results

Data Collection

Immunization rates vary greatly between counties. Counties in the western part of the state, where a recent oil boom has led to rapid population growth, reported lower immunization rates. (Figure 4)

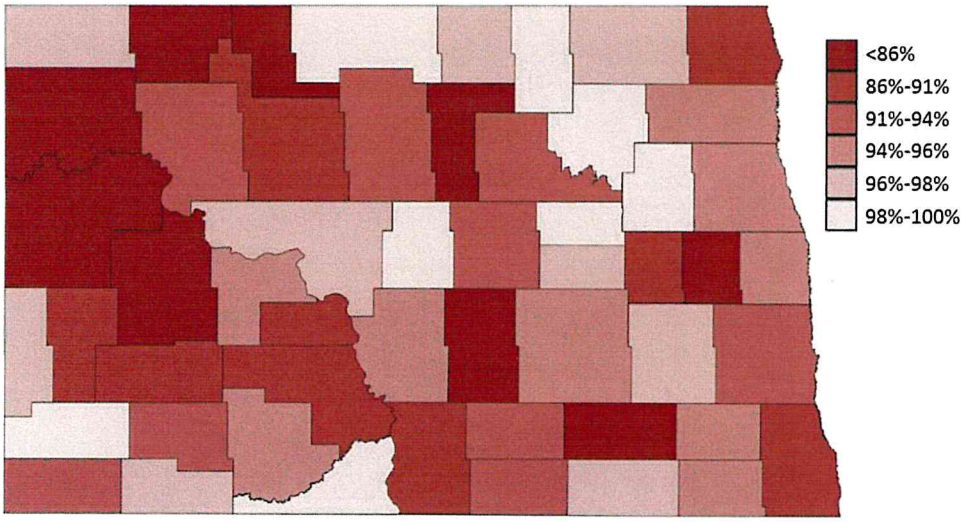

Figure 4. Kindergarten Immunization Rates by County, 2015-2016; Includes 2014-2015 Kindergarten Immunization Rates for Slope County
Source: North Dakota Department of Health

According to the 2014 North Dakota Epidemiology Report and the NDDoH (A. Barber, written communication, May 2016), private schools have higher kindergarten exemptions rates than public schools. For the 2015-2016 school year, exemption rates in private school were near 6%, while public school exemptions were approximately 3%. (Figure 5)[19]

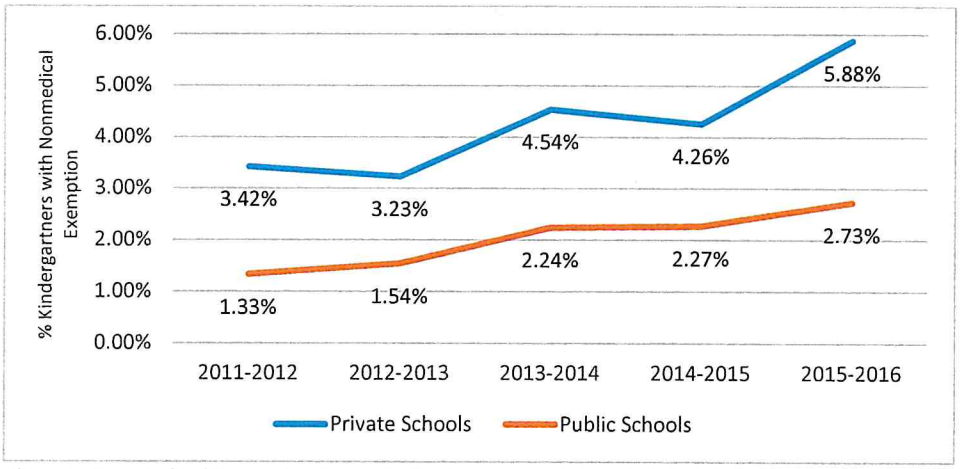

Figure 5. Nonmedical Exemption Rates for Kindergartners in North Dakota's Public and Private Schools
Source: North Dakota Department of Health

Evaluating the Effect of School Enforcement Policy on Immunization Rates

After analyzing data from the school immunization survey, it was determined that kindergarten immunization rates for all required immunizations were significantly higher in the schools that enforced immunization requirements at the beginning of the 2015-2016 school year than the schools that did not enforce immunization requirements. Immunization rates for polio, DTaP, MMR, hepatitis B, and varicella were significantly higher in enforcing schools. (Figure 6) As a group, enforcing schools achieved the Healthy People 2020 goals for kindergarten immunization rates for all of the required immunizations, whereas none of the goals were met in the non-enforcing schools.

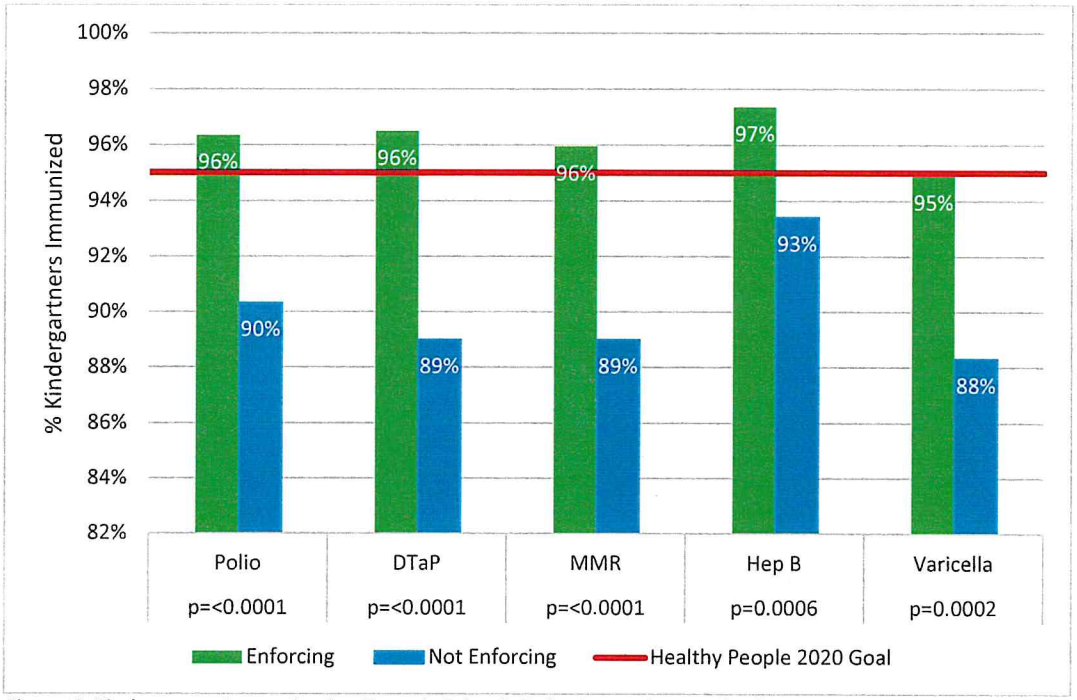

Figure 6. Kindergarten Immunization Rates in Schools Enforcing and Not Enforcing Immunization Requirements, Fall 2015
Source: North Dakota Department of Health

Evaluating Immunization Rates Before and After Enforcement

After analyzing immunization rates from fall 2015 and spring 2016, it was determined that immunization rates were higher for all vaccines in the school districts that began enforcing immunization requirements compared to the school district that did not enforce immunization requirements. Figures 7 and 8 show immunization rate changes for DTaP and MMR.

In the school district annually enforcing immunization requirements, immunization rates were consistently high and there was not a significant change in immunization rates from fall 2015 to spring 2016. In the two school districts that decided to enforce immunization requirements, there was a significant increase in immunization rates for all vaccines, and the school districts achieved immunization rates above 95%, reaching the Healthy People 2020 goal for kindergarten immunization rates. In the school district that did not enforce immunization requirements, there was an increase in immunization rates, but they were not able to achieve the Healthy People 2020 goals of a 95% coverage rate. This increase may be attributable to increased efforts to

improve immunization compliance short of excluding noncompliant children during the 2015-2016 school year.

Of note, significant increases were not seen in the number of parents filing nonmedical exemptions in schools that began to more strictly enforce immunization requirements. Additionally, schools noted that very few children were excluded because of noncompliance. One principal stated, "We ended up withholding two individuals for a short period of time, and then they were back in school. It was just a couple of days."

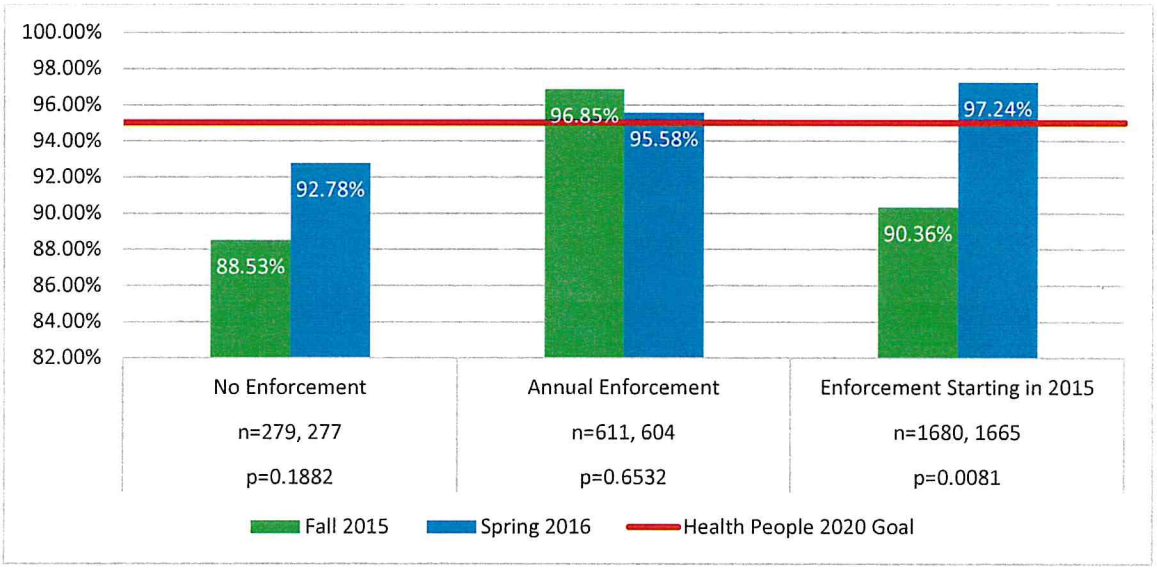

Figure 7. MMR Immunization Rates for Kindergartners in School Districts Before and After Assistant Attorney General's Notification in October 2015, Grouped by Enforcement Practices

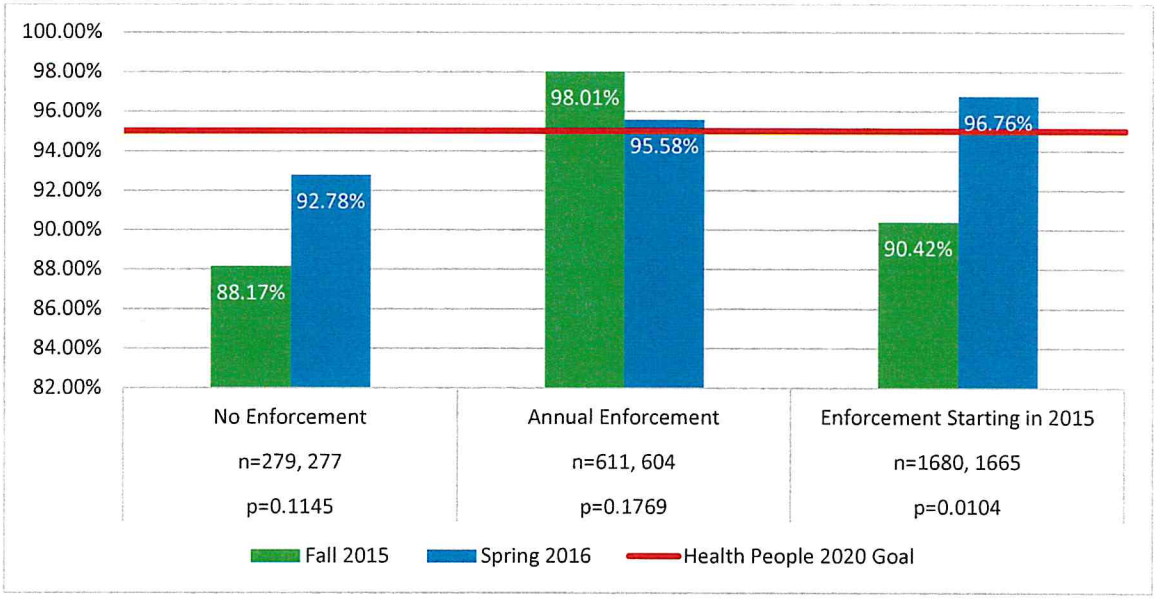

Figure 8. DTaP Immunization Rates for Kindergartners in School Districts Before and After Assistant Attorney General's Notification in October 2015, Grouped by Enforcement Practices

Literature Review: State by State Policies and Practices

Upon reviewing every states' immunization policies and practices, it was determined that immunization policies, practices, requirements, enforcement, and record collection vary greatly from state to state. (Appendix F)

Each state determines which immunizations are required for school and child care entry, at what ages the immunizations are required by, and how many doses of each vaccine are required. Most states, including North Dakota, follow age-appropriate immunization recommendations put forth by the Advisory Committee of Immunization Practices (ACIP), while some states determine their own requirements.

Currently, every state requires kindergarten immunization against pertussis for school entry except for Pennsylvania. Thirty-nine states require varicella vaccination. Usually, two doses of the measles, mumps, and rubella vaccine are required for school entry, but in Alaska, California, and Oregon, the number of required doses against each disease varies for school entry. In these states, two doses of the measles vaccine are required while only one dose of the mumps and rubella vaccines are required. However, many children in these states have received two doses against measles, mumps, and rubella because the vaccine against these diseases is only readily available as a combination vaccine in the United States.

Each state is also able to decide which types of immunization exemptions are allowed and the process by which these exemptions are granted. Every state allows for medical exemptions to vaccination, which can be granted to children whose immune status may be compromised, who might have a serious allergic reaction to a vaccine component, or who have had a prior adverse event following vaccination. Currently, West Virginia and Mississippi allow only medical exemptions. In July 2016, California will become the third state to allow only medical exemptions.

Religious exemptions to immunization are intended for parents whose religious affiliation or belief conflicts with vaccination. Currently, 48 states allow religious exemptions to immunization; in July 2016, only 47 states will allow a religious exemption. A recent review of the world's major religions found that most religions do not object to immunization and believe in preservation of life, caring for others, and duty to community. The review found that Christian Scientists and a subset of the Dutch Reformed Church may be two exceptions. The review did state that smaller denominations, sects, and branches of certain religions may oppose immunization, but these beliefs do not follow the overarching beliefs of the religion.[20]

Lastly, personal belief exemptions to immunization are intended for parents whose personal beliefs conflict with vaccination. Personal belief exemptions to immunization are allowed for school entry in 18 states. In 2015, Vermont became the first state to remove personal belief exemptions from its vaccination law, and the state will only allow medical and religious exemptions beginning in July 2016.

The process for obtaining an immunization exemption differs in every state and ranges in difficulty to complete. North Dakota has been recognized as one of the easiest states to get a nonmedical immunization exemption.[21]

In many states, including North Dakota, medical exemptions forms must be signed by a healthcare provider when a child enters kindergarten and seventh grade. The healthcare provider must also indicate which vaccines are included in the medical exemption. In other states, such as Mississippi, the medical exemption form must be signed by a physician and then approved by the state health department. Some states require the medical exemption to be renewed yearly, while others only require the exemption be renewed for children in kindergarten and middle school.

Parents and guardians in North Dakota wishing to file for a religious or personal belief exemption need to sign an exemption form and turn it in to their child's school. This form is easily accessible online or by other means. On this form, parents must indicate which vaccines are being declined. In other states, the process is much more rigorous. For example, in Alaska, the religious exemption form must be notarized and renewed yearly. In New Jersey, a written statement from the parent explaining the religious belief is sufficient to file a religious exemption. Of the 48 states that currently allow a religious exemption, only seven[iv] states, including North Dakota, require only a parental signature.

Some states allowing personal belief exemptions require parental education before an exemption can be granted. In Oregon, parents must visit with a healthcare provider or complete an online vaccine education module to be granted an exemption. In other states, the exemption form must be notarized or the exemption must be renewed yearly. Of the 17 states that allow personal belief exemptions, only three[v] states, including North Dakota, require only a parental signature. The other 14 states require an additional step(s) beyond a parental signature.

In some states, accessing the exemption form(s) is laborious. In Texas, parents wishing to file a personal belief exemption must complete an electronic affidavit request. After submitting an electronic request form, the Texas Department of State Health Services Immunization Branch mails parents the appropriate forms for their request. In other states, the form is only available from a healthcare provider or a local public health unit.

North Dakota also allows a "history of disease" exemption for the varicella vaccination. A physician, parent, or guardian must sign the exemption form stating a child has had the chickenpox to be exempt from this vaccination. All states allow immunization exemptions for a reliable "history of disease", but in some states, proof of immunity via laboratory confirmation is required.

The ways in which immunization records and rates are collected and reported also varies by state. In North Dakota, all immunizations given in the state are entered into the state

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[iv] Arizona, Maryland, North Dakota, Oklahoma, Rhode Island, Washington, and Wisconsin require only a parental signature for religious exemptions. Other states require additional steps, such as a signature from a religious officials, notary signature, or yearly renewal.

[v] Arizona, North Dakota, and Wisconsin only require a parental signature. Other states require additional steps, such as yearly renewal, notary signature, or education.

immunization registry, the NDIIS. Immunization records from out-of-state can also be entered into the system when a person moves into the state. Across the country, each jurisdiction determines if and how immunizations are recorded in a database. Currently, a national immunization registry does not exist, but every state except New Hampshire does have an immunization registry. Some large cities also have their own registries, including New York City, Philadelphia, and the District of Columbia.

All North Dakota schools are required to collect immunization records from each student and report immunization and exemption rates to the NDDoH. Not all states conduct immunization surveys of their school populations. Some states sample the population to estimate overall immunization rates.

Every state sets their own laws regarding school enforcement of immunization requirements and possible exclusion of students who are noncompliant with state laws. Many states will exclude children from school who do not meet state immunization requirements, but policies and practices vary from state to state and even within states.

In the event of an outbreak, many states have determined that it is in the best interest of children with immunization exemptions if they are removed from school until the threat of the outbreak has passed. Twenty-seven states have the authority to exclude unimmunized children during an outbreak.[5] Depending on the infectious disease causing the outbreak and the threat to the community, children could be removed from school for an extended period of time.

Literature Review: Immunization Rates, Exemption Rates, and Outbreaks of Vaccine-Preventable Diseases

As a result of immunization exemptions being widely available and parents claiming exemptions in increasing numbers, the United States has seen an increased incidence in the number of vaccine-preventable diseases, including measles, pertussis, and mumps.[21,22] In many areas of the United States, immunization rates have fallen below 95%, the immunization rate commonly recognized as needed to prevent outbreaks of highly-infectious diseases.[6,23]

Many factors have contributed to declining immunization rates and increasing exemption rates, including parental concerns about vaccines and the availability of immunization exemptions. Currently, many parents are concerned about the safety and efficacy of vaccines, the ingredients in vaccines, and the number of vaccines and doses of each vaccine given to children.[24] In addition to parental concerns, systematic processes can affect the effectiveness of a state's policy and can make the exemption process easier or harder for parents seeking an exemption to immunization.

Bradford et al ranked states on the effectiveness of their vaccination laws and policies as "most", "somewhat", "less", or "least" effective. Then, the study compared states' pertussis rates against the effectiveness of their vaccine policy. It was determined the states with the most effective policies had lower incidence rates of pertussis.

In states where the process for obtaining an exemption is very simple, exemption rates tend to be higher; in states that make the process more burdensome or inconvenient, immunization rates tend to be higher. Omer et al compared exemption rates in states that allow and don't allow personal belief exemptions. The study also classified the process for obtaining an exemption as "easy", "medium", or "hard". The study showed significantly higher rates of nonmedical exemptions in states that allow religious and personal belief exemptions versus states that only allow religious exemptions. The study also found higher nonmedical exemption rates in states where the process of obtaining the exemption is "easy".[21]

Conversely, Olshen et al found that the availability of a personal belief exemption did not correlate with exemption-seeking among certain demographics and locales. In this study, researchers found that school immunization mandates were the main factor leading to higher immunization rates, highlighting the importance of school immunization requirements.[25]

Because exemptions are widely available, some studies have tried to determine the factors that predict immunization exemption seeking among parents. Many studies have determined that exemption rates are higher in private schools.[26–28] Other factors that have been correlated with higher exemption rates include parents who are wealthy; have vaccine concerns, specifically about safety; have a distrust of or don't use traditional medicine; and have knowledge of someone who was injured by a vaccine.[27,29,30]

In areas with low vaccination rates, vaccine-preventable diseases can make a comeback. Yang et al studied the relationship between vaccine exemptions and the incidence of vaccine-preventable diseases. This study found that states with more restrictive exemption policies had lower incidences of vaccine-preventable disease.[31]

In 2003, Arkansas revised their immunization policies by adding a philosophic exemption to vaccination. Exemption rates increased each year from 2003-2010, with an average increase each year of 23.1%. Nonmedical exemptions in this state do cluster geographically, but higher exemption rates have not yet been linked to an outbreak of a vaccine-preventable disease.[32,33]

Adding personal belief exemptions to school exemption policies can be costly. Wells and Omer estimated the medical and nonmedical costs of pertussis disease in the state of Iowa with and without a personal belief exemption. They determined that the impact of adding a personal belief exemption in Iowa would be a 50% increase in medical and nonmedical costs per year; this includes an expected 50% increase in pertussis cases in Iowa, which would be expected due to the addition of the personal belief exemption.[34,35]

Focus Groups and One-on-One Interviews

In total, 23 focus groups and 13 interviews were conducted with 189 immunization stakeholders in seven cities with participants from 24 counties across the state. Of the 23 focus groups conducted, eight groups were school administrators, nurses, and staff; six groups were healthcare providers, clinic nurses, and staff; three were parent groups; five were public health groups; and one focus group was done with state employees. Legislators and other key stakeholders were also interviewed as part of this process. (Appendix G)

Schools:

Overall Thoughts

In visiting with representatives from 11 school districts across the state, the CIRE learned that the enforcement of immunization requirements is at the discretion of each school or school district. Each school district shared their varying philosophies and practices surrounding school enforcement of immunization requirements, ranging from the exclusion of children noncompliant with state immunization requirements to very minimal enforcement of school immunization requirements.

School administrators and staff were asked about their thoughts on the current state immunization requirements for school entry. There was nearly universal support from administrators, nurses, and staff for school immunization requirements, with school representatives recognizing the importance of childhood vaccinations. Although most school representatives understood the importance of immunizations, administrators disagreed over whether or not schools were the most appropriate avenue for enforcement of school immunization requirements.

Immunization practices, specifically enforcement of immunization requirements, were often reflective of the philosophies of local superintendents. Some school administrators shared that providing a safe and healthy school environment was a top priority for them. These administrators believed immunization compliance is a part of this environment, which is ultimately required for successful learning. Other school administrators shared a very different perspective, stating how enforcement of immunization requirements by excluding children from school presents a philosophical conflict. These school administrators shared that it is their mission and job to educate students, and by removing children from school for noncompliance, they are not able to fulfill their mission as educators. While many school districts are displeased that enforcement falls on the schools, many understand why schools are in charge of enforcement and have accepted their role in the process.

The schools strictly enforcing immunization requirements and excluding noncompliant children are setting their own exclusion deadlines rather than following the 30 day exclusion deadline outlined in the N.D.C.C. Because there is not a consistent immunization enforcement deadline being practiced around the state, some school employees expressed support for a statewide exclusion deadline, rather than a 30 day grace period. School employees suggested this deadline even though a 30 day grace period is already in law and schools believed 30 days was sufficient time to collect immunization records and enforce the state policy.

School officials noted how easy it is to obtain an immunization exemption in North Dakota and believed the process of obtaining an exemption should be changed. Some schools acknowledged they have offered the immunization exemption form to parents as an option for immunization compliance, even though they have been discouraged from doing so by the NDDPI. Additionally, school staff shared that parents have signed the form out of convenience when an immunization record could not be found or making an immunization appointment for their child

was not convenient. School administrators and staff strongly supported a policy change that would require immunization education from a vaccine expert before parents could file a religious or personal belief exemption. They believed requiring education in order to obtain an exemption will remove the convenience factor of simply signing the exemption form; if parents are required to visit with a healthcare provider, school officials felt many parents would opt to receive the vaccines.

Schools stressed the need for increased access to immunizations, whether it be through school immunization clinics or extended hours at public health units and local clinics. School administrators shared how convenience and scheduling are often barriers for noncompliant children and their families.

One group discussed ways to motivate parents to complete their child's immunizations, noting that parents are ultimately the ones responsible for meeting all school requirements, including immunization compliance. They believed incentives and penalties for immunization compliance should be aligned with motivators of parents. One school group suggested denying benefits of the Supplemental Nutrition Assistance Program (SNAP) to parents whose children who are not compliant with immunization requirements. This school group did note that families receiving SNAP benefits are not the only families not compliant with immunization requirements, and that other incentives and penalties may be needed. Other schools noted that exclusion of children from school, loss of child care, and taking time off of work was enough of a motivator for many parents to bring their child into immunization compliance.

During the focus groups and one-on-one interviews, school participants made one thing very clear: if any changes are made to immunization policies and practices in the state, school administrators and participants do not want more responsibility put on the schools. Schools feel like many responsibilities outside of education are given to them, and extra tasks are often not financially compensated.

Challenges

When asked about challenges associated with enforcing school immunization requirements, schools stressed the ambiguity in interpreting the North Dakota Century Code and Administrative Rules. In North Dakota, some requirements are clearly stated, while the interpretation of other requirements is left up to the individual school or school district. For example, the N.D.C.C allows a 30-day grace period after the start of school for students to get caught up on their immunizations. The N.D.C.C. does not articulate how those 30 days should be calculated, whether it be 30 calendar days, 30 week days, or 30 school days. Another area of ambiguity is whether or not schools should admit students who are not currently up-to-date on their immunizations. Schools believe the N.D.C.C. contains two conflicting statements, "A child shall not be admitted to school…" and the allowance of a 30 day grace period for those not compliance with state immunization requirements.

Another area of confusion is the seventh grade immunization requirement for the tetanus, diphtheria, and acellular pertussis booster (Tdap) and meningococcal immunizations. Currently, North Dakota Administrative Rules only require these vaccines for seventh grade entry, and in

subsequent school years, the immunizations are not required for school entry. Some schools are requiring the vaccines for all students in grades seven through twelve, while other schools are only requiring the vaccines for seventh graders. In addition to seventh grade, school nurses recommended that the North Dakota Administrative Rules language be changed to require the meningococcal and Tdap immunizations for students in grades eight through twelve, if not immunized at seventh grade.

Lastly, schools shared their confusion in determining an "institutional authority" in each school and defining the role of this person. Overall, schools would like to see more guidance from the NDDPI and NDDoH regarding interpretation of the N.D.C.C. and Administrative Rules.

Schools in specific parts of the state identified populations needing to overcome barriers to become compliant with state immunization requirements. In the western part of North Dakota, which has recently seen a rapid increase in population due to an oil boom, many out-of-state and out-of-country children have entered the school systems. Often times, parents of these children do not bring their immunization records with them to their new school when they move. As a result, parents are not always able to track down their child's immunization record and deliver it to their new school in a reasonable amount of time. This has hindered the schools' ability to collect immunization records and enforce immunization requirements.

In the eastern part of the state, school representatives recognized the New American population as a group that has to overcome many barriers to become compliant with immunization requirements. Stakeholders shared that education, language, and transportation are large barriers for this population; they are often unaware of the immunizations they need for school entry, they face language barriers when communicating with school officials and healthcare providers, and they may lack transportation to and from their healthcare provider. It is important to note that these families are not purposefully not up-to-date on their immunizations, and once they learned about the need for immunizations, school officials noted that they often became compliant with immunization requirements in a timely fashion with the help of many school and healthcare staff. Schools in one region also mentioned the main healthcare provider for many of the New Americans is understaffed, ran out of one key immunization during the past school year, and fell behind in entering immunizations into the NDIIS. This was problematic for schools and New Americans, and additional steps were taken by school staff to determine and achieve immunization compliance for affected children.

In addition to collecting immunization records for students, schools expressed challenges with tracking immunization schedules and records for kids who move into and out of the school district. For example, some school districts are seeing over 1,000 new students enter during the school year. With children moving into the school districts every day, school staff are continuously collecting immunization records, determining compliance, and tracking progress towards full immunization within the 30 day grace period. For school staff, this is an extremely tedious process.

Schools without school nurses expressed the challenges that school secretaries must overcome to determine immunization compliance. School secretaries are often not trained in medical terminology or the reading of immunization records, so determining immunization compliance

for students can be a challenge. While some schools without school nurses have working relationships with local public health units, other schools without that working relationship must be able to determine immunization compliance for their students, and this can be a challenge when reading immunization records from North Dakota and sometimes other states and countries.

Lastly, some schools shared they were either unaware of their responsibility to enforce immunization requirements in the homeschool population or how to enforce immunization requirements for homeschooled students. According to the NDDPI (G. K. Marback, written communication, March 2016), homeschooled students make up 2.6% of North Dakota's student population and are required to submit immunization records to the school districts in which they file their statement of intent to homeschool. In some school districts, parents of homeschooled children are not turning in immunization records, and currently there is not a way to enforce the requirements since the students do not attend school. One superintendent said, "When somebody registers as homeschool we have to ask them for their immunization records. What are we supposed to do with them? I don't know. I have no idea. I don't know if we are supposed to set up a database and track it. But why the district is responsible for doing any type of monitoring for homeschooled students is beyond my imagination. It's a process that has no enforcement ability."

In some instances where a home schooled child enters a school system for extracurricular activities or certain classes, the students can be excluded from school activities for being noncompliant with state immunization requirements. Overall, schools said they would like more guidance on how to more effectively enforce immunization requirements and report immunization rates in the school immunization survey for the homeschool population.

Non-Enforcing School Districts

In the schools not regularly enforcing immunization requirements, school administrators voiced that they did not agree with and had concerns over excluding noncompliant children from school over a public health issue. A school superintendent said, "We want the kids in school. We want them there because we want to educate the kids. We don't want them kicked out of school or not allowed to come to school." It was also mentioned that vaccinations are something parents are responsible for, and by excluding noncompliant children, a school is excluding a child for something the parent is ultimately in charge of and responsible for. A superintendent said, "As educators, it's hard to keep a kid out of school for something their mom and dad didn't do. It's not the kids fault they aren't immunized. It's mom and dad's fault."

Administrators who shared these sentiments mentioned many, but not all, of the students noncompliant with state immunization requirements came from households with low socioeconomic status or poor home life. One superintendent said, "The kids who need to be in school the most are the ones who don't have the records." A principal echoed the superintendent's thoughts by asking, "Are these kids better off at home or are they better off at school?" Administrators also mentioned that school is the best place for these children; they are safe, warm, and comfortable, receive a meal, and are able to learn. One principal stated, "The

ones that are not immunized are the ones who need to be at school because school is warm, school is safe, and we feed them."

School officials also shared concerns about the number of children that would be missing school after the enforcement deadline and the number of days children might be out of school. They are concerned with the number of children that would not be up-to-date on their immunizations and be excluded from school, requiring extra work from teachers and other school staff once a student returned from exclusion. They also worried about children missing too much school and not meeting school requirements for passing classes and graduation. Finally, schools shared that state and federal funding is partially based on school attendance, and they worried that excluding children for being noncompliant with immunization requirements would have a negative impact on the amount of funding the schools receive.

Lastly, some schools shared they have received mixed messages about the enforcement of immunization requirements from the NDDPI. In the past, schools had received correspondence from the NDDPI outlining the N.D.C.C. requirements and the importance of immunizations. School superintendents were notified again at a conference in fall 2015. When schools followed up with the NDDPI about potential financial consequences of not enforcing immunization requirements, superintendents were told "They [NDDPI] may do this." One superintendent was told, "We don't want to withhold money from you. We aren't going to withhold money from you. We want you to get the immunizations. We want you to keep asking. We don't want you to give up. We want you to keep making an effort. As long as you're making an effort, that's what we want you to do."

Enforcing School Districts

Focus groups were conducted with two school districts that routinely require students to be compliant with state immunization requirements. In these schools, parents are given a deadline by which students must be compliant with state immunization requirements. Those students that do not meet immunization requirements by the deadline are excluded until they become compliant with state laws. Most schools in the state are not enforcing immunization requirements to this extent.

Leadership in the two school districts that regularly enforce immunization requirements shared that maintaining a safe and healthy school is a top priority for them, and having all students in compliance with North Dakota's immunization requirements is one small piece of that priority.

A superintendent in an enforcing school district said, "I think we are charged with providing a safe environment for our students, and that includes students who are medically fragile or vulnerable. We have an obligation to provide a safe environment for them, so it starts with the doorstep. We have to make sure our kids are healthy and immunized before they can get into our school setting." Another administrator added, "I do think our priority is to educate kids, and [immunizations] is certainly part of it. And it's our state law. If we don't have that feeling in our school that every child is safe, they can't learn."

School officials in enforcing schools shared that very few children, if any, are excluded each year. When asked about the students excluded for noncompliance, a principal said, "It's a quick turnaround." Another principal reflected, "They are back in school the next day." Representatives from enforcing schools shared kids are rarely out of school for more than a few days.

Study Opportunity

The NDDPI and NDDoH recently emphasized the importance of immunization requirements for schools and the laws mandating school enforcement in North Dakota. In October of 2015, school superintendents attended a statewide conference where they learned about North Dakota's legal requirements for immunization. School superintendents were informed by North Dakota's Assistant Attorney General that by not enforcing immunization requirements and not excluding noncompliant children, schools were not abiding by N.D.C.C. and could face legal and financial consequences; specifically, they were told foundation aid, or funding for the schools, could be withheld for every student that is noncompliant with the law. Upon hearing this, some school districts in the state decided to more strictly enforce immunization requirements to the extent of excluding children noncompliant with North Dakota law during the remainder of the 2015-2016 school year.

The CIRE met with representatives from two large school districts deciding to more strictly enforce immunization requirements after the Annual School Boards Association Conference with school superintendents. Administrators and staff from these two schools acknowledged the laborious process that took place when trying to collect missing immunization records, determine compliance, and contact the parents of children needing further immunizations. In many schools, the use of PowerSchool, a software for managing school data, aided in this process.

Schools more strictly enforcing immunization requirements for or during the 2015-2016 school year began sending out letters to parents in the fall of 2015 letting parents know which immunizations their child still needed and the deadline by which the immunizations were required. Schools also had school principals, nurses, and administrative assistants make phone calls home to families. Schools set exclusion deadlines in which children had to be fully compliant with North Dakota immunization requirements or they would be removed from school.

Because many schools had never enforced immunization requirements or had not done so for many years, many students in both school districts were noncompliant with state requirements. In one large school district, over 6% of children were either missing immunization records, partially immunized, or not immunized when stricter enforcement of immunization requirements began in November 2015.

The CIRE followed up with the school districts to see how the enforcement and exclusion processes went and how many children were excluded. These school districts had previously expressed they thought many children would be excluded from school once immunization requirements were enforced. In reality, very few students were ultimately excluded from school. In total, only 13 students in one large school district (0.14%) and 27 students in another large

school district (0.24%) were excluded on the deadline. Most of the excluded students became compliant and returned to school within a few days.

School Nurses

It is important to note the role of school nurses and the appreciation schools have for their role in immunization enforcement. In the two schools regularly enforcing immunization requirements and the two school districts enforcing immunization requirements for the first time in 2015, all have school nurses on staff and administrators recognize the impact they make in this process. In these school districts, school nurses are in charge of reading immunization records, determining immunization status, and filling out the annual school immunization survey for the NDDoH. In schools without school nurses, the completion of these tasks often falls to a school secretary or local public health unit, depending on the relationship between the two entities.

Schools without school nurses acknowledged that limited resources did not allow them to have a school nurse on staff to assist with immunization practices. Some schools were open to the idea of contracting nursing services through the local public health unit to assist schools in determining immunization compliance and completing the school survey, while other schools did not believe adequate resources were available to add nursing services in their school district.

Policy Recommendations

When asked whether or not North Dakota should allow three types of immunization exemptions, opinions of school employees were mixed. Some school officials believed only medical exemptions should be allowed for school entry, with one principal stating, "I would strongly encourage our legislators to eliminate all but the medical exemption." Others thought religious and/or personal belief exemptions should continue to be allowed.

School officials were also asked whether or not immunization exemptions should be renewed by parents yearly. Most school employees were not in favor of having exemptions renewed every year. They thought yearly renewals would just cause more paperwork for school staff, add expenses, and not result in more children being immunized, especially considering that the current process in North Dakota only requires parents to sign a form. When schools were asked about requiring a notary's signature on immunization exemption forms, most agreed that notaries are readily available, and that this extra step would not deter many parents from seeking an exemption or positively impact immunization rates.

Lastly, school officials were asked whether or not immunization rates should be published by school. Most schools administrators and staff did not support immunization rates being published by individual school. One superintendent mentioned that publishing immunization rates by schools is ranking a school or an educational setting on a public health matter, and this would be inappropriate. "I see it as any time you start ranking schools, it's going to be interpreted by some as a good school or not if you put a label on it like that. It could have a negative impact on all of our schools. I'm always cautious about that." Another superintendent echoed those statements, "I think it might be unfair. If two principals did the same job (enforcement) but have different

immunizations rates, through no fault of their own, one's rate are going to be much lower." Another principal added, "If it doesn't impact learning, then no [I don't support it]. I don't think it would have an impact [on immunization rates]."

Other school officials questioned the effectiveness of publishing immunization rates by school. One superintendent said, "If publishing rates had an impact on immunization rates in the states that were doing it, they would be at 100%." School nurses added, "I'm afraid parents would say, 'Oh, I can make them exempt?' I don't know how the data would be a positive or cause a positive impact at all for the district."

Because North Dakota is a very rural state, some school nurses worried about data privacy. "Schools are too small. Parents would figure out who these [unimmunized] kids are and they would be discriminated against." Lastly, some school officials questioned whether or not this information would be sought out by parents and what parents would ultimately do with the information. In North Dakota, only some schools have open enrollment. As a result, if a parent's child was in a district or school with low immunization rates, they may not be able to move their child to another school.

Some school officials offered their own suggestions for how to improve immunization policies in the state.

Some school nurses and one superintendent supported a policy where children would not be able to start school without an immunization record on file. A superintendent voiced, "They don't get in the door without the paperwork being complete."

Other educators did not support a policy change requiring exclusion on the first day of school and talked about parents needing more flexibility. "We are supposed to be educating. Our job is to educate them. Why do we have to look at parents on the first day of school and say, 'No, take your kid home.'" Other school staff said children are often very excited for the first day of school, and if a child is not allowed to attend school because of a missing immunization record, they may have a negative image of school and retain those thoughts throughout their school careers.

A superintendent shared his concerns about this suggested policy change. "I can't imagine the trauma that is going to be on a five year old. All dressed up, brand new clothes, brand new shoes, brand new backpack, coming to school for the very first day, and one of my principals says, 'No, I'm sorry you have to go home.' We want kids to see school as a welcoming place. We want kids to be excited to come to school. If we have to turn away kindergarten kids because they don't have their shots, we probably just created at-risk students who are now at risk for not graduating from high school because of the negative experience on their very first day of school."

Two school superintendents who did not believe schools are the best place to enforce immunization requirements to the point of exclusion suggested schools could collect the immunization records and data each school year and then pass the list of noncompliant children on to another government agency to enforce. Law enforcement, health departments, and social services were recommended as other agencies for enforcement.

A superintendent shared his ideas, "I know it's a difficult thing, but our job is to educate the kids. I don't have a problem having my principals track these things, but the enforcement needs to fall [in] some other department at some other level. I don't have a problem with trying to help track it, but once we've tracked it, it should become someone else's issue to deal with the enforcement. It either becomes the job of the Department of Health or the Department of Social Services."

Additional Recommendations

Some school staff acknowledged the schools' change in immunization enforcement practices was a surprise to their local communities, and healthcare providers and public health were not always willing or able to handle the increased demand for immunization appointments. These staff members expressed how they thought a statewide announcement to local public health units and healthcare providers should have been shared concurrently with the announcement to school superintendents, so vaccine providers could adjust their schedules, supplies, and staff accordingly.

Most of the large school districts in the state are using PowerSchool to collect and record immunization records and complete the school immunization survey. School staff shared they would like to see PowerSchool linked to the NDIIS. This would allow the NDIIS data to load in PowerSchool, saving public health nurses, school nurses, and school staff time spent inputting individual immunization records into PowerSchool.

Some schools also suggested changes to the school immunization survey filled out each fall. Currently, schools report the number of children in each grade, the number of children with medical, religious, and personal belief exemptions, and the number fully vaccinated against each disease. Schools would like to see an "in progress" column added to the school survey to track the number of students who are in the process of becoming fully immunized but are not fully compliant. While some school employees favored this change, others believed it may cause confusion and was not a worthwhile change.

Public Health

Overall Thoughts

In visiting with public health nurses and employees across the state, many expressed that the overall opinion of immunizations among parents and families in their communities was favorable, while also noting the bias that may be occurring in the populations served by public health. One nurse said, "I would say the majority of the people we see are in favor of immunization. I think the reason behind that may be in part that they are coming to public health for immunizations." Public health employees shared how very few people are truly against vaccinations. One nurse said, "It's really a small group of people that are unimmunized." The increasing number of parents requesting an alternative immunization schedule was also noted in many public health focus groups.

Public health nurses shared social media and internet search engines have had a negative impact on the perception of immunizations. Many public health employees also shared that certain chiropractors in their respective districts have had a negative impact on immunization rates, confidence, and uptake. Public health nurses did acknowledge that outbreaks of vaccine-preventable diseases increase the number of children coming in to receive immunizations against the diseases causing outbreaks around the country.

Public health employees stated that the reason parents are not getting their children immunized is not because parents do not believe in immunizations. Instead, they shared the many barriers that are impacting immunization rates, including access to healthcare, scheduling, and convenience. One public health nurse stated, "We called parents whose children weren't up-to-date with their immunizations. For the most part I would say they were open to immunizations. It just wasn't a priority to get them taken care of." Another nurse shared, "The kids that aren't up to date – it's not as much scheduling as it is other barriers in the home - like drug or alcohol abuse. It's not personal beliefs. It's other issues."

Working Relationships with Local Schools

Many public health nurses work closely with schools around the state for immunizations, and mentioned schools are inconsistent in enforcing immunization requirements and making immunizations a priority.

The relationships between local public health units and local schools in the state vary greatly. In the rural areas of the state, many local public health units are working closely with the schools on immunizations. Public health units are assisting with immunization record compliance checks, sending letters to families with noncompliant children, and assisting in the completion of the school immunization survey. Many local public health units are also doing school immunization clinics to provide catch-up vaccines to children missing immunizations, influenza vaccinations, and other recommended vaccinations. Many public health nurses noted the success of school immunization clinics in small communities.

In the urban areas of the state, the local public health unit's involvement in the schools varies. Many of the larger schools have their own school nurses, or their school nurses are contracted through the local public health unit. Most of the urban areas in the state are not doing immunization clinics in their schools for school-required immunizations through the local public health unit, although there was mention of some influenza vaccination clinics occurring throughout the state. Public health units said that immunization clinics in large schools are laborious and time-consuming and staffing is limited.

Public health employees stated that before the school superintendents' meeting with North Dakota's Assistant Attorney General in October 2015, immunizations were not a priority for many schools. One public health nurse noted, "It became a priority. When it became a priority from the top, everyone was willing to do what they needed to do. It was not seen as a priority

before." Another nurse shared how she immediately received phone calls and emails from superintendents in her district, stating the urgency with which immunization compliance needed to be addressed. One public health nurse met with her local superintendent "the next day." Because of the new emphasis on enforcement, many public health units around the state noticed a significant increase in children coming in to public health clinics to receive immunizations.

Policy Recommendations

When asked about the current immunization exemption process in the state, public health employees universally shared that the process for obtaining an exemption is weak, too easy, and should be made more difficult. Public health employees also stated they did not know the difference between a moral and philosophical exemption. They would like to see those options combined on the immunization exemption form or combined to be called a personal belief exemption or maybe a conscientious exemption.

Public health employees were asked about potential changes to current immunization policies. Nearly all public health staff agreed that making the process for obtaining an exemption less convenient was important. One nurse said, "If you make it harder, more people will get the immunizations."

Public health employees strongly favored changing the immunization exemption form. They also strongly favored a policy change requiring parents to receive immunization education from a vaccine expert before a nonmedical exemption could be filed. While they strongly favored healthcare providers as the vaccine educators, many public health nurses acknowledged they would be willing to provide the education to parents seeking an exemption. Some public health employees believed clinic nurses within a healthcare system could also provide this education to parents.

Public health employees stressed how they felt the education provided to parents needs to have a consistent message across the state. They suggested the creation of a check list of items that healthcare providers or public health nurses would need to go over before signing the immunization exemption form. Specifically, public health nurses would like parents to acknowledge they are aware of the consequences of non-vaccination, such as the potential to be removed from school for extended periods of time in the event of an outbreak.

Public health nurses did not agree on whether or not publishing immunization rates by school would be successful. While some liked the idea, others expressed publishing immunization rates might not solve the problem of low immunization rates and no school enforcement. "I think in some situations, especially being so rural, it would cause even more problems." Another nurse stated, "Schools are too small. Parents would figure out who these kids are and they would be discriminated against." Public health nurses were split on whether yearly renewal of a nonmedical exemption would increase immunization rates.

Practice Recommendations

The creation and implementation of a national immunization registry was a sentiment repeated consistently in focus groups with public health employees. Many nurses stated they sometimes work for hours trying to obtain a single immunization record for a child from out-of-state. They would like to see a national immunization registry or the creation of data sharing agreements between North Dakota and states where many of the new families are migrating from.

Public health employees would also like to see the NDDoH create a template letter for schools to use when sending out letters to parents of children who are noncompliant with state immunization requirements. They said current immunization reminder letters from the NDDoH are very helpful. They would also like to see the NDIIS have communication capabilities with PowerSchool since many public health nurses work with schools in some capacity.

Some public health employees would like to see additional funding for the local public health unit to contract with the schools on immunization record collection, recording, and reporting. Some would also like to see hepatitis A and other childhood vaccines required for school entry. Public health nurses also would like to see North Dakota Administrative Rules language changed to articulate that the Tdap booster and meningococcal vaccinations are required for all students entering seventh grade through twelfth grade. Public health nurses also mentioned there is no option in the NDIIS to properly categorize children who are immune to hepatitis B.

Public health nurses did share their frustrations with the communication of electronic medical records and the NDIIS. Specifically, they mentioned that the system's ability to forecast immunization schedules and review the schedules of previously administered vaccines does not work in electronic medical records, misleading some providers only using the electronic medical record to determine immunization compliance. They also shared their continual problems with the NDIIS, some noting that it crashes as often as once per day.

Lastly, public health providers believed vaccine ordering could be done more efficiently. They believed vaccines could all be purchased privately and the state could reimburse the local public health units for the vaccinations given to those who are eligible for the Vaccines for Children program. They believed a change like this would save the local public health units' time in the fall, when they typically have to wait for delayed state vaccines to start immunization clinics.

Healthcare Providers

Overall Thoughts

Healthcare providers stated the majority of parents immunize on schedule and are in favor of immunizations. Many healthcare providers mentioned that over the last few years, the number of parents choosing an alternative vaccine schedule was increasing.

One pediatric clinic in the state does not see patients whose parents refuse vaccines. In this practice, the decision to discharge non-vaccinating families from the clinic was a decision that was made to protect children who are sick or cannot be immunized. There is a small, but growing, trend nationwide to exclude unimmunized patients from medical practices.[36,37]

Nationally, the American Academy of Pediatrics does not support discharging patients based on a parent's decision to refuse vaccination.[38] The NDDoH also discourages this practice.

The use of internet search engines and the influence of social media were mentioned by healthcare providers frequently as factors affecting parents' confidence in vaccines and ultimately vaccine uptake. One healthcare provider said, "There's a lot of misinformation out there." Healthcare providers also talked about the "strong chiropractic hold" in the state and the "big influence" chiropractors have on parents regarding vaccine confidence. It was mentioned in many cities throughout the state that certain chiropractors are spreading anti-vaccine sentiment, holding vaccination seminars, and distributing false information about vaccines.

They shared that outbreaks of vaccine-preventable diseases around the country motivate parents to bring their children in to the clinic for immunizations, even parents who have never immunized before. One pediatrician shared this story, "I had one family that had forever done no vaccines. After the measles outbreak in California, they came in and I caught all four of their kids up."

Healthcare providers stated that they rarely see diseases like chickenpox anymore, making history of disease exemptions very rare. Some providers are filing a history of disease exemption for hepatitis B immune children, although North Dakota state law only allows for history of disease exemptions for varicella. Medical exemptions to immunization are extremely rare, with many providers stating they have never seen a child needing this type of exemption. Providers throughout the state mentioned problems with the NDIIS and electronic medical record communication. They shared their desires for a national immunization registry, which would ultimately help track immunization records of North Dakota's transient populations. |

This year, healthcare providers noticed an increase in the number of parents bringing their kids in to the clinics to be vaccinated, attributing the increase to the school systems deciding to more strictly enforce immunization requirements. One provider said, "Something happened, because we had a pile of kindergartners in [for their immunizations]." A North Dakota parent, after learning her child could be excluded from school for an extended period of time in the event of an outbreak, told her healthcare provider, "I can't afford to be out of work. My kids are going to be immunized."

Policy Recommendations

Healthcare providers believed the process for obtaining an exemption in North Dakota was too easy, calling the policy "lackadaisical" and "worthless". Many stated they were unaware of how easy it is to get an immunization exemption in the state. One nurse stated, "I didn't know you could just sign a piece of paper."

Healthcare providers strongly supported a change in state policy to make the process of obtaining immunization exemptions more difficult. One physician stated, "It should be harder to refuse

vaccines than it is to get them. And it's not. It's simple. You sign the form and you're done." Another said, "I think stronger legislation is required to reverse this trend (of decreasing immunization rates)." A family medicine physician said, "I think most of us would love to see a tougher law that would allow fewer exemptions and didn't make it so easy." One pediatrician noted, "Even more than pediatrics, it's an issue of politics and state legislature."

Healthcare providers overwhelmingly supported a policy change allowing only medical exemptions in North Dakota. A pediatrician stated, "I don't think [nonmedical exemptions] should even be an option." If the current exemptions are kept in North Dakota, they supported policy changes making it tougher to receive a religious and personal belief immunization exemption in North Dakota.

One physician suggested parents wishing to file a religious exemption must submit a signature form a religious leader and documentation that a person's religion conflicts with immunization.

One common suggestion from healthcare providers was a policy change requiring parents to receive education before being able to file an immunization exemption. Healthcare providers believed this was very important, with one physician stating, "Parents don't understand the risks of not vaccinating their kids."

Many types of education were offered as suggestions. The most popular suggestion was requiring parents who are seeking an immunization exemption to meet with a healthcare provider (physician, physician's assistant, or nurse practitioner) or public health nurse in the state to receive immunization education. Some groups did suggest a clinic nurse could provide the education. Clinic nurses tended to support a change requiring healthcare providers to do the education, saying doctors have more success than the nurses in convincing people to get immunized.

Other providers suggested an online education module with a quiz at the end to test the parents' knowledge and comprehension of the material. At the end of the educational module, a certificate could be printed off that would be turned into the school and allow a religious or personal belief exemption. Another suggestion to educate parents was to hold a class on immunizations; parents wanting to file an exemption would need to attend the class (or classes) and show proof of attendance to receive an immunization exemption. The educator of the class could be a local healthcare provider, a public health nurse, or a standardized immunization education video could be shown.

Yearly renewal of the immunization exemption was also suggested many times and received overwhelming support as a change that would lead to higher immunization rates, especially if it was coupled with an educational requirement.

When healthcare providers were asked whether they would be willing to spend part of their practice educating parents about immunizations, the overwhelming response was "yes". One pediatrician stated, "It's part of my duty as a general pediatrician to care about the public's health. And when I talk to people that refuse vaccines, I'm saying, 'I'm talking about your child being at risk.' But I also consider the community, the kids at school, my own children. And I feel

like that's my job as a general pediatrician that I have to be concerned about the community. So if it takes me talking to somebody individually and they have to do that because the law requires it, that would be part of my practice I would value." Another stated, "I'd be ok with educating parents as long as we get the vaccination rates up, because I think getting the vaccination rates up is more important."

Healthcare providers suggested other policy changes, including a policy where parents would be required to write a statement to explain their beliefs. This statement would be turned in to a child's school to receive a nonmedical immunization exemption.

Healthcare providers were asked if they thought immunization rates should be published by school in North Dakota. Unlike the other stakeholder groups, many healthcare provider groups supported publishing immunization rates by school. When asked why they supported publishing immunization rates, healthcare providers stated that they like transparent data, they thought it might cause peer pressure among parents, and it might generate fear among the public. Many healthcare providers are parents themselves and mentioned they would like to know that information. One nurse said she would pick a different school for her child if she knew the immunization rates were low in her child's school. "It would cause a lot of uproar, especially if you don't have a choice [in the school your child attends]."

Some healthcare providers thought publishing school immunization rates might lower immunization rates if parents knew exemptions were available. Some thought bullying or exclusion might occur among children if parents were able to determine which children were not immunized. Others weren't sure if publishing the rates would make a difference. One doctor said, "I don't know if it would do any good."

One healthcare provider suggested removing the exemption form from the NDDoH website and requiring parents to visit a location to pick it up. "You have to make parents work for it. Most of the time they don't have to. Make them go to the courthouse and get their form notarized." Only a few healthcare providers thought a notary requirement for the exemption form would improve rates, with most healthcare providers believing it would only deter a few parents from signing the exemption form. Another provider suggested the immunization exemption form should only be available at a healthcare provider's office. "If we are making the change that providers have to sign it, then providers [should] have to provide the form."

Practice Recommendations

Healthcare providers would like to see a change in how state-provided vaccine is handled at the clinic level. They described this as a "two fridge" problem when giving vaccines, stating that having two fridges for vaccines, one for private and one for state vaccine, often leads to waste. They also mentioned the large amount of paperwork required for reimbursement of state vaccine.

Parents:

Overall Thoughts

Parents in the focus groups believed immunizations were important. Many parents stated that many other parents are misinformed about what vaccinations are and why children are recommended to have them. Parents shared that they believed immunizations protected those who lack proper immunity because of age and health conditions. They shared stories about vaccinating parents being worried about non-vaccinated kids that may come to school with a disease and infect others. They also shared the stress an outbreak might put on the staff in a school with children potentially being out of school for weeks.

Some parents believed schools should be more strictly enforcing immunization requirements, with a government entity overseeing their work and making sure they are following through with state laws. Some parents shared how the enforcement of immunization requirements is a large burden on the school systems. One mother believed public health was using schools as a scapegoat, stating she believed medical professionals should be tracking immunization rates of children, not the schools. She mentioned the burden placed on school secretaries, who are tasked with reading immunization records, sometimes from many different states and/or countries, with no medical training.

Some parents believed school nurses could help alleviate some of the pressure on school administrators and staff. Parents also suggested community immunization clinics and school clinics to help children stay up-to-date on their immunizations.

Policy Recommendations

Many parents shared they were not aware that immunization exemptions were available in the state and were subsequently surprised at how easy it was to obtain an exemption. One parent said, "I didn't know you could get away with not [immunizing]. The whole exemption thing is new to me."

When parents were asked whether or not they thought children should have to be immunized to attend school, the responses were mixed. While some believed parents should have rights, other parents disagreed and said immunizations are important for the public's health and everyone should have to be vaccinated.

When parents were asked whether or not nonmedical exemptions should be allowed in North Dakota, again, parents were divided. Some parents believed only medical exemptions should be allowed, while others believed religious and/or personal belief exemptions should be available.

Parents almost universally agreed that the process for obtaining a nonmedical immunization exemption in North Dakota is too easy, and they supported an educational requirement for those parents who would like to obtain an immunization exemption. They believed parents should have to go over a checklist of items with a healthcare provider, such as the advantages and disadvantages of vaccinating and the risks of vaccinating and not vaccinating. They also believed parents should be told, "In the event of an outbreak, your child could be removed from school for an extended period of time." They believed this education would help parents make a better-informed decision.

Parents believed immunization education could be provided by a healthcare provider, public health nurse, or school nurse. One parent suggested a non-biased person provide the education, such as an osteopathic physician, an alternative provider, or a government official. They also believed an educational video could be created and shown in place of receiving education from a vaccine expert. Parents suggested vaccine education session(s) or educational video(s) could be done with parents seeking an exemption on nights when parents are engaged with the school system, such as registration, back-to-school nights, and parent teacher conferences. Other parents suggested a quiz at the end of the educational video to gauge learning.

Parents were also asked about the potential impact of having to renew nonmedical exemptions each year with their school district. Some agreed it would help increase immunization rates, while other parents stated that if the process does not change and parents are only required to sign a form, it becomes more paperwork and work for the schools and may be extra work for healthcare providers.

When parents were asked about publishing immunization rates by school, their responses were mixed. Some parents were in favor of publishing immunization rates by school, stating it helps with awareness. Others did not see its benefit, believing it could cause feuding parents and kids would switch schools, all with no positive impact on immunization rates.

One parent recommended that children should not be able to start school without an immunization record on file, while other parents believed the immunization exemption form should only be available at a healthcare provider's office or at the local public health unit. These parents believed this change would encourage parents to seek out information, or if parents were filing the exemption simply out of convenience, they may be more willing to get the immunizations if they have to obtain the form through those offices anyways.

Legislators:

Overall Thoughts:

Legislators all believed children should be immunized, and most believed the school systems were the appropriate place to enforce the school immunization requirements. One legislator said, "I believe it's appropriate. If not the schools, who? Who else can put that type of pressure on a parent who is just being lackadaisical about it or anything even if they are not sure or they are believing rumors? I don't know who else to really put that pressure on."

Another legislator stated, "I believe it's appropriate. Enforcement is an appropriate role for the school because non-vaccination and epidemics would directly affect them. It is the schools' jobs to educate. That's true. But if kids are home sick and other things are totally disrupting, you are not educating ideally either. To me, schools can't use that argument."

A different legislator shared, "Should schools enforce? I think it is the logical place to go. It may not be the best, but it's where you get at all of them. I like it because it tends to work. How else will you get [to] everyone? School is the appropriate place because kids go to school. Using that

as your place of enforcement is probably the best place to go right now. I don't see one that's better."

One legislator voiced a very different opinion on the enforcement of school immunization requirements, believing the enforcement of immunization requirements should not be the responsibility of schools. "A lot of the responsibility falls on the superintendent of the schools now, which I think we need to change. The school can report that this child is not compliant but I don't see where the responsibility and the liability should end up with the school district."

In visiting with legislators, most believed leadership within the NDDoH and NDDPI strongly supported immunizations, immunization requirements for school entry, and enforcement of school immunization requirements.

When questioned about why they believed children were noncompliant with immunization requirements, one legislator pointed to parents not making immunizations a priority and taking full responsibility for their child's health and well-being. "It's really the parents' responsibility, not the school districts. We need to put it on them. It's not a priority in their lives, I'll tell you that. They are just plain procrastinators."

Another legislator pointed to scheduling barriers, convenience, and finances as reasons that parents were not fully immunizing their children. "If it were for financial reasons...they tend to be the ones who don't have great flexibility in their work schedules either. I could see why that could be a bit more of a problem."

Lastly, a legislator also shared that parents who are refusing immunization "are coming from the position of ignorance and putting other kids in danger." Legislators repeated the sentiments of other focus groups; parents are using internet search engines and social media to look up immunization information, and as a result they may be receiving false information and are choosing not to vaccinate.

Practice Recommendations

Upon reviewing North Dakota's school immunization data, one legislator was quick to point out that a large percentage of kindergartners are unaccounted for in the school immunization survey data because of noncompliance. "The question is, 'Why are we letting people into kindergarten without their immunizations?'"

Legislators recognized how easy the current process for obtaining an exemption is, and mentioned that exemptions have gone up for several reasons. The legislator mentioned above pointed out one of the reasons, "When a child presents to kindergarten and he doesn't have all of his immunizations, somebody at the school sticks that [exemption] form in front of the parents to sign."

This legislator also strongly believed the NDDoH should work closely with schools and the NDDPI to enforce school immunization requirements, as that will give the state its biggest increase in immunization rates. "Even if you eliminated one hundred percent of the exemptions,

you would increase your rate by 3%, which wouldn't bring it up much. There are other avenues that we could use to spend our time and energy on more efficiently than to try and change the exemptions. I think since our exemption rates are [about] 3%, and some of those we know are because somebody just sticking the [exemption] form in front of the parents…that it seems to me it's kind of the wrong approach to spend time and energy legislatively on the change in the form for the options of people to make those exemptions. I think we ought to focus on the other avenues which are through the NDDPI, education of the superintendents and making that nurse available to give those immunizations when the kids are coming to school."

Legislators noted that the NDDPI, the School Boards Association, and school superintendents all need to be engaged on this issue. A legislator said, "I think the school leaders being on board with this is important. Another followed up and said, "We should talk a bit more about the seriousness of vaccine-preventable diseases and outbreaks and get the schools on board. It would go a long way towards solving our problems."

Two legislators shared that since the NDDPI has the ability to withhold foundation aid, the legislature needs an agreement from the NDDPI to do just that. If the NDDPI is not willing to withhold funding from schools, the legislature alternatively could say, "You have to withhold the money." As a follow-up, the state legislature could take additional steps if the NDDPI did not begin enforcing immunization requirements and withholding funding from schools with noncompliant children in attendance.

Legislators also identified areas where the NDDoH and local public health units could assist with immunization practices. They suggested the NDDoH could provide trainings to schools around the state, ultimately being responsible for training schools on best practices for enforcing immunization requirements. Legislators also recommended that local clinics and public health units could have more immunization clinic dates and options for parents who still need to immunize their child.

When asked about designated funds from the state for school nurses, a legislator said, "It's unlikely that the state legislature will approve enough money for that. However, it might be that the state could encourage these schools to have a nurse available under contract, for example, for the first two weeks of the school session to get those immunizations when the kids don't have them." Another legislator added, "It seems to me that any school that really cares about this will figure out how to budget, even for two weeks, for someone to assist with this particular new important thing. There's extraordinary, positive impact on students in the long run if they get immunized. So, there just needs to be a little more engagement with the School Board Association and the superintendents with this."

Lastly, one legislator acknowledged the work of the schools and the number of things they are tasked with accomplishing in a given year. Legislators made a point to not make immunization requirements more of a burden on the schools than they already are.

Policy Recommendations

Legislators were asked about potential policy changes in the state regarding immunization exemptions. First and foremost, they did not believe North Dakota legislators would remove religious and personal belief exemptions from the N.D.C.C. Legislators referred to North Dakota's "culture of independence" and parents' mentality of "wanting to choose what is best for their child" as reasons the state legislature would not make this change.

They did agree the current process of signing a form to obtain an immunization exemption was too easy. They suggested a number of changes, ranging from where the form can be accessed to who needs to sign it.

Every legislator agreed making parents receive education on vaccines before they could file a personal belief exemption would make a difference in the state. They believed the education could be provided by a healthcare provider, including physicians, physician's assistants, and nurse practitioners in the state. They also believed public health nurses could provide vaccine education. Legislators also mentioned adding language to the exemption form where a parent must acknowledge the risks associated with not vaccinating and potential outcomes of claiming an immunization exemption.

One legislator believed making a parent at the school receive another signature on the exemption form would make a difference, whether the parent has to go and visit with a religious official or a healthcare provider. This legislator thought the parent should have to leave the school to get another signature if the forms are being handed out. Legislators believed requiring a notary for immunization exemptions was not a barrier; believing this was not enough of a roadblock to hinder parents who are seeking an immunization exemption out of convenience.

One legislator did mention that in rural communities, parents may feel that having to visit with a healthcare provider is inconvenient. This legislator also mentioned finances could be an issue, making immunization exemptions a bigger hurdle to overcome. Regarding future policy changes, this legislator stressed not to make changes that are one-size-fits-all because it does not work well in North Dakota. Specifically, any education needed for an immunization exemption could be provided by a healthcare provider or a public health nurse. This would be more appropriate for a state like North Dakota, with its rural characteristics and healthcare accessibility challenges.

Lastly, one legislator was quick to mention how a policy change may not have a large effect on immunization rates. "This doesn't solve our problem of school administrators ignoring the [school immunization] requirements."

State Government Employees:

Overall Thoughts:

Government employees shared varying ideas and opinions regarding ways to improve immunization rates in North Dakota. Specifically, they shared the challenges and barriers of enforcing immunization requirements in schools, ideas for improving school immunization rates, and ways to improve the enforcement of school immunization requirements.

State government employees did not believe declining immunization rates in the state were solely attributable to personal immunization attitudes and beliefs. Instead, employees recognized that school enforcement of immunization requirements access to immunizations, and barriers to immunization were contributing to the decline more than immunization attitudes and beliefs. They also recognized the challenges in collecting immunization records from North Dakota's out-of-state, transient population, which is a major factor in declining immunization rates in the western part of North Dakota due to the recent oil boom.

One state employee said, "It's not that people are against immunizations. In North Dakota, our completion rate for the first dose of the MMR immunization for children between 12 and 15 months, according to the NDIIS, is 96%. It's not that people don't want the vaccine. It's that they're not going in or they're not presenting their record to the schools."

One state employee also believed most schools do not understand what could happen in the event of an outbreak. This employee believed more emphasis on educating school administrators on the diseases immunizations are meant to prevent, how quickly a disease could spread throughout a school, and the impacts an outbreak would have on learning and attendance was needed. This person also shared that superintendents would appreciate more information regarding which immunizations are required and recommended so school secretaries are better-informed and more able to complete the annual school survey.

School Enforcement

State employees were asked about the role that schools, the NDDPI, and the NDDoH play in the enforcement of immunization requirements. Varying opinions were shared regarding what the schools' role should be in enforcement and how immunization requirements are enforced at the state-level.

One state employee commented on how much of an issue school enforcement of immunization requirements has become. "We always say that immunizations should just be a natural part of what everybody does, and the work that both the [NDDoH] and the [NDDPI] do on that should really just be a pebble and a stone, but instead it's like a boulder. It's a boulder that gets in the way. And we spend more time on it than we should. [Immunizations] should just be a no-brainer."

Another employee stated how immunization enforcement is not common in North Dakota. "It's become a cultural thing of us not enforcing [immunization requirements]. I believe if it was enforced one year, parents would know, 'That's the way it is.' and they would get their kids in [to the clinics to be immunized]."

A different employee talked about why enforcement may not be a common practice in North Dakota schools. "I think the reason we have so many reluctant superintendents is simply, 'We are North Dakota nice. We simply are.' And most often, the kids that aren't being immunized aren't those middle class or affluent kids from affluent families. So the kids that are going to be jeopardized [by enforcement] are the kids that are in most need of our hot breakfast program or our hot lunch program. And it's hard for our educators, who are nurturers, to say for one or three

days that that child can't come into our schools those days for breakfast, for love, for instruction, for education, for lunch."

There were varying opinions within the NDDPI as to whether or not enforcement of immunization requirements was the responsibility of the department, whether this department should be leading efforts towards stronger school enforcement, and whether or not funding should be withheld from non-enforcing schools. The enforcement of immunization requirements has been supported by the NDDPI in statewide communications to school administrators, but so far, no punitive actions have been taken by the NDDPI towards schools for not enforcing the requirements.

Participants were also asked how schools across the state would react to stronger enforcement, specifically inquiring as to whether they thought many children would be missing school and the number of days children would be out of school. One participant said, "The only way we are going to find out the answer of that question is to do it. I suspect you are going to see a variance in responses from across the state. Do you see schools ready to take that firm line? I don't know what's going to happen in the small towns. I don't know. But, we probably won't know what happens until we do it and right now we are speculating."

When asked about the current immunization exemption policy in North Dakota, an employee mentioned how easy the current process was in North Dakota. "I think the ease of claiming an exemption is a problem. It's easier to get an exemption than it is to get [immunized]. You just sign a piece of paper."

State employees were also asked if they believed schools were the appropriate place to enforce immunization requirements. An employee said, "One thing I've heard is, 'This should not be the schools' responsibility.' They struggle with this in every state across the country. It is enforced by the school systems and that's because the schools systems are the touch point for all of these kids; they congregate together, and you have a situation where kids can spread disease easily. Practically, who else could enforce it?"

A different employee questioned why schools are in charge of enforcing immunization requirements instead of a healthcare provider? "Why is more of a responsibility of a school superintendent? Why is it more suitable to have the authority lie there on a health issue than it would be to have a physician responsible?"

An employee responded, "If the enforcement is on a physician, the problem is you are not going to have every child go to a physician or a healthcare provider necessarily at the time when they need to be immunized. I think the reason this became an issue where the schools are enforcing it across the country is because schools are a places where all children go. Even if they don't see a physician or healthcare provider, the school is the touchpoint between the government and the child."

Another state employee believed the state of North Dakota has not given schools enough resources to effectively enforce immunization requirements. "In North Dakota, the responsibility [of enforcement] is given to the schools. One caveat of this is that North Dakota is not fortunate

enough to have nurses in all of our schools. I understand what the law says, and I understand the interpretation of that law. It seems we are asking the schools to do things that are difficult without that school nurse infrastructure. I think we have to have a way to require those immunizations to be up-to-date in schools. I'm not sure we have provided, as a state, the appropriate mechanisms to make that happen in a reasonable way for the schools."

Another employee referred to the N.D.C.C. and the inability of the NDDPI to currently require schools to enforce immunization requirements. "The law says schools are the enforcers. If schools don't comply with the law, the NDDPI can impose sanctions on them. What [sanctions] might or might not be is at the state superintendent's discretion. I don't see a situation where the NDDPI has any resources to do local level enforcement. There's no agency or full-time employees that could play that enforcement role."

A different state employee responded, "N.D.C.C. says [NDDPI] is required to enforce or regulate, and we rely on our local superintendents [to enforce]. That's as far as [NDDPI] goes." This person also added, "[It's not about] who's responsible or who should be responsible. I think the schools are more than willing to, for the most part, or at least the NDDPI understands their role and responsibility in this. We want to make sure we share [best practice] information with school districts. That will be where our solutions lie and what we are committed to."

This employee also stated, "Schools are the gateway between government and children. More and more and more has been placed on the schools to be the enforcer. [Schools] have all of these responsibilities and we are the enforcers for everything. We don't like to be the enforcer either. I think we should focus on, 'How can we get the resources and the partnerships [for immunizations] to a better place in North Dakota?'"

School Funding and Immunization Enforcement

Many schools around the state have shared concerns with the NDDPI about enforcing immunization requirements because the loss of students due to exclusion has the potential to affect school attendance which affects school funding, and the NDDPI representatives shared school sentiments during the focus group. One state employee said, "If schools do exclude a child for immunization reasons, I would hope that it wouldn't affect the schools' financials."

Remove Barriers, Increase Access

Many state employees focused on how to remove barriers to immunization throughout the state, including increasing access to immunizations to get more children immunized.

One suggestion to increase access was to engage and/or incentivize local public health units to conduct school immunization clinics and administer immunizations to children who are noncompliant with state immunization requirements. State employees noted how this practice has been historically successful, and how it would remove barriers for parents of children who are not immunized. One state employee shared an example of a school district and local public health unit having an agreement to provide immunizations to children who are not compliant with immunization requirements as a best practice that could be modeled throughout the state.

Other state employees mentioned that local public health units can bill for vaccines and their administration, although some units are resistant to billing for these services and will not do it unless pushed.

State employees also recognized there may not be adequate resources in the state to conduct immunization clinics in each school. One state employee suggested changing state policy to allow paramedics and pharmacists to administer vaccinations to children to help fill the human resource gap. This person also said a pilot program may be needed to see how using paramedics and pharmacists to assist in school immunization clinics and the administration of vaccines would work.

Lastly, state employees acknowledged the schools' challenges in getting immunization records from out-of-state students.

Policy Recommendations

One state employee recommended shifting the penalties for noncompliant students off of the schools and onto the parents of noncompliant students through state taxes. The group did not believe this was possible or logical. The same employee suggested having incentives for schools with total immunization compliance. This suggested incentive for schools was either grant money for school playgrounds or laptops or possible recognition as a healthy school in North Dakota.

One state employee was in favor of changing state policy to allow paramedics and pharmacists to administer school-required vaccinations to children under eleven years old, believing this change could help with the human resources needed to conduct school immunization clinics.

When asked about making the exemption form harder to obtain, such as removing the form offline, state employees were not supportive, saying that this practice would not be transparent and it would be unethical.

Lastly, when discussing policy changes and ways to motivate local public health units to assist with school immunization clinics, one state employee recommended engaging the North Dakota Association of Counties or another similar, influential, socially minded organization to help support the change.

Changing Policy

State employees were very hesitant to change North Dakota's immunization policies, stating, "We don't like opening up that law because you don't know what could happen to it. In other states, they [have not been] as successful as California." Another added, "People will try to get into the vaccination system. By opening that [law] up, you never know where that is going to go. We still have ACIP recommendations [in our state policy, and we would like to keep these recommendations].

Another employee said, "If schools aren't going to enforce this, are they going to make parents go in [to the doctor] and sign the form? [If they aren't], that needs to get corrected. Our [bad] rates are mostly [not because of] exemptions. It's the other part, [the percent who are unaccounted for]. If 97% of kids were vaccinated, I would take that and be proud of it. Unless we can get enforcement figured out, I don't know if it's worth changing [the law]."

Chiropractor Survey

The chiropractic survey received 15 responses. Preliminary results show a broad range of opinions on immunization practice and policy, but the number of responses at this time is too low to have any statistical significance.

Discussion

Focus Groups

The focus group discussions revealed that most parents around the state are immunizing their children. While a significant number of children are entering school only partially immunized, only a very small population does not vaccinate their children at all. It appears that most children who are only partially immunized are so because parents are unaware of immunization requirements or it is inconvenient to get immunizations.

This finding was reassuring, as it suggests that many parents in the state are supportive of vaccinating their children and only a small proportion are not vaccinating their children at all. It also helps to identify areas of improvement, such as parental education or notice when immunizations are due, such as before kindergarten and seventh grade entry.

School's Role in Enforcement of Immunization Requirements

In the United States, high vaccination coverage has been achieved for almost two centuries by making immunizations a requirement for admission to school. The enforcement of immunization requirements is a responsibility given to schools across the United States because schools are a point of contact for the majority of children. Schools also have a large potential for the spread of diseases among children closely quartered for long periods of time, and in the event of a disease outbreak, learning could be disrupted for long periods of time.

While many school administrators expressed frustration with schools being the enforcement arm for immunization requirements, all agreed immunizations were important and many understood why schools have been given this task. Schools are the touchpoint for nearly all children in North Dakota, with over 97% of them attending public or private schools in the state. No other entity can reasonably enforce immunization requirements while also holding parents accountable.

Schools enforcing immunization requirements for the first time mentioned the laborious tasks that occurred to get every child in compliance, with some school districts having hundreds of

students that were noncompliant. Since so many students were brought into compliance during the 2015-2016 school year, it has been anticipated that there will be fewer students noncompliant next year in these schools. With processes already in place and one year of experience to rely on, the process of ensuring immunization compliance among all students will be easier for these schools next year and in years to come.

Some schools shared that they give the immunization exemption form to parents to sign and become compliant with immunization requirements, and it was noted that some parents did sign the form out of convenience. This shows that not all parents claiming exemptions are truly against immunizations, which was also found by Omer et al.

Another barrier for school enforcement is the lack of resources for schools to achieve immunization compliance. Most schools in the state do not have a school nurse, and school secretaries are often tasked with reading and interpreting immunization records and completing the school immunization survey. Local public health units can help fill this role in schools without school nurses, but agreements between the schools and the local public health units need to be reached and services need to be agreed upon.

School Enforcement of Immunization Requirements

It is not a surprise that state and school leadership influence school enforcement policies and enforcement policies impact immunization rates. State leadership and school administration play a very important role in the enforcement of immunization requirements; state leadership sets expectations for school enforcement and school administration are tasked with the execution of enforcement at the local level. Throughout the state, it was observed how inconsistent guidance and direction from state leadership regarding immunization enforcement led to varying school enforcement practices and this ultimately impacted the immunization rates of schools.

In schools where superintendents believed that full childhood immunization compliance was important, immunization rates were significantly higher. Conversely, in schools where leadership expressed that immunization compliance was not of high importance, lower immunization rates were observed.

Many school administrators in schools not enforcing immunization requirements expressed that they were concerned about the number of children that would be excluded from school and the amount of time they would out of school if immunization requirements were strictly enforced. Historical examples from two large school districts that regularly enforce immunization requirements and the two districts that began enforcing this year strongly suggest that significant absenteeism is unlikely to occur and it is essentially a nonissue for enforcing schools. Nearly all enforcing schools reported that most students are back in school within a few days of exclusion.

It was important to determine if immunization rates were different in schools that enforced immunization requirements and those that did not at the beginning of the 2015-2016 school year. During focus groups, schools that annually enforce immunization requirements shared that they make an effort to collect immunization records and exclude children on a deadline. Strict

enforcement policies encourage parents to complete missing immunization records or turn records in to their child's school, resulting in high immunization rates.

In contrast, schools that were not enforcing immunization requirements at the beginning of the 2015-2016 school year had many children with missing records or that weren't up-to-date on all required immunizations. With no motivation to complete immunizations and turn in immunization records, lower immunizations rates in these schools were observed.

Higher immunization exemption rates were not seen in schools enforcing immunization requirements, suggesting that even though the process for obtaining an immunization exemption in North Dakota is relatively easy, most parents in school districts enforcing immunization requirements are not taking advantage of North Dakota's convenient exemption option and are actually immunizing their child according to school requirements.

This data highlights the importance of enforcing school immunization requirements at the beginning of the school year and the large role that it plays in assuring a vaccinated population in each school. The children attending schools that enforce immunization requirements had average immunization rates for each school-required vaccine at or above the Healthy People 2020 goal of 95% of kindergartners being vaccinated. Enforcing schools should be models for North Dakota and the country, achieving high immunization rates in varying communities with varying socioeconomics statuses, class sizes, and resources.

The results are of particular interest for many reasons. Immunization rates have declined in recent years in North Dakota, but data from this project shows that exemption seeking is not the main reason immunization rates were declining. For kindergartners, religious and personal belief exemptions account for a very small proportion of unimmunized or unaccounted for kindergartners.

Data from this project suggests that in North Dakota, Healthy People 2020 Goals could be reached statewide with existing laws and strict school enforcement of immunization requirements. Schools regularly enforcing immunization requirements and schools beginning to enforce immunization requirements during the 2015-2016 school year achieved Healthy People 2020 goals, and statewide enforcement has the potential to increase rates dramatically. While many school administrators shared that they do not believe enforcement of immunization requirements is in their scope of work, enforcement, when exercised, did have a dramatic impact on immunization rates. With a strong recommendation and mandate from the NDDPI regarding school enforcement of immunization requirements, school immunization rates in the state would probably increase significantly.

Policy Changes

Stakeholders universally agreed the process for obtaining immunization exemptions in the state of North Dakota is too easy and should be strengthened. Stakeholders also believed that if North Dakota has three types of immunization exemptions, it should be harder to get them; specifically, many stakeholders believed it should be harder to get an immunization exemption than it is to get vaccinated.

Many ideas were proposed for how to strengthen the current policy, and nearly all focus group participants believed education from a vaccine expert would strengthen the current policy. Healthcare providers and public health nurses were mentioned as professionals that could provide this information. It is important that healthcare providers, including physicians, physician's assistants, and nurse practitioners, along with public health nurses, be able to provide vaccine education to parents. In a rural state like North Dakota where access to healthcare can be limited, public health nurses will be another access point for those requiring education or choosing not to immunize.

Healthcare providers overwhelmingly supported policy changes, and agreed to provide the education to parents should a change occur. Public health nurses, while not as enthusiastic as the healthcare providers, agreed this task could fall within their roles and that they would be willing to provide the education, as well. This is contradictory to healthcare provider opinions previously noted in Arizona. Arizona healthcare providers were asked if they would support a change in immunization policy requiring them to sign off on exemptions. Only 37% of healthcare providers were supportive, believing it would not reduce the number of immunization exemptions, and it would burden their practices.[39]

Making exemptions harder to obtain has helped improve immunization rates in some areas. In Washington State in 2009, legislators passed a law requiring the signature of a healthcare provider for parents wishing to opt out of school required immunizations. Eighteen months after the law took effect, exemption rates had decreased by 25%.[40] In Michigan in 2015, the state began requiring education for parents seeking an immunization exemption. In the first year of the law change, the results were incredibly promising with exemption rates decreasing by 39% statewide.[41]

Washington and Michigan's results reveal how making the process for obtaining an immunization exemption more difficult reduces exemption rates, specifically among two populations. The first population is parents who obtain immunization exemptions out of convenience because they struggle to find time to make immunization appointments or take time off of work. When this population is required to visit with a healthcare provider or public health nurse, they will be more likely to receive the immunizations because their child is usually already partially immunized.

The second group that is affected is those who are hesitant to vaccinate. When hesitant parents visit with a vaccine expert and receive education, they may be more likely to immunize their children. In previous studies, parents have stated that healthcare providers are the most important source of information when making decisions about vaccination, and this change in North Dakota's immunization policy may help sway parents who are hesitant and currently filing immunization exemptions to begin vaccinating their children.[24]

When stakeholders were asked about other potential policy changes, responses were mixed.

Healthcare providers were the only group that strongly supported publishing immunization rates by school. Other groups were not sure if publishing rates would make an impact, while school officials did not believe it would improve immunization rates. Stakeholders were also mixed on whether or not requiring exemptions to be renewed yearly would increase immunization rates and decrease exemption rates.

Although North Dakota may achieve immunization goals through stricter school enforcement as previously mentioned, it should be noted that the rate of parents seeking exemptions in North Dakota has been steadily increasing and could potentially impact immunization rates, even in enforcing schools. A policy change requiring education for parents seeking an exemption would provide a more consistent policy that does not incentivize nonimmunization due to convenience and could not be used by schools as a way to achieve full compliance. This change should be strongly considered by lawmakers.

Policy and Practice Changes Must Work Together

If all schools in North Dakota begin enforcing immunization requirements and excluding noncompliant child and the exemption process is kept the same, it is expected that immunization rates will increase. The change in the rates of exemptions filed in the state will need to be closely monitored. While there is a chance that parents and school administrators may opt for the easy way out and use the exemption form to achieve compliance, significant increases in exemption rates were not seen in the two schools that began enforcing immunization requirements in 2015, providing a small glimpse into what could happen if all schools decide to enforce.

Other Topics

Immunization rates in the state vary drastically by county and from east to west. In the western part of the state where a recent oil boom has occurred, the collection of immunization records from transient populations and new students has been a large, overwhelming barrier for schools when determining immunization rates. As such, counties with low immunization rates appear to cluster in the western part of the state.

The collection of out-of-state immunization records was a challenge mentioned in nearly every focus group, especially in the western part of the state. The difficulty in obtaining a record is a barrier for many parents, and is sometimes enough of a barrier for parents that they will complete an immunization exemption form. States must work together to share immunization records more easily to help parents. Presumably, North Dakota is not the only state dealing with this issue, and a national immunization registry was mentioned many times as a solution. While there are many barriers to the creation and implementation of this registry, it would ultimately benefit the users and is worth pursuing. If a national registry is not realistic, states should work on data sharing agreements between individual states.

Conclusions

State immunization requirements are important for achieving and maintaining high vaccination coverage rates and low rates of vaccine-preventable diseases. When evaluating immunization policy and practice in the state of North Dakota, it is clear that the rapidly changing demographics of the state along with a lack of enforcement of immunization requirements has led to a decline in immunization rates. In addition, the current immunization exemption policy makes it easy for parents to claim exemptions, and it is often being misused by parents seeking exemptions out of convenience.

North Dakota could improve its immunization rates by changing its exemption policy and by requiring strict enforcement of immunization requirements. Both of these changes will increase immunization rates, with the biggest gain coming from strict enforcement in local schools.

Previous studies have shown how immunization policy impacts immunization and exemption rates and incidence of vaccine-preventable diseases, while few have discussed the impact of school enforcement on immunization rates. Further research is needed to understand how to standardize and improve school enforcement of immunization requirements in North Dakota. Further research is also needed to determine how the following impact school-level enforcement, immunization rates, and exemption rates: the enforcement philosophies of statewide leadership and school administrators, school immunization clinics, and the availability of school nurses.

Recommendations to Improve Immunization Rates in North Dakota

To improve immunization rates in North Dakota, the CIRE recommends the following changes, which are organized by policy, rule, and practice/process. Policy changes need legislative approval; rule changes need approval from the state health council; and practice/process changes are activities needed to increase immunization rates.

Policy Changes

The CIRE will offer recommendations for policy changes, which do not include eliminating religious or personal belief exemptions. While stakeholders believed a change in state policy was necessary, the NDDoH should determine the effectiveness of school immunization enforcement before legislative changes are enacted.

North Dakota should require parents and guardians to obtain the signature of a healthcare provider (physician, nurse practitioner, or physician's assistant) or public health nurse to receive a nonmedical exemption to school immunization requirements. The signature would be obtained after healthcare providers or public health nurses provide education to parents and guardians about the benefits and risks of vaccination. The nonmedical exemption form should be available online and once signed by the appropriate provider and the parent or guardian, be turned into a child's school. This process will eliminate parents filing an exemption in North Dakota out of

convenience.

North Dakota Century Code language should be changed; moral and philosophic exemptions should be combined into one exemption and jointly called personal belief exemptions.

Rule Changes

In the North Dakota Administrative Rules, almost all vaccines required for kindergarten are required for subsequent grades if a child missed the kindergarten requirement. When the tetanus, diphtheria, and acellular pertussis (Tdap) booster and meningococcal conjugate (MCV4) vaccines were added as requirements for seventh grade entry in 2008, the law stated it was only required for seventh grade entry and not for subsequent school years. To ensure consistency, the policy should be changed in the Administrative Rules to reflect that these immunizations are required for seventh grade entry and all subsequent school years, if missed at seventh grade.

Practice/Process Changes

The NDDPI, working closely with the NDDoH, should mandate the enforcement of school immunization requirements. This should include a consistent, strong message supporting school enforcement of immunization requirements from the head of the NDDPI and the NDDoH. This message will advocate for the importance of vaccines and the need for schools to be compliant with immunization requirements by a specific date. An expectation should be set by the NDDPI that school superintendents and principals must follow N.D.C.C. and have high vaccination and compliance rates. Support for this initiative is needed from the North Dakota Governor's Office, the NDDPI, the NDDoH, the Attorney General's Office, and more.

If the policy change requiring the signature of a healthcare provider or public health nurse on the nonmedical exemption form is not deemed to be feasible or advisable, the NDDoH should limit access to the immunization exemption form. The immunization exemption form should be available at the NDDoH by request only. The form should not be readily available at schools or on the internet. This recommendation would require the NDDoH to create an electronic form for parents to fill out online for each child for whom they are requesting an immunization exemption. The NDDoH would process each request, and exemption forms would be mailed to the parent or guardian. Exemption forms should have some quality of authentication to protect against duplication, such as an embossed seal. With this option, schools would not be able to hand out the exemption form. Exemptions should be renewed yearly in this proposed change.

If schools are unwilling to enforce immunization requirements, foundation aid should be withheld from schools until all children are compliant with state immunization requirements.

The NDDoH should create a new immunization exemption form. The new form should be separated from the Certificate of Immunization. Moral and philosophical exemptions should be combined into one exemption option on the form. The new form will clarify which vaccines a child is exempt from, which kind of exemption is being requested for each vaccine, and will have

a checklist of items that parents must initial, including acknowledging the risks of not vaccinating and signing the exemption form. The new exemption form be filled out for all exemptions: medical, religious, and personal belief.

The NDDPI and NDDoH should modify the state immunization manual. It should include sample documents, current requirements, best practices, and frequently asked questions. This should be distributed and/or promoted among schools and local public health units. It should include interpretations of the N.D.C.C. for schools to follow and abide by, including guidance on the 30-day grace period and defining the roles of the institutional authority. It should include best practices from schools already enforcing immunization requirements in the state.

The NDDoH should provide more guidance to schools on how to manage immunization compliance and exclusion for homeschooled children in local school systems and how homeschooled children should be accounted for in the school immunization survey. Homeschool data should be provided separately in the school immunization survey.

The NDDPI should incorporate immunization training sessions, round tables, question and answer sessions, and other educational activities for school administrators to take part in and learn about how to best incorporate immunization policies into their school. This will be very beneficial, specifically for new administrators. Trainings could include a panel with representatives from the Attorney General's Office, the NDDPI, the NDDoH, the CIRE, and from school districts currently enforcing immunization requirements. Key messages in these sessions should be: 1) vaccine necessity, 2) 100% compliance, 3) enforcement, 4) financial and legal consequences of noncompliance, and 5) the expectation that exemption forms not be handed out. (The fifth recommendation could be omitted if the process of obtaining the exemption form is changed.)

Properly aligned incentives are imperative for successful enforcement of immunization requirements. The NDDPI and school administrators should review the processes for determining average daily membership and the distribution of foundation aid, as these processes should be aligned with immunization policies. Schools should not be penalized financially when children miss school because of noncompliance with immunization requirements, which negatively impacts average daily attendance. Instead, foundation aid should be withheld for noncompliant students attending school past the exclusion deadline. The NDDPI, with assistance from the NDDoH, should randomly validate school enforcement policies and practices in schools each year.

The NDDPI and NDDoH should encourage all schools to track immunization status and compliance through the use of an electronic system.

The NDDPI and NDDoH should better market the resources they have available to schools regarding immunization policy and practice. This includes a template letter for schools to send to parents of noncompliant children, school immunization survey guidance, and other resources as

requested by schools, the NDDoH, and the NDDPI.

The NDDoH should develop and target educational strategies for schools with high immunization exemption rates, particularly private schools.

All schools should follow the 30-day grace period outlined in the N.D.C.C., and should exclude noncompliant students 30 days after the start of the school year or 30 days after enrolling in a school system. This consistent exclusion deadline will help standardize enforcement practices in the state. Alternatively, if schools do not follow the 30-day grace period outlined in the N.D.C.C., schools should exclude noncompliant students by November 1st of each year. This deadline will help ensure immunization compliance and accuracy in the school immunization survey, which is typically due in mid-November.

All schools should work closely with local public health units to improve immunization rates and compliance with state immunization requirements. This will reduce barriers such as transportation and convenience.

Local public health units, particularly in rural communities, should create a memorandum of understanding with local schools so they can assist the schools with immunization record collection, determining immunization compliance, and completing the school immunization survey accurately. Local public health units should also assist the school in sending letters to families of children noncompliant with immunization requirements.

In many communities, local public health units also attend school registration and kindergarten round-up events to provide immunization records, interpret immunization records and answer parent questions on site. Local public health units could also schedule immunization appointments during registration events for children noncompliant with school requirements or administer immunizations at that time.

Schools receiving out-of-state records should implement a process where these records are passed on to local public health units after school verification so the records can be entered into the NDIIS. This will allow more accurate, real-time tracking of immunization rates, help with future data collection, and be a resource for parents and children should they move to another state and need immunization records in the future.

School immunization clinics are an important part of achieving high immunization rates across the state. They remove barriers for parents and help noncompliant children receive missing immunizations. In the state of North Dakota, many rural public health units are working with schools to give catch-up immunizations in schools to children not fully compliant with state requirements. All local public health units should work with schools in their counties and districts to provide immunization clinics for school-required immunizations, seasonal influenza vaccinations, and other recommended vaccines, such as the human papillomavirus vaccine.

Schools should work with local public health units to schedule school immunization clinics. Schools should designate time and space for clinics to occur, and children should be excused from class to receive immunizations. Parental consent forms should be sent home to parents before immunization clinics to be filled out and returned to the school by an acceptable deadline.

For children that are in the process of receiving all school-required immunizations, schools should follow-up with those children every 30 days to reassess immunization compliance. This 30-day grace period should also be used to follow-up with students entering a school during the school year. The 30-day period should only be allowed and started in the following circumstances: 1) after the start of the school year, 2) after a child enters the school system, or 3) when a child is in the process of receiving a series of immunizations and the child becomes eligible to receive the next immunization in the series.

When the 30-day grace period is complete and the exclusion deadline occurs, schools should only allow children to attend school if progress has been made towards completing school required immunizations, including 1) receiving immunizations, or 2) an immunization appointment has been made. Exclusion should only occur for children who have not made any progress towards becoming compliant with state immunization requirements.

The NDDoH should continue to work with other states on data sharing agreements to easily access immunization records of children from out-of-state. In addition, a national immunization registry should be explored in depth.

Local immunization stakeholders should meet yearly to discuss best practices, immunization clinics, potential collaborations, and concerns. This should include healthcare providers, public health nurses, and school administrators and staff. The NDDoH and NDDPI should encourage participation and assist when needed.

Lastly, to help increase immunization understanding and compliance in the New American community, the NDDoH should work closely with New Americans, translators and local public health units to develop culturally competent, basic immunization materials in the languages spoken by New Americans. Materials could be provided to parents and other members of New American communities, and this would greatly benefit schools and New Americans and help them achieve immunization compliance. The NDDoH should work closely with Lutheran Social Services and healthcare centers serving the New American populations to develop practices that will help New Americans achieve immunization compliance.

Best Practices

The following are best practices that were found during focus groups and one-on-one interviews. The NDDoH should provide guidance on best practices to schools and clinics. Other best practices, once identified, should be compiled into an immunization toolkit or manual and given

to North Dakota schools.

School Immunization Clinics and Working with Local Public Health Units

In 2014, First District Health Unit in north central North Dakota contacted Burlington Public Schools about a Quality Improvement Pilot Project for North Dakota's Required School Immunizations. This project included public health staff assessing immunization records in the spring of 2014 and giving immunizations to sixth, seventh, and eighth graders who were not compliant with N.D.C.C. or who needed immunizations for the fall of 2014. In the fall of 2014, public health staff assessed and updated records, assisted parents in acquiring immunization records, administered immunizations required for school entry, and also administered recommended immunizations.

The school and local public health unit worked together to review all sixth, seventh, and eighth grade students' immunization records. For the students missing required immunizations, a letter, consent form, and vaccine information sheets were sent home to parents. The letter informed parents about which immunizations their child was missing, and instructed them to indicate which vaccines they wanted their child to receive in a school immunization clinic. Students in seventh and eighth grade that were missing immunizations were brought up-to-date, and 6th graders were brought into immunization compliance for the following school year.

In the fall of 2014, public health staff attended registration events and held school immunization clinics on those days. Public health staff were available to give immunizations, look up immunization records, and answer questions.

At the beginning of the 2014-2015 school year, Burlington Elementary School had 100% immunization compliance among their student body. School clinics improved immunization rates and the relationship between the local public health unit and the school. Parents and school staff found the clinics to be convenient and save time. (M. Fettig. Written and oral communication, March 2016)

The CIRE also learned of some collaborations and agreements between local public health units and schools.

In some agreements, public health staff are assigned a position in the school so they can come into the schools and have access to immunization records to help determine immunization compliance. The NDDoH worked with the North Dakota Attorney General's Office to draft a memorandum on how the agreement can be structured, and this is available to groups who desire a reference.

In other settings, North Dakota schools and their local public health units have verbal agreements where public health nurses come in to schools multiple times a year for school immunization clinics. Public health nurses review students' records, help determine who needs immunizations, and assist the schools in sending letters, immunization forms, and insurance forms to parents of noncompliant children. The forms are returned to the school, space is designated for school

immunization clinics, and this positive working relationship has helped increase immunization compliance in participating schools.

Limitations of This Project

There are limitations to this work. For focus groups, the majority of stakeholders resided in or near the larger, more urban cities according to North Dakota standards. Although there was some participation from rural stakeholders in focus groups and in interviews, much of the results in this paper are from participants in urban areas of North Dakota. Additionally, nearly all enforcement data used was from larger school districts. Because North Dakota is a very rural state, future research could be more inclusive of rural stakeholders and data to gain a broader perspective.

Because of time, resources, and other factors, this project did not have participation from a representative sample of immunization stakeholders in North Dakota. In total, the CIRE only met with 189 immunization stakeholders in the state, and their views may not be representative of all stakeholders in each category, particularly parents. Parents were recruited through parent teacher organizations and university staff listserv emails. This is likely to introduce some skewing away from less educated parents or parents of lower socioeconomic status. Because the focus groups were primarily a qualitative study of attitudes and practices based on a convenience sample, readers should not assume that any expressed opinions represent statistically significant results from a definitive representative sample of stakeholders across the entire state.

There is potential for bias in the study populations, specifically selection bias. Focus groups relied mostly on volunteer stakeholders for participation, resulting in self-selection for people with strong opinions on either side of an issue. Additionally, stakeholders were surveyed in a group setting, likely causing more neutral participants to respond in a more extreme way given the environment.

Focus groups were not conducted with chiropractors and legislators, although some legislators were interviewed. With legislators being spread throughout the state, and without a current legislative session in progress, the CIRE did not feel that a focus group of legislators would be feasible. Because chiropractors work varying schedules with very few in large practices, the logistics of bringing chiropractors together for a focus group was also impractical. After visiting with the NDCA about the immunization survey, the CIRE offered to conduct a focus group of chiropractors; the CIRE received no response.

Nearly all of the data used in this project was aggregate data, especially when considering school immunization rates. Individual data was not available at the two time points where enforcement was compared, therefore, a change in vaccination rates could represent 1) a change in behavior of the same set of students, 2) a change in the individuals that entered and left a school, or 3) a combination of both. Most students will be the same at both time points, but data was analyzed by treating the samples as independent, as this is the more conservative option. Thus, all statistically significant results would carry the same interpretation had students been analyzed under the other assumption using the same student at both time points.

Lastly, the CIRE's goal is to improve immunization rates in the upper Midwest. Although the goal was to provide neutral facilitation of all focus groups, the CIRE should not be viewed as an uninterested and independent third party facilitator.

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About the Center for Immunization Research and Education:

The CIRE was founded in 2015 at North Dakota State University within the Department of Public Health.

The mission and purpose of the CIRE is to address concerning trends in vaccine coverage through education and research, improve regional rates of vaccine acceptance and uptake, and thereby decrease the risk for vaccine-preventable diseases in the upper Midwest.

CHAPTER 23-07
REPORTABLE DISEASES

23-07-01. State department of health - Collection of public health information.

The state department of health shall designate the diseases or conditions that must be reported. Such diseases or conditions may include contagious, infectious, sexually transmitted, or chronic diseases or any illness or injury which may have a significant impact on public health. The state department of health shall maintain a uniform statewide population-based registry system for the collection of data pertaining to the incidence, prevalence, risk factors, management, survival, mortality, and geographic distribution of cancer and reportable benign tumors.

23-07-01.1. Reporting of physical or mental disorders.

The state department of health shall define disorders characterized by lapses of consciousness, gross physical or mental impairments for the purposes of the reports hereinafter referred to:

1. A physician or other health care provider may report immediately to the department of transportation in writing, the name, date of birth, and address of every individual fourteen years of age or over coming before them for examination, attendance, care, or treatment if there is reasonable cause to believe that the individual due to physical or mental reason is incapable of safely operating a motor vehicle or diagnosed as a case of a disorder defined as characterized by lapses of consciousness, gross physical or mental impairments, and the report is necessary to prevent or lessen a serious and imminent threat to the health or safety of the individual or the public.
2. Such reports as required in this section are for the information of the director of the department of transportation in determining the eligibility of any person to operate a motor vehicle on the highways of this state and must be kept confidential and not divulged to any person or used as evidence in any trial, except that the reports may be admitted in proceedings under section 39-06-33.
3. The physician-patient privilege provided for by rules 501 and 503 of the North Dakota Rules of Evidence may not be asserted to exclude evidence regarding the mental or physical incapacity of a person to safely operate a motor vehicle in the reports as required under the provisions of this section.
4. Any physician or other medical professional who fails to make a report or who in good faith makes a report, gives an opinion or recommendation pursuant to this section, or participates in any proceeding founded upon this section is immune from any liability, civil or criminal, that might otherwise be incurred, as a result of such report, except for perjury.

23-07-01.2. Rules.

The department may adopt rules under chapter 28-32 for the efficient enforcement of this chapter.

23-07-02. Who to report reportable diseases.

Except as otherwise provided by section 23-07-02.1, the following persons or their designees shall report to the state department of health any reportable disease coming to their knowledge:

1. All health care providers, including physicians, physician assistants, nurse practitioners, nurses, dentists, medical examiners or coroners, pharmacists, emergency medical service providers, and local health officers.
2. The director, principal manager, or chief executive officer of:
   a. Health care institutions, including hospitals, medical centers, clinics, long-term care facilities, assisted living facilities, or other institutional facilities;
   b. Medical or diagnostic laboratories;
   c. Blood bank collection or storage centers;

d. Public and private elementary and secondary schools;
e. Public and private universities and colleges;
f. Health or correctional institutions operated or regulated by municipal, county or multicounty, state, or federal governments;
g. Funeral establishments and mortuaries; and
h. Child care facilities or camps.

3. The state veterinarian, if the disease may be transmitted directly or indirectly to or between humans and animals.
4. A person having knowledge that a person or persons are suspected of having a reportable disease may notify the department and provide all information known to the person reporting concerning the reportable disease or condition of the person or persons.

If the person reporting is the attending physician or the physician's designee, the physician or the physician's designee shall report not less than twice a week, in the form and manner directed by the state department of health, the condition of the person afflicted and the state of the disease. A person making a report in good faith is immune from liability for any damages which may be caused by that act.

23-07-02.1. Reports of human immunodeficiency virus infection - Penalty.

Every attending physician treating an individual known by the physician to have a diagnosis of human immunodeficiency virus infection, acquired immune deficiency syndrome, or human immunodeficiency virus-related illness, including death from human immunodeficiency virus infection, shall make a report on that individual to the state department of health. A person treating an individual known to have human immunodeficiency virus infection in a hospital, a clinic, a sanitarium, the physical custody of the department of corrections and rehabilitation, a regional or local correctional facility or juvenile detention center, the North Dakota youth correctional center, or other private or public institution shall make a report on that individual to the facility administrator or the facility administrator's designee. Further disclosure of information on any individual known to have human immunodeficiency virus infection may only be provided to medical personnel providing direct care to the individual or as otherwise authorized by law. The designated official shall, if satisfied that the report is valid, make a report to the department on each individual having a diagnosis of human immunodeficiency virus infection, acquired immune deficiency syndrome, or human immunodeficiency virus-related illness, including death from human immunodeficiency virus infection, unless the diagnosed individual's attending physician has made such a report. The reports required under this section must contain the name, date of birth, sex, and address of the individual reported on and the name and address of the physician or designated official making the report. Failure by a facility to designate an official to whom reports must be made is an infraction. Any person who in good faith complies with this section is immune from civil and criminal liability for any action taken in compliance with this section.

23-07-02.2. Confidentiality of reports.

A report required by section 23-07-02.1 and held by the state department of health is confidential information. The information may not be disclosed, shared with any agency or institution, or made public, upon subpoena, search warrant, discovery proceedings, or otherwise, except that:

1. Disclosure may be made of medical or epidemiological information for statistical purposes in a manner such that no individual person can be identified;
2. Disclosure may be made of medical or epidemiological information to the extent necessary to enforce section 23-07-02.1 and this section and related rules concerning the treatment, control, and investigation of human immunodeficiency virus infection by public health officials; or
3. Disclosure may be made of medical or epidemiological information to medical personnel to the extent necessary to protect the health or life of any individual.

No officer or employee of the state department of health may be examined in any judicial, executive, legislative, or other proceeding regarding the existence or content of any individual's report retained by the department under section 23-07-02.1.

23-07-02.3. Emergency reporting.

1. The state health officer may issue a temporary order for emergency reporting of disease conditions or information if the state health officer finds probable cause to believe there is a threat caused by an imminent or emerging condition affecting the public health, including actual or threatened terrorism.
2. The state health officer may designate who must report, what conditions or information must be reported, what information must be contained in the report, the methods and frequency of reporting, and may make any other pertinent requirement.
3. The temporary order may be issued and is effective without regard to chapter 28-32 for a period of ninety days, unless earlier revoked by the state health officer. Emergency rulemaking must be initiated under chapter 28-32 within ninety days of the order or the order expires. The temporary order and any emergency rulemaking under this section are effective without the necessity of approval from the health council.

23-07-03. Report of cases of sexually transmitted disease.

The superintendent of a hospital, dispensary, or charitable or penal institution, in which there is a case of sexually transmitted disease, or the superintendent's designee, shall report such case to the nearest health officer having jurisdiction. The report must be made in the form and manner directed by the state department of health.

23-07-04. Report of reportable disease by township board of health.

Repealed by S.L. 1999, ch. 242, § 7.

23-07-05. Local health officers to report reportable disease to state department of health.

At such time as may be required by the state department of health, each local health officer shall submit to such department, on blanks furnished by the department for that purpose, a summarized report of the reportable diseases reported to the health officer during the week. When no cases have been reported during the week, the report must be made with the notation "No cases reported".

23-07-06. Contagious or infectious diseases - Power of local board of health to quarantine.

Whenever a local board of health knows that a case of a contagious or infectious disease exists within its jurisdiction, the board immediately shall examine the facts of the case and may adopt such quarantine and sanitary measures as in its judgment tend to prevent the spread of such disease. The board immediately may cause any person infected with such disease to be removed to a separate house if, in the opinion of the health officer, such person can be removed without danger to that person's health. If the infected person cannot be removed without danger to that person's health, the local board shall make such quarantine regulations as it deems proper with reference to the house within which such infected person is, and may cause the persons in the neighborhood to be removed, and may take such other measures as it deems necessary for the safety of the inhabitants within its jurisdiction. Quarantine measures adopted under this section must be in compliance with chapter 23-07.6.

23-07-07. Sexually transmitted diseases - Additional powers and duties of health officers.

The state health officer, and each district, county, and city health officer within the officer's jurisdiction, when necessary for the protection of public health, shall:

1. Make examination of any person reasonably suspected of being infected with a sexually transmitted disease and detain that person until the results of the examination are known.
2. Require any person infected with a sexually transmitted disease to report for treatment to a reputable physician and to continue such treatment until cured or, if incurable, continue indefinitely such treatment as recommended by the physician.
3. Investigate sources of infection of sexually transmitted diseases.
4. Cooperate with the proper officials whose duty it is to enforce laws directed against prostitution, and otherwise to use every proper means for the repression of prostitution, including providing proper officials with all relevant information available concerning individuals who are infected with the human immunodeficiency virus and who are engaged in prostitution.

23-07-07.1. Blood sample of pregnant woman must be submitted for serological test for syphilis.

Repealed by S.L. 1991, ch. 263, § 1.

23-07-07.2. Definitions.

Repealed by S.L. 1991, ch. 263, § 1.

23-07-07.3. Certificates reporting births and stillbirths to state whether blood test made.

Repealed by S.L. 1991, ch. 263, § 1.

23-07-07.4. Penalty.

Repealed by S.L. 1991, ch. 263, § 1.

23-07-07.5. Testing of inmates and convicted individuals for exposure to the human immunodeficiency virus - Reporting - Liability.

1. The following individuals must be examined or tested for the presence of antibodies to or antigens of the human immunodeficiency virus:
   a. Every individual convicted of a crime who is imprisoned for fifteen days or more in a grade one or grade two jail, a regional correctional facility, or the state penitentiary;
   b. Every individual, whether imprisoned or not, who is convicted of a sexual offense under chapter 12.1-20, except for those convicted of violating sections 12.1-20-12.1 and 12.1-20-13; and
   c. Every individual, whether imprisoned or not, who is convicted of an offense involving the use of a controlled substance, as defined in chapter 19-03.1, and the offense involved the use of paraphernalia, including any type of syringe or hypodermic needle, that creates an epidemiologically demonstrated risk of transmission of the human immunodeficiency virus.
2. The results of any positive or reactive test must be reported to the state department of health in the manner prescribed by the department and to the individual tested. Subsection 1 does not require the testing of an individual before sentencing or the testing of an individual held in a jail or correctional facility awaiting transfer to the state penitentiary.
3. A licensed physician, nurse, technician, or employee of a hospital or clinic who draws blood from any person for the purpose of conducting a test required by this section is not liable in any civil action for damages arising out of such action except for an act or omission that constitutes gross negligence.

23-07-07.6. Report of testing result of imprisoned individuals.

Notwithstanding any other provision of law, the state department of health or any other agency shall release the results of any testing for any reportable disease performed on an

individual convicted of a crime who is imprisoned if the request is made by any individual and the individual provides written proof from the administrator of the facility with control over the individual imprisoned which states that the individual has had a significant exposure as defined in section 23-07.3-01.

23-07-08. Persons in prison examined and treated for sexually transmitted diseases.

Every person convicted of a crime who is imprisoned fifteen days or more in a state, county, or city prison must be examined for sexually transmitted disease and, if infected, must be treated therefor by the health officer within whose jurisdiction the person is imprisoned.

23-07-09. Sexually transmitted diseases - Persons isolated in prison - Exceptions.

The prison authorities of any state, county, or city prison shall make available to the health officers such portion of the prison as may be necessary for a clinic or hospital wherein the following persons may be isolated and treated:

1. Persons who are imprisoned in the prison and who are infected with a sexually transmitted disease.
2. Persons who are suffering with a sexually transmitted disease at the time of the expiration of their term of imprisonment.
3. Persons isolated or quarantined by the health officer when no other suitable place for isolation or quarantine is available.

In lieu of such isolation, any of such persons, in the discretion of the health officer, may be required to report for treatment to a licensed physician. This section may not be construed to interfere with the service of any sentence imposed by a court as punishment for the commission of crime.

23-07-10. Preventing infant blindness - Duty of physician or midwife.

All physicians, midwives, or other persons in professional attendance upon a birth always shall examine the eyes of the infant carefully. If there is the least reason to suspect the presence of a disease of the eyes, such person shall apply such prophylactic treatment as may be recognized as efficient in medical science.

23-07-11. Duty of parent to report to health officer.

If one or both eyes of an infant becomes inflamed, swollen, or reddened, or shows any unnatural discharge or secretion at any time within two weeks after birth, and if no legally qualified physician is in attendance upon the infant at that time, the parents of the child, or in their absence, whoever is caring for said infant, shall report the fact in writing, within six hours after discovery, to the health officer having jurisdiction. Such report need not be made from a recognized hospital.

23-07-12. Health officer to place reported infant in charge of physician.

Upon receipt of a report as provided for in section 23-07-11, the health officer shall direct the parents or whoever has charge of the infant suffering from inflammation, swelling, redness, or unnatural secretion or discharge of the eyes, to place it immediately in charge of a legally qualified physician.

23-07-13. Contagious or infectious diseases - Local board may establish temporary hospital.

Each local board of health may provide such temporary hospital or place of reception for persons afflicted with any contagious or infectious disease as it judges best for their accommodation and the safety of the inhabitants. It may provide a means of transportation to such hospital for persons suffering from any such disease. All such hospitals, and all private houses or other places in which exists any contagious or infectious disease, during the existence of such disease, are under the control and subject to the regulations of the local board of health.

23-07-14. Contagious or infectious diseases - Local board may destroy or disinfect infected clothing.

Any local board of health may cause to be destroyed any bed, bedding, clothing, carpets, or other articles which have been exposed to infection from a contagious or infectious disease and may allow reasonable compensation for the same. The board also may provide a proper place with all necessary apparatus and attendants for the disinfection of such articles and may cause all such articles to be conveyed to such place to be disinfected.

23-07-15. Removal of person afflicted with contagious or infectious disease - Removal of person who died of such disease - Prohibited.

No person, unless the person has a permit from the local board of health or state department of health, may remove or cause to be removed from without this state into this state, or from one building to another within this state, or from or to any railroad car or motor vehicle, any person afflicted with a contagious or infectious disease, or the body of any person who died of any such disease.

23-07-16. Child having contagious or infectious disease prohibited from attending school - Exception.

Except as provided by section 23-07-16.1, no principal, superintendent, or teacher of any school, and no parent or guardian of any minor child, may permit any child having any significant contagious or infectious disease, or any child residing in any house in which any such disease exists or has recently existed, to attend any public or private school until permitted to do so under the regulations of the local board of health.

23-07-16.1. School district to adopt policy relating to significant contagious diseases.

Each school district shall adopt a policy governing the disposition of children attending school within the school district, employees of the school district, or independent contractors under contract with the school district who are diagnosed as having a significant contagious disease. The state department of health shall, with advice from the superintendent of public instruction, adopt rules establishing guidelines for the policy. The guidelines may include methods and procedures relating to a determination of whether and under what conditions a child with a significant contagious disease may not continue attending school or whether and under what conditions an employee or an independent contractor with a significant contagious disease may not continue in a work assignment.

23-07-17. Vaccination or inoculation not required for admission to any school or for the exercise of a right.

Repealed by S.L. 1975, ch. 224, § 2.

23-07-17.1. Inoculation required before admission to school.

1. A child may not be admitted to any public, private, or parochial school, or day care center, child care facility, head start program, or nursery school operating in this state or be supervised through home-based instruction unless the child's parent or guardian presents to the institution authorities a certification from a licensed physician or authorized representative of the state department of health that the child has received age-appropriate immunization against diphtheria, pertussis, tetanus, measles, rubella (German measles), mumps, hepatitis B, haemophilus influenza type b (Hib), varicella (chickenpox), poliomyelitis, pneumococcal disease, meningococcal disease, rotovirus, and hepatitis A. In the case of a child receiving home-based instruction, the child's parent or legal guardian shall file the certification with the public school district in which the child resides.
2. A child may enter an institution upon submitting written proof from a licensed physician or authorized representative of the state department of health stating that the child has started receiving the required immunization or has a written consent by the child's parent or guardian for a local health service or department to administer the needed

immunization without charge or has complied with the requirements for certificate of exemption as provided for in subsection 3.

3. Any minor child, through the child's parent or guardian, may submit to the institution authorities either a certificate from a licensed physician stating that the physical condition of the child is such that immunization would endanger the life or health of the child or a certificate signed by the child's parent or guardian whose religious, philosophical, or moral beliefs are opposed to such immunization. The minor child is then exempt from the provisions of this section.
4. The enforcement of subsections 1, 2, and 3 is the responsibility of the designated institution authority.
5. The immunizations required, and the procedure for their administration, as prescribed by the state department of health, must conform to recognized standard medical practices in the state. The state department of health shall administer the provisions of this section and shall promulgate rules and regulations in the manner prescribed by chapter 28-32 for the purpose of administering this section.
6. When, in the opinion of the health officer, danger of an epidemic exists from any of the communicable diseases for which immunization is required under this section, the exemptions from immunization against such disease may not be recognized and children not immunized must be excluded from an institution listed in subsection 1 until, in the opinion of the health officer, the danger of the epidemic is over. The designated institution authority shall notify those parents or guardians taking legal exception to the immunization requirements that their children are excluded from school during an epidemic as determined by the state department of health.
7. When, in the opinion of the health officer, extenuating circumstances make it difficult or impossible to comply with immunization requirements, the health officer may authorize children who are not immunized to be admitted to an institution listed in subsection 1 until the health officer determines that the extenuating circumstances no longer exist. Extenuating circumstances include a shortage of vaccine and other temporary circumstances.

23-07-18. Physician to report death from contagious or infectious disease to local board of health.

Each practicing physician in this state shall report to the local board of health within the jurisdiction of which the death occurred, in writing, the death of any of the physician's patients who has died of any contagious or infectious disease. The report must be made within twenty-four hours after such death and must state the specific name and character of the disease.

23-07-19. Appropriation made on report showing action necessary to prevent spread of tuberculosis.

If any society or association organized and existing for the purpose of controlling the spread of tuberculosis in this state considers it necessary to secure the services of a visiting nurse or nurses, or to disinfect any building, room, residence, hotel, or other place infected with tuberculosis, the society shall report such fact to the president of the county board of health and to the board of county commissioners. The report must recommend the course of action advisable to be adopted by the board of county commissioners in relation thereto and in accordance with the provisions of this chapter, and such board, at its next meeting, shall consider such report and recommendation and act on the same. The board may audit and allow bills for services rendered in carrying into effect any action taken by it under the provisions of this section.

23-07-20. Board of county commissioners may appropriate money to prevent the spread of tuberculosis.

The board of county commissioners of any county in this state may appropriate county money and levy taxes within the county levy limitations for the purpose of paying for the

services of visiting nurses or other necessary medical attention or advice in preventing the spread of tuberculosis in the county, or for the purpose of disinfecting any building, room, residence, hotel, or other place in such county infected with tuberculosis, and may cooperate with neighboring counties to establish homes or hospitals for incurable tuberculosis patients.

23-07-20.1. Disclosure of records.

To protect the integrity of disease control records, to ensure their proper use, and to ensure efficient and proper administration of the department's disease control function, it is unlawful for any person to permit inspection of or to disclose information contained in disease control records, including results of laboratory tests, or to copy or issue a copy of all or part of any such record except as authorized by rules.

23-07-21. Penalties.

Except as otherwise provided in this section, a person is guilty of an infraction:

1. Who violates or fails to obey any provision of this chapter, any lawful rule made by the state department of health, or any order issued by any state, district, county, or municipal health officer;
2. Who violates any quarantine law or regulation, or who leaves a quarantined area without being discharged; or
3. Who, knowing that the person is infected with a sexually transmitted disease, willfully exposes another person to infection.

Any person required to make a report under section 23-07-02.1 who releases or makes public confidential information or otherwise breaches the confidentiality requirements of section 23-07-02.2 is guilty of a class C felony.

CHAPTER 33-06-05
SCHOOL IMMUNIZATION REQUIREMENTS

33-06-05-01. Requirements.

1. **Definitions.** As used in this section:

   a. "Advisory committee on immunization practices" refers to a panel of experts in fields associated with immunization who have been selected by the secretary of the United States department of health and human services to provide advice and guidance to the secretary, the assistant secretary for health, and the centers for disease control and prevention on the most effective means to prevent vaccine-preventable diseases.

   b. "Age-appropriate immunizations" refers to the vaccines a child should receive based on age and previous immunization history as recommended by the advisory committee on immunization practices of the United States department of health and human services and outlined by the North Dakota immunization schedule.

   c. "Beliefs" as used in subsection 3 of North Dakota Century Code section 23-07-17.1 means sincerely held religious, philosophical, or moral beliefs which are not a pretense for avoiding legal requirements.

   d. "Institution" includes all early childhood facilities, head start programs, preschool educational facilities, public and private kindergartens, and elementary, middle, and high schools operating in North Dakota.

   e. "Institutional authority" means anyone designated by the governing body of an institution.

   f. "Medical exemption" means an exemption from an immunization requirement based on a form signed by a licensed physician stating that the physical condition of the child seeking the exemption is such that the vaccine administered would endanger the life or health of the child.

2. **Minimum requirements.**

   a. Minimum requirements for children attending early childhood facilities, head start programs, and preschool educational facilities shall be age-appropriate immunizations against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella,

haemophilus influenzae type B disease, varicella (chickenpox), pneumococcal disease, rotavirus, and hepatitis A.

b. Minimum requirements for children attending kindergarten through grade twelve shall be age-appropriate immunizations against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, varicella (chickenpox), and meningococcal disease.

3. **Effective dates.**

a. Effective with the 1992-93 school year, a second dose of measles, mumps, and rubella vaccine is required for school entry into kindergarten or first grade if the student's school does not have a kindergarten. Each subsequent year, the next higher grade will be included in the requirement so those students transferring into North Dakota schools are added to the measles, mumps, and rubella immunization cohort.

b. Effective with the 2000-01 school year, a student must complete the hepatitis B vaccine series prior to entry into kindergarten or first grade if the student's school does not have a kindergarten. Each subsequent year, the next higher grade will be included in the hepatitis B immunization requirement so those students transferring into North Dakota schools are added to the hepatitis B immunization cohort.

c. Effective January 1, 2004, in order to attend an early childhood facility, head start program, or preschool educational facility, each child must be adequately immunized against varicella (chickenpox) disease according to the advisory committee on immunization practices.

d. Effective with the 2004-05 school year, a student must receive the varicella (chickenpox) vaccine before being admitted into any kindergarten or first grade if the student's school does not have a kindergarten. Each subsequent year, the next higher grade will be included in the varicella immunization requirement so those students transferring into North Dakota schools are added to the varicella immunization cohort.

e. Effective January 1, 2008, in order to attend an early childhood facility, head start program, or preschool educational facility, each child must be adequately immunized according to the advisory committee on immunization practices against pneumococcal disease, rotavirus, and hepatitis A.

f. Effective with the 2008-09 school year, a student must receive a second dose of varicella (chickenpox) vaccine before being admitted into kindergarten or first grade if the student's school

does not have a kindergarten. Each subsequent school year, the next higher grade will be included in the second dose varicella (chickenpox) immunization requirement so those students transferring into North Dakota schools are added to the second dose varicella (chickenpox) immunization cohort.

g. Effective with the 2014-15 school year, a student must receive meningococcal and tetanus, diphtheria, and pertussis (tdap) vaccine before being admitted into any seventh grade.

4. **Exemptions.** A child with a medical or a beliefs exemption is exempt from any one or all of the immunization requirements. A physician must sign an exemption form indicating the vaccines that are included in the medical exemption. A parent or guardian must sign an exemption form stating that the child has a beliefs exemption and indicate which vaccines are exempt because of beliefs. A child with a reliable history of chickenpox disease is exempt from varicella (chickenpox) immunization requirements. A physician or parent or guardian must sign an exemption form stating that the child has had chickenpox disease. Exemption forms must be kept on file with the immunization records at the child's school, early childhood facility, head start program, or preschool educational facility.

5. **Recordkeeping and reporting.** Records and reports requested by the state department of health shall be completed and submitted to the state department of health.

   a. Certificates of immunization, a North Dakota immunization information system (NDIIS) record, or other official proof of immunization must be presented to the designated institutional authority before any child is admitted to an institution.

   b. Upon request by the institutional authority and approval by the department, the department shall provide access to the NDIIS by institutional authority. The department of health shall disclose immunization records maintained by the NDIIS to an institutional authority to fulfill the required proof of immunization.

   c. The parent or guardian of a child claiming a medical or beliefs exemption shall present an appropriately signed statement of exemption to the designated institutional authority. Proof of immunization or the statement of exemption must be maintained by the child's school or early childhood facility.

   d. The school or early childhood facility immunization summary report must be submitted to the state department of health by November first of each year or such other annual date as the department may designate.

6. **Appointment of an institutional authority.**

   a. An institutional authority shall be appointed for each institution by its governing board or authorized personnel. The authority must be an employee of such institution.

   b. The name of the designated institutional authority, the institution, address, and telephone number shall be submitted to the appropriate governing state department by July first of each year.

7. **Provisional admission - Exclusion.** Any child admitted to school or early childhood facility under the provision that such child is in the process of receiving the required immunizations shall be required to receive the immunizations according to the recommended schedule set forth by the state department of health. Any child not adhering to the recommended schedule shall provide proof of immunization or a certificate of immunization within thirty days of enrollment or be excluded from school or early childhood facility.

History: Amended effective November 1, 1979; September 1, 1991; January 1, 1998; February 1, 2000; January 1, 2004; January 1, 2008; January 1, 2014.
General Authority: NDCC 23-01-03
Law Implemented: NDCC 23-07-17.1

Appendix B. North Dakota Certificiate of Immunization

CERTIFICATE OF IMMUNIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 16038 (Revised 05-2012)

Division of Disease Control
2635 East Main Ave. PO Box 5520
Bismarck, ND 58506-5520
800.472.2180 or 701.328.3386

North Dakota law requires this form be completed* and provided to the childcare facility or school.

Child's Name (Last, First, Middle Initial):	Date of Birth:
Parent's Name:	Telephone Number:

Vaccine Type		Exemption Check type below[€]	Enter Month/Day/Year for Each Immunization Given				
Hepatitis B	Hepatitis B	☐					
Rotavirus	Rotavirus	☐					
Hib	*Haemophilus influenzae* type B	☐					
PCV	Pneumococcal conjugate	☐					
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis	☐					
OPV/IPV	Polio	☐					
MMR	Measles-Mumps-Rubella	☐					
Varicella	Chickenpox	☐			**History of Disease Date:**		
Hepatitis A	Hepatitis A	☐					
Td/Tdap	Tetanus-Diphtheria (and Pertussis)	☐					
MCV4	Meningococcal	☐					
HPV	Human Papillomavirus	☐					
Other		☐					

To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.

Physician, Nurse, Local/State Health	Title	Date

If additional doses are added after initial signature, please initial dose and sign below.

Update signature #1:		
Physician, Nurse, Local/State Health:	Title:	Date:
Update signature #2:		
Physician, Nurse, Local/State Health:	Title:	Date:

My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) that my child's immunizations are incomplete and to submit a signed Certificate of Immunization.

Parent/Guardian Signature: Date:

Statement of Exemption to Immunization Law

In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

Medical Exemption: **The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.**

Physician Signature:	Date:

[€]***Exemption:*** *(Indicate vaccine above)*

(Please check one) ☐ Religious ☐ Philosophical ☐ Moral ☐ History of Disease

Parent/Guardian Signature	Date

NDSU NORTH DAKOTA STATE UNIVERSITY

NDSU CENTER FOR IMMUNIZATION RESEARCH AND EDUCATION

STUDENT FOCUSED • LAND GRANT • RESEARCH UNIVERSITY

Immunization Practices and Policies in North Dakota

North Dakota State University
Department of Public Health
Center for Immunization Research and Education (CIRE)

NDSU NORTH DAKOTA STATE UNIVERSITY

NDSU CENTER FOR IMMUNIZATION RESEARCH AND EDUCATION

Purpose

- To learn about immunization policy, practices, knowledge, attitudes and beliefs in North Dakota, and contrast that with other states
  - Exemptions to school vaccination requirements
- To have focus group discussions on immunization policies and practices
- To make suggestions for potential policy, process, or rule changes in N.D.

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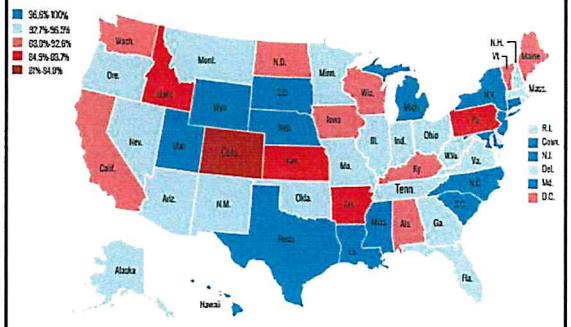
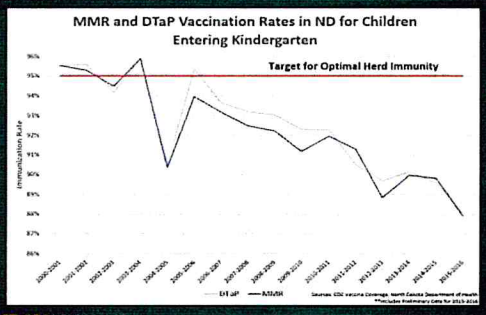
Vaccination Rates by State

Percentage of kindergartners vaccinated by state, 2013-2014 school year



North Dakota Kindergarten Immunization Rates



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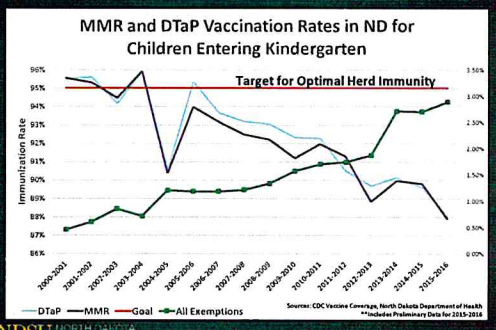
North Dakota Kindergarten Exemption Rates



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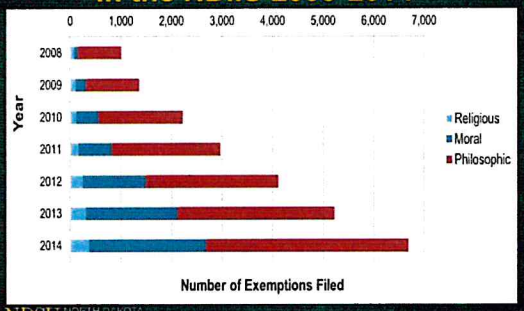
Number of Vaccine Exemptions in the NDIIS 2008-2014



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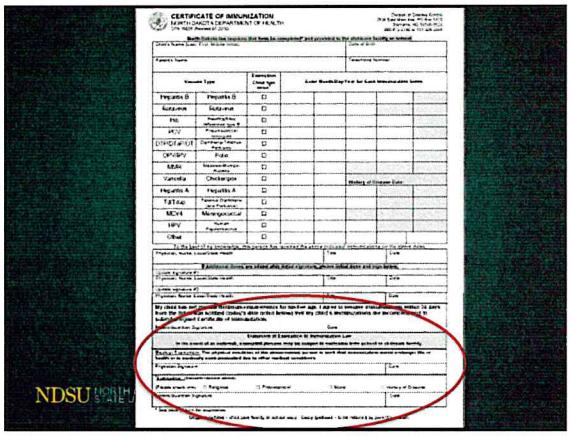

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Current ND Immunization Policy

- School Immunization Requirements
- Provisional Admission – Exclusion
- Exemption
- Epidemics

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Current Practices

School Immunization Survey

- Completed by each school in the fall
- Collects individual school data on immunizations and immunization exemptions

North Dakota Immunization Information System (NDIIS)

- State immunization database

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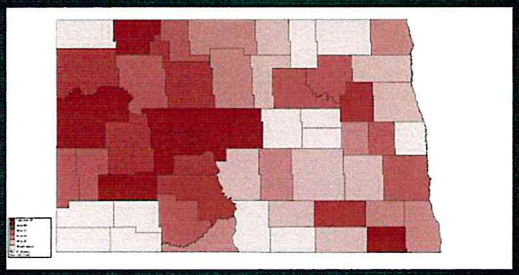
Kindergarten Immunization Rates by County: 2014-2015*



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*Average Percentage of Kindergarteners fully vaccinated against DTaP, MMR, and Varicella by county. Source: ND School Immunization Survey, North Dakota Department of Health

Focus Group and One-on-One Questions: Sector Specific

Physicians/Health Care Providers/Nurses

Opening Question:

Who are you, what area of medicine do you work in, and how long have you been working with immunization programs/records/policy/etc.?

Transition Questions:

From what you experience in your position, what do you think the prevailing opinion about immunizations are?

In your position, what do you hear people/parents/organizations saying about immunizations and immunization exemptions?

How well do you feel you know the current ND laws and policies regarding obtaining exemptions to school immunization requirements?

Key Questions:

Exemptions

How often do parents request exemptions to immunizations in your practice?

- What reasons do parents give when requesting exemptions to immunizations?
- When requesting exemptions, are parents requesting exemptions to one vaccine, multiple vaccines, or all vaccines?

In your practice, what is the process for granting a medical exemption to child care or school immunization requirements for children?

- When granting such an exemption, what evidence do you require?

In your practice, what is the process for granting children an exemption to a vaccination based on a prior history of the disease?

- Which vaccines do you grant a history of disease exemption for?
- When granting such an exemption, what evidence do you require?
- Is the parents' history of disease statement for the child alone sufficient?

Practice & Procedure

What is your general approach to the vaccine hesitant parent?

How do you handle non-vaccinating families?

- Do you make them wear masks?
- Do you schedule their appointments at a certain time of day?
- Do you use a declination form?
- Do you dismiss them from your practice?

Do you conduct reminder/recall for kids entering kindergarten in need of immunizations?

How well does the current NDIIS system work in your practice for providing accurate and timely vaccine information on your patient?

How well does the NDIIS system interface with your electronic medical record, if you have one?

Please describe how vaccine exemptions are uploaded into the NDIIS within your practice?

- Who updates NDIIS?
- Who uses/has access to NDIIS?

Policy

What are your thoughts and opinions regarding North Dakota's current immunization requirements?

What are the strengths of the current policy?
What are the weaknesses of the current policy?
Challenges?
Unintended consequences?

What are your thoughts and opinions regarding North Dakota's current Personal Belief Exemption Policy for Immunizations?

What are the strengths of the current policy?
What are the weaknesses of the current policy?
Challenges?
Unintended consequences?

How do the current immunization requirements and exemption policies in the state affect your practice?

Would you support an immunization exemption policy change, such as a state requirement that parents must visit with a physician or healthcare provider for immunization education and obtain a signature prior to filing a personal belief exemption to school officials?

How could this be implemented?

What type of health care provider should be able to provide immunization education and sign the exemption form?

Do you feel that additional immunizations need to be added to the school immunization requirements?

If so, which immunizations should be added?

How should the school immunization requirements be enforced?

Whose responsibility is it to enforce the school immunization requirements?

Should immunization rates and exemption rates be published by school?

<u>Ending Questions:</u>

Do you think revisions should be made to the North Dakota Personal Belief Exemption policy?

What are your suggestions for revisions to North Dakota's current Personal Belief Exemption Policy for Immunizations?

How should changes to the current policy be actualized?
How best should these changes be communicated to you and your constituents?
If revision(s) are made to the Exemption Policy, what barriers exist, if any, to the adoption of the changes?

If revision(s) are made to the Exemption Policy, are there any specific needs that may arise for you or your practice (*i.e.*, technological or program changes, training and education for providers and/or staff)?

Is there anything that we missed? Is there anything that you came wanting to say that you did not get a chance to say?

Public Health Nurses, Public Health Employees, Local Public Health Agencies & Organizations

Opening Question:

Tell us who you are, what area of public health you work in, and how long have you been working with immunization programs/records/policy/etc.?

Transition Questions:

From what you experience in your position, what do you think the prevailing opinion about immunizations are?

In your position, what do you hear people/parents/organizations saying about immunizations and immunization exemptions?

**How well do you feel you know the current ND laws and policies regarding obtaining exemptions to school immunization requirements?

Key Questions:

Exemptions

How often do parents request exemptions to immunizations in your practice?

- What are the reasons that parents give when requesting exemptions to immunization?
- When requesting exemptions, are parents requesting exemptions to one vaccine, multiple vaccines, or all vaccines?

Practice and Procedure

What is your general approach to the vaccine hesitant parent?

How do you help patients, schools, and community members understand the immunization requirements and exemption policy in North Dakota?

Do you work with schools to determine vaccine compliance?

Do you work with schools to complete the school immunization survey?

- If yes, how do you work with schools to complete the school survey?

Do you give vaccines in schools?

- If yes, which grades do you vaccinate?
- If yes, which vaccines do you give?
- How often do you hold vaccine clinics in schools?
- If no, why not?

Do you conduct reminder/recall for kids entering kindergarten in need of immunizations?

How much time per month does it take your facility to process immunization records requests for back to school?

How well does the current NDIIS system work for providing accurate and timely vaccine information on patients?

Please describe how vaccine exemptions are uploaded into the NDIIS within your practice?

- Who updates NDIIS?
- Who uses/has access to NDIIS?

Policy

What are your thoughts and opinions regarding North Dakota's current immunization requirements?

- What are the strengths of the current policy?
- What are the weaknesses of the current policy?
- Unintended consequences?

What are your thoughts and opinions regarding North Dakota's current Personal Belief Exemption Policy for Immunizations?

- What are the strengths of the current policy?
- What are the weaknesses of the current policy?
- Unintended consequences?

What are the main challenges with the current immunization requirements, enforcement, and the exemption policy?

- How can these challenges be addressed?

How do the current immunization exemption policies in the state affect your work?

Would you support an immunization exemption policy change, such as a state requirement that parents must visit with a physician or healthcare provider for immunization education and obtain a signature prior to filing a personal belief exemption to school officials?

- How should this be implemented?
- What type of healthcare provider should be able to provide education and sign the form?

Do you feel that additional immunizations need to be added to the school immunization requirements?

- If so, which ones?

Whose responsibility is it to enforce the school immunization requirements?
How should the school immunization requirements be enforced?
Should immunization and exemption rates be published by school?
Do you feel that the immunization requirements are enforced by the schools in your area?

<u>Ending Questions:</u>

Do you think revisions should be made to the North Dakota Personal Belief Exemption policy?
What are your suggestions for revisions to North Dakota's current Personal Belief Exemption Policy for Immunizations?

- How should changes to the current policy be actualized?
- How should these changes be communicated to you and your constituents?
- If revision(s) are made to the Exemption Policy, what barriers exist, if any, to the adoption of the changes?

If revision(s) are made to the Exemption Policy, are there any specific needs that may arise for you, your agency, and/or your members (*i.e.*, technological or program changes, training and education for staff, revisions to reporting requirements and/or data collection methods)?
Is there anything that we missed? Is there anything that you came wanting to say that you did not get a chance to say?

School Superintendents, Principals, Nurses, and Secretaries

Opening Question:

Tell us who you are, what school you work in and your position, and how long you have been working in this school system.

Transition Questions:

From what you experience in your position, what do you think the prevailing opinion about immunizations are?

In your position, what do you hear people/parents/organizations saying about immunizations and immunization exemptions?

How well do you feel you know the current ND laws and policies regarding obtaining exemptions to school immunization requirements?

Key Questions:

Exemptions

How are/were you made aware of North Dakota's immunization requirements and exemption policy?

What kind of education are you given on immunization requirements and exemption policies?

Practice and Procedure

When and how do you notify parents of the immunization requirements necessary for school entry?

Does your school determine a child's vaccination status before the start of school so that parents can be notified by the first day of school if their child needs additions vaccinations?

How does your school work with parents to obtain immunization records?

- Does your school use an electronic system or is everything paper based?
- If your school uses an electronic system to obtain immunization records, which one do they use?
- Who collects the immunization records?
- When are records collected?
- Where are they filed?
- Who compiles all of the immunization records/data for the school immunization survey?

Where does collecting immunization records rank in your list of priorities during the beginning of the school year?

What is your school procedure for students that do not have an immunization record on file?

- Are there certain groups of students who are less likely to have an immunization record? (i.e. out of state, military)

If a child does not meet the immunization requirements required for school entry, what actions are taken at your school?

- If a non-compliant child does not meet the requirements after the 30 day grace period, what actions are taken at your school?
- What factors affect your decision to enforce/not enforce the immunization requirement?
- What are your main challenges with implementing and enforcing the immunization policy?
  - How can these challenges be addressed?
- If you do not exclude non-compliant students, what factors prevent you from excluding?

Do you ever encourage parents to claim an exemption if they do not have an immunization record for their child?

Does your school use the North Dakota Immunization Information System?

- If yes, who in your school knows how to use this system?
- Does your school/school nurse use the North Dakota Immunization Information System to look up immunization records?

What kind of education are staff given on the reading of immunization records?

Do you ever accept a history of disease exemption for a disease other than chicken pox?
At your school, who fills out the immunization school survey for the North Dakota Department of Health?

What information/materials could improve the process of completing the school survey for you?

Do you feel you are given an adequate amount of time to collect student data before the school immunization survey is due?

If no, what amount of time would be adequate?

Would you prefer the survey to be released earlier in the school year with an earlier due date?

How long does it take your school staff members to complete the school immunization survey?
Does your local public health unit assist you with the school immunization survey?

If no, have you asked for their assistance?

Do you feel the data you provide you completing the school immunization survey is relatively accurate?
Who do you call if you have questions regarding the school survey or immunization policies?
How well do you feel changes to immunization requirements and immunization exemption policies in North Dakota are communicated by state and local public health officials?

What would be the best way to receive information on immunization requirements and exemptions in the future?

Policy

What are your thoughts and opinions regarding North Dakota's current immunization requirements?

What are the strengths of the current policy?

What are the weaknesses of the current policy?

Challenges?

Unintended consequences?

What are your thoughts and opinions regarding North Dakota's current Personal Belief Exemption Policy for Immunizations?

What are the strengths of the current policy?

What are the weaknesses of the current policy?

Challenges?

Unintended consequences?

Whose responsibility is it to enforce the school immunization requirements?
How should the school immunization requirements be enforced?
Do you think there should be penalties for allowing non-compliant students to attend school or incentives for schools that have fully compliant students?
Should immunization and exemptions rates be published by school?

<u>Ending Question:</u>

Do you think revisions should be made to the North Dakota Personal Belief Exemption policy?
What are your suggestions for revisions to North Dakota's current Personal Belief Exemption Policy for Immunizations?

How should changes to the current policy be actualized?

How best should these changes be communicated to you and your constituents?

If revision(s) are made to the Exemption Policy, what barriers exist, if any, to the adoption of the changes?

If revision(s) are made to the Exemption Policy, are there any specific needs that may arise for you or your constituents (*i.e.*, technological or program changes, revisions to school or district level policies, training and education for parents and guardians, tailored communications to parents and guardians)?
Is there anything that we missed? Is there anything that you came wanting to say that you did not get a chance to say?

North Dakota Department of Public Instruction, North Dakota Attorney General, North Dakota Department of Health, North Dakota Governor's Office

Opening Question:
Tell us who you are, what area of North Dakota government you work in, and how long you have been working for the state of North Dakota.

Transition Questions:
From your position, what challenges do you see in North Dakota's current immunization requirements and policies, if you see any?

Key Questions:

Practice
Whose responsibility is it to enforce the school immunization requirement?
How should the school immunization requirements be enforced?
- Do you think there should be penalties for allowing non-compliant students to attend school or incentives for schools that have fully compliant students?

How do your individual departments encourage the enforcement of school immunization requirements?
- How do you work with schools to make sure the school immunization survey is completed?
- How do you work with schools to make sure the school immunization requirements are followed?

What are your main challenges with schools abiding by the immunization policy?
- How can these challenges be addressed?

Do you have suggestions to improve the process of ensuring that students are compliant with the school immunization requirements?

Department of Public Instruction
Does the North Dakota Department of Public Instruction encourage the enforcement of school immunization requirements?
- How do you work with schools to make sure the school immunization survey is completed?
- How do you work with schools to make sure the school immunization requirements are followed?

What are your main challenges with schools abiding by the immunization policy?
- How can these challenges be addressed?

Department of Health
How does the state health department assist local schools in completing the school survey?
What are the main challenges the state health department faces with the current immunization requirements and exemption policy?
- How are these challenges addressed?

What are ways to strengthen the current immunization requirements?

Policy
What are your thoughts and opinions regarding North Dakota's current immunization requirements?
- What are the strengths of the current policy?
- What are the weaknesses of the current policy?
- Challenges?

Unintended consequences?

What are your thoughts and opinions regarding North Dakota's current Personal Belief Exemption Policy for Immunizations?

What are the strengths of the current policy?
What are the weaknesses of the current policy?
Challenges?
Unintended consequences?

Should immunization and exemption rates be published by school?

What process would be required to change the current immunization requirements or exemption policy?

What changes would require a change in legislation versus a rule change?

Ending Question:

Do you think revisions should be made to the North Dakota Personal Belief Exemption policy?

What are your suggestions for revisions to North Dakota's current Personal Belief Exemption Policy for Immunizations?

How should changes to the current policy be actualized?
How best should these changes be communicated to you and your constituents?

If revision(s) are made to the Exemption Policy, what barriers exist, if any, to the adoption of the changes?

If revision(s) are made to the immunization exemption policy, are there any specific needs that may arise for you or your constituents (*i.e.*, technological or program changes, revisions to school or district level policies, training and education for parents and guardians, tailored communications to parents and guardians)?

Is there anything that we missed? Is there anything that you came wanting to say that you did not get a chance to say?

Parent, Guardian and Advocacy Organizations

Opening Question:

Tell us who you are, what you do for a living, and what you enjoy most about your job.

Transition Questions:

From your experiences, what do you think the prevailing opinion about immunizations are?

What do you hear people/parents/organizations saying about immunizations and immunization exemptions?

How well do you feel you know the current ND laws and policies regarding obtaining exemptions to school immunization requirements?

Key Questions:

Practice and Procedure

Where do you go to get information about vaccine safety?

Where do you go for information on immunizations and immunization exemptions in North Dakota?

How do schools communicate their immunization requirements to parents?

How have you obtained your child's immunization record in the past?

Where do you go if you have questions about immunizations or school immunization requirements?

Is your school able to answer your questions?

Do your children's schools and daycare facilities abide by the state's immunization requirements?

Policy

What are your thoughts and opinions regarding North Dakota's current immunization requirements?

What are the strengths of the current policy?

What are the weaknesses of the current policy?

Challenges?

Unintended consequences?

What are your thoughts and opinions regarding North Dakota's current Personal Belief Exemption Policy for Immunizations?

What are the strengths of the current policy?

What are the weaknesses of the current policy?

Challenges?

Unintended consequences?

If your child was not up to date with the immunization requirements, how would you feel if he/she was kept out of school until they began receiving the necessary immunizations?

What actions would you take if this were to occur?

Why should/shouldn't there be a personal belief exemptions to immunizations in North Dakota?

Whose responsibility is it to enforce the school immunization requirements?

How should the school requirements be enforced?

Should immunization and exemption rates be published by school?

Why should/shouldn't children be immunized to attend school?

Ending Question:

Do you think revisions should be made to the North Dakota Personal Belief Exemption policy?

What are your suggestions for revisions to North Dakota's current Personal Belief Exemption Policy for Immunizations?

How should changes to the current policy be actualized?

How best should these changes be communicated to you and your constituents?

If revision(s) are made to the Exemption Policy, what barriers exist, if any, to the adoption of the changes?

If revision(s) are made to the Exemption Policy, are there any specific needs that may arise for you, your agency, and/or your members (*i.e.*, technological or program changes, training and education for staff, revisions to reporting requirements and/or data collection methods)?

Is there anything that we missed? Is there anything that you came wanting to say that you did not get a chance to say?

North Dakota State Legislators

Opening Question:

Tell us who you are, what district you represent, and how long you have served in the North Dakota Legislature.

Transition Questions:

From what you experience in your position, what do you think the prevailing opinion about immunizations are?

In your position, what do you hear people/parents/organizations saying about immunizations and immunization exemptions?

How well do you feel you know the current ND laws and policies regarding obtaining exemptions to school immunization requirements?

Key Questions:

Policy

What are your thoughts and opinions regarding North Dakota's current immunization requirements?

- What are the strengths of the current policy?
- What are the weaknesses of the current policy?
- Challenges?
- Unintended consequences?

What are your thoughts and opinions regarding North Dakota's current Personal Belief Exemption Policy for Immunizations?

- What are the strengths of the current policy?
- What are the weaknesses of the current policy?
- Challenges?
- Unintended consequences?

What are ways to strengthen the current immunization requirements?

What changes to the law/policy are legal?

Do you think there should be penalties for allowing non-compliant students to attend school or incentives for schools that have fully compliant students?

- If yes, who should receive these incentives or penalties?

Whose responsibility is it to enforce the school immunization requirements?

How should the school immunization requirements be enforced?

Should immunization and exemptions rates be published by school?

Practice and Procedure

What process would be required to change the current immunization requirements or exemption policy?

Ending Question:

Do you think revisions should be made to the North Dakota Personal Belief Exemption policy?

What are your suggestions for revisions to North Dakota's current Personal Belief Exemption Policy for Immunizations?

- How should changes to the current policy be actualized?
- How best should these changes be communicated to you and your constituents?
- If revision(s) are made to the Exemption Policy, what barriers exist, if any, to the adoption of the changes?

If revision(s) are made to the Exemption Policy, are there any specific needs that may arise for you, your agency, and/or your members (*i.e.*, technological or program changes, training and education for staff, revisions to reporting requirements and/or data collection methods)?

Is there anything that we missed? Is there anything that you came wanting to say that you did not get a chance to say?

Appendix E. Chiropractic Survey Questions

Chiropractic Survey Questions

Q1. Age: (Required)
- ○ Under 25
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65+

Q2. Race: (Optional, Can Select More Than One)
- ☐ White
- ☐ Black/African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other _____

Q3. Sex: (Required)
- ○ Male
- ○ Female

Q4. Occupation: (Required)
- ☐ Chiropractor
- ☐ Other _____

Q5. Zip Code of Medical Practice: (Optional)

Q6. Which school did you attend for your medical training? (Optional) _____

Q7. Does the topic of vaccination come up in your practice?
- ○ Yes
- ○ No

Q8. If yes, how often does the topic of vaccination come up in your practice?
- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Frequently
- ○ Usually
- ○ All of the Time

Q9. If yes to question 7, when the topic of vaccination comes up in your practice, who initiates the conversation?

- ☐ Healthcare Provider
- ☐ Patient
- ☐ Other: Please Specify _____

Q10. Do you feel that counseling others on their decision to vaccinate or not to vaccinate falls within your scope of practice?

- ○ Yes
- ○ No
- ○ Unsure

Q11. How well do you feel your chiropractic/naturopathic medicine training and education prepared you to counsel people on immunization?

- ○ Not well at all
- ○ Slightly well
- ○ Moderately well
- ○ Very well
- ○ Extremely well

Q12. How often do you recommend vaccinations in your practice?

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Frequently
- ○ Usually
- ○ All of the Time

Q13. How likely are you to recommend vaccines if a patient asks about them?

- ○ Very unlikely
- ○ Unlikely
- ○ Neither likely nor unlikely
- ○ Likely
- ○ Very likely

Q14. Do you utilize vaccines for your own health?

- ○ Yes
- ○ No
- ○ Unsure

Q15. Would you vaccinate/do you vaccinate your children?

- ❍ No, not at all.
- ❍ Yes, with some recommended vaccinations.
- ❍ Yes, with most recommended vaccinations.
- ❍ Yes, with all recommended vaccinations.

Q16. If you were traveling to another country in which certain infectious diseases were prevalent and recommended vaccines were available, would you seek out and undergo prior vaccination?

- ❍ Yes
- ❍ No
- ❍ Unsure

Q17. How familiar are you with North Dakota's school and child care immunization laws and policies?

- ❍ Not familiar at all
- ❍ Slightly familiar
- ❍ Moderately familiar
- ❍ Very familiar
- ❍ Extremely familiar

Q18. What would you estimate the percentage of kindergartners fully vaccinated against diphtheria, tetanus, pertussis, measles, mumps, rubella, and varicella (chickenpox) was in North Dakota in 2014-2015?

- ❍ 80-84%
- ❍ 85-89%
- ❍ 90-94%
- ❍ 95%+

Q19. According to North Dakota's Century Code, children entering kindergarten and seventh grade must have age-appropriate immunizations or have an exemption on file for those immunizations to attend school. Do you agree with this policy?

- ❍ Yes
- ❍ No
- ❍ Unsure

Q20. Do you think immunization rates should be published by school in North Dakota?

- ❍ Yes
- ❍ No
- ❍ Unsure

Q21. Currently in North Dakota, parents can sign a form to claim a religious exemption to immunization in order for their child to attend child care or school. Do you think North Dakota should allow a religious exemption to immunization?

- ❍ Yes
- ❍ No
- ❍ Unsure

Q22. Currently in North Dakota, parents can sign a form to claim a philosophic or moral exemption, sometimes referred to as a personal belief exemption, to immunization in order for their child to attend child care or school. Do you think North Dakota should allow a personal belief exemption to immunization?

- ❍ Yes
- ❍ No
- ❍ Unsure

Q23. Currently in North Dakota, parents can sign a form to claim a philosophic or moral exemption to immunization for their child in order to attend child care or school. Do you think parents/guardians should have to meet with a physician, healthcare provider, or public health employee to receive vaccine education before they can file a philosophic or moral exemption to immunization for their child?

- ❍ Yes
- ❍ No
- ❍ Unsure

Please state your level of agreement with the following statements.

Q24. The low risk of adverse reactions to vaccines is acceptable because the majority of the population gains protection against an infectious disease.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neutral
- ❍ Agree
- ❍ Strongly Agree

Q25. There is proof that immunization prevents infectious disease.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neutral
- ❍ Agree
- ❍ Strongly Agree

Q26. Vaccines have changed the incidence of many major infectious diseases.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neutral
- ❍ Agree
- ❍ Strongly Agree

Q27. Vaccines prevent more diseases than they cause.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neutral
- ❍ Agree
- ❍ Strongly Agree

Q28. Vaccines should be given to elderly persons.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neutral
- ❍ Agree
- ❍ Strongly Agree

Q29. Vaccines should not be given to infants under 1 year of age as they may weaken the immune system.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neutral
- ❍ Agree
- ❍ Strongly Agree

Q30. In general, contracting an infectious disease naturally is better than being vaccinated against it.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neutral
- ❍ Agree
- ❍ Strongly Agree

Q31. On a scale of 0-10, with 0 being not at all concerned and 10 being very concerned, how concerned are you about vaccinations overall?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

Q32. On a scale of 0-10, with 0 being not safe at all and 10 being extremely safe, how safe do you think vaccines are overall?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

Q33. Which vaccines do you believe are not safe? Please select all that apply.

- ❑ All are safe
- ❑ None are safe
- ❑ Diphtheria/Tetanus/Pertussis
- ❑ Haemophilus influenza b (Hib)
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Human Papillomavirus (HPV)
- ❑ Influenza
- ❑ Measles/Mumps/Rubella
- ❑ Meningococcal
- ❑ Pneumococcal
- ❑ Polio
- ❑ Varicella (Chickenpox)
- ❑ Other: (Please specify) _____
- ❑ Unsure

Q34. Which vaccine do you believe is the "least safe"?

- ○ All are safe
- ○ None are safe
- ○ Diphtheria/Tetanus/Pertussis
- ○ Haemophilus influenza b (Hib)
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Human Papillomavirus (HPV)
- ○ Influenza
- ○ Measles/Mumps/Rubella
- ○ Meningococcal
- ○ Pneumococcal
- ○ Polio
- ○ Varicella (Chickenpox)
- ○ Other: (Please specify) _____
- ○ Unsure

Q35. Where do you get your information or recommend your patients get information about vaccines and vaccine safety? (Can select more than one)

- ❑ Primary Care Physician
- ❑ Coworkers
- ❑ Public Health Workers
- ❑ Family and Friends
- ❑ Textbooks
- ❑ Internet Search Engines
- ❑ Social Media
- ❑ Television or Radio
- ❑ Trusted websites (Centers for Disease Control and Prevention or other public health websites)
- ❑ Other: (please specify) _____

Q36. Are you aware of someone who has had a negative or harmful reaction to vaccination?

- ○ Yes
- ○ No
- ○ Unsure

Q37. If yes, which vaccine(s) did they have a negative or harmful reaction to? (Can select more than one)

- ❑ Diphtheria/Tetanus/Pertussis
- ❑ Haemophilus influenza b (Hib)
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Human Papillomavirus (HPV)
- ❑ Influenza
- ❑ Measles/Mumps/Rubella
- ❑ Meningococcal
- ❑ Pneumococcal
- ❑ Polio
- ❑ Varicella (Chickenpox)
- ❑ Other: (Please specify) _____
- ❑ Unsure

Q38. On a scale of 0 to 10, with 0 being not at all beneficial and 10 being very beneficial, how beneficial do you believe vaccines are overall?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

Q39. Which vaccine do you believe is the "most beneficial"?

- ○ All are beneficial
- ○ None are beneficial
- ○ Diphtheria/Tetanus/Pertussis
- ○ Haemophilus influenza b (Hib)
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Human Papillomavirus (HPV)
- ○ Influenza
- ○ Measles/Mumps/Rubella
- ○ Meningococcal
- ○ Pneumococcal
- ○ Polio
- ○ Varicella (Chickenpox)
- ○ Other: (Please specify) _____
- ○ Unsure

Q40. Do you believe that current recommendations to give multiple vaccines in one setting is safe, or do you believe they need to be spaced out more than the current recommended schedule?

- ○ The current recommendations for multiple vaccines in one setting is safe
- ○ Vaccinations should be spaced out more than the current recommended schedule
- ○ Unsure

Q41. How well do you think you understand the risks associated with vaccination?

- ○ Not well at all
- ○ Slightly well
- ○ Moderately well
- ○ Very well
- ○ Extremely well

Q42. How risky do you believe vaccines are?

- ❍ Very risky
- ❍ Moderately risky
- ❍ Minimally risky
- ❍ No risk
- ❍ Uncertain

Q43. Please write any additional comments here:

Appendix F. State Immunization Exemption Policies and Requirements

	Medical							Religious								Personal Belief							Miscellaneous									
	Physician Note/Signature Required	Permanent Medical Exemption Only	Distinguishes between permanent and temporary medical exemptions	Renewal Required	Written Statement from healthcare provider required	Notary Signature Required	Form Available Online	Renewal Required	Written Statement Replaces Form	Notary Signature Required	Completion of Educational Component Required	Physician Signature Required	Signature of Religious Official Required	Form Available at Health Department	Form Available Online	Renewal Required	Written Statement Replaces Form	Notary Signature Required	Completion of Educational Component Required	Physician Signature Required	Form Available at Health Department	Form Available Online	History of Disease Exemption Allowed	Parental Education Required to Obtain Exemption	Approval Goes Through Department of Health	Affidavit Required	Exemptions for Individual Vaccines Available	Exclusion of Exempted Students During an Outbreak	Parents Must Acknowledge Risk of Exclusion During Outbreak	Schools can be Penalized for Non-Compliance with State Policies***	Non-Compliance Penalties Enforced ***	Parents Informed of Potential Exemption Consequences***
ALABAMA	x	x							x														x		x		x			x	x*	
ALASKA	x	x					x	x			x				x								x				x			x	x	†
ARIZONA	x		x				x								x							x	x	x			x	x			NA	x
ARKANSAS	x		x	x		x		x			x			x		x		x	x		x	x	x	x		x	x	x	x	x	x	x
CALIFORNIA	x		x		x																		x	x			x	x			NA	x
COLORADO	x						x	x							x	x						x	x				x	x		x		
CONNECTICUT	x	x	x				x				x				x								x							x		
DELAWARE	x									x	x												x				x	x		x	x*	x
DISTRICT OF COLUMBIA	x						x			x													x				x	x		x	x	x
FLORIDA	x		x											x									x				x	x		x	x	
GEORGIA	x		x	x							x				x								x					x		x	x*	
HAWAII	x		x							x[6]													x					x		x	x	x
IDAHO	x						x								x							x	x				x	x		x	x*	
ILLINOIS	x	x						x					x		x								x				x			x	x	x
INDIANA	x		x	x			x			x													x				x			x		
IOWA	x		x	x			x				x				x								x				x			x	x	
KANSAS	x			x			x			x													x				x			x	x*	x
KENTUCKY	x						x						x		x								x				x			x	x	
LOUISIANA	x				x					x							x						x				x	x		x	x	x
MAINE	x			x	x			x		x						x	x						x				x	x		x	x	NA
MARYLAND	x		x				x								x								x				x			x	x	
MASSACHUSETTS	x			x	x			x		x													x				x			x	x*	x
MICHIGAN	x		x									x		x					x		x		x	x	x		x			x	x	x
MINNESOTA	x						x				x				x			x				x	x		x		x			x	x	
MISSISSIPPI	x																						x				x			x	x	
MISSOURI	x	x												x									x				x	x			NA	x
MONTANA	x		x				x	x			x				x								x				x	x			NA	
NEBRASKA	x						x				x				x								x				x			x		x
NEVADA	x				x					x					x								x				x	x		x	x	x
NEW HAMPSHIRE	x			x	x						x				x								x				x	x		NA	NA	NA
NEW JERSEY	x		x		x					x					x								x				x	x		x	x	x
NEW MEXICO	x			x			x	x			x				x								x				x				NA	
NEW YORK	x		x	x			x			x													x				x	x		x	x	x
NORTH CAROLINA	x		x				x			x													x				x			x	x	
NORTH DAKOTA	x	x					x								x							x	x				x	x	x	x	x	
OHIO	x				x					x							x						x				x	x		x	x	
OKLAHOMA	x						x						x[9]		x							x	x				x			x	x	
OREGON	x				x							x			x				x		x	x	x				x			x	x	x
PENNSYLVANIA	x		x		x					x							x						x				x			x	x*	x
RHODE ISLAND	x						x								x								x				x	x		x	x*	x
SOUTH CAROLINA	x		x								x			x									x				x				NA	x
SOUTH DAKOTA	x	x			x					x													x				x			NA	NA	NA

	Medical							Religious								Personal Belief							Miscellaneous									
	Physician Note/Signature Required	Permanent Medical Exemption Only	Distinguishes between permanent and temporary medical exemptions	Renewal Required	Written Statement from healthcare provider required	Notary Signature Required	Form Available Online	Renewal Required	Written Statement Replaces Form	Notary Signature Required	Completion of Educational Component Required	Physician Signature Required	Signature of Religious Official Required	Form Available at Health Department	Form Available Online	Renewal Required	Written Statement Replaces Form	Notary Signature Required	Completion of Educational Component Required	Physician Signature Required	Form Available at Health Department	Form Available Online	History of Disease Exemption Allowed	Parental Education Required to Obtain Exemption	Approval Goes Through Department of Health	Affidavit Required	Exemptions for Individual Vaccines Available	Exclusion of Exempted Students During an Outbreak	Parents Must Acknowledge Risk of Exclusion During Outbreak	Schools can be Penalized for Non-Compliance with State Policies***	Non-Compliance Penalties Enforced ***	Parents Informed of Potential Exemption Consequences***
TENNESSEE	x				x				x														x			x				x*		
TEXAS	x			x	x			x						x		x					x		x			x	x	x		NA	x
UTAH	x							x						x							x**		x	x	x			x		x*		
VERMONT	x						x	x							x								x	x			x			x	x*	x
VIRGINIA	x		x		x					x					x								x				x	x		x		
WASHINGTON	x		x				x								x					x		x	x				x	x		x	x*	x
WEST VIRGINIA	x		x				x																x		x		x			x		
WISCONSIN	x						x								x							x	x				x	x		x	x	
WYOMING	x					x	x			x					x							x				x	x	NA	NA	NA
TOTALS	51	7	20	10	14	2	25	10	17	14	2	2	1	7	24	4	4	2	3	1	4	9	51	8	6	2	46	28	2	41	35	23

NA = Not Available
x* = Variable; In some cases it applies
δ = The Hawaii Department of Health states that a religious exemption form can be obtained from a child's school; state code requires an objection in writing.
° = In Oklahoma, the religious exemption form can be signed by a religious leader or parent/guardian
x** = Form must be signed by representative at local health department
† = Reported as unknown
*** = Association of Immunization Manager Survey - Fall 2015

In Texas, yearly renewal of medical exemptions are required unless the exemption is permanent.
In Arkansas and Texas, the religious and personal belief exemption forms are available from the state health department.
In Illinois, religious exemptions must be renewed in kindergarten, sixth, and ninth grade.
In Massachusetts, renewal of the religious exemption is suggested, not mandatory.

California will only have medical exemptions beginning July 2016.
Vermont will have medical and religious exemptions in July 2016.

Appendix G. Focus Group Totals

Sector	Occupation	Fargo Region	Grand Forks Region	Bismarck/ Mandan Region	Williston Region	Minot Region	Dickinson Region	Total
Schools	Superintendents	3	1	3	1		1	9
	Principals	5	2	3			2	12
	Nurses	9	2	3		1		15
	Staff	9	2	3	5			19
Public Health	Nurses	6	6	10	1	6	8	37
	Staff			1	1	2	2	6
Clinical	Family Physicians	3			1	2		6
	Pediatricians	5			1	3	4	13
	Advanced Practice Providers	1				1		2
	Residents					13		13
	Nurses	8			4	5	7	24
	Other	2						2
State Government	Dept. of Health			4				4
	Dept. of Public Instruction			2				2
	Attorney General's Office			2				2
	Legislators	3	1	1			1	6
Parents	Parents	9			2		5	16
Others	Others	1						1
Total		64	14	32	16	33	30	189

My name is Linda Mittlestadt. I am a resident of Mandan, ND.
I am submitting written testimony in OPPOSITION of HB 1469.

It has been proven that vaccines come with risks. Risks of permanent damage to an individual's health and can also result in death. It has also been proven that each individual has a unique set of health criteria to consider before any immunizations. Therefore exemptions need to exist per each individual's health and concerns.

In regards to this bill – It is the choice of the parent/guardian to vaccinate their child or not! It is a decision that most parents do not take lightly and once that decision is made there is absolutely NO reason to require them to take more of their time to fill out additional forms or to view what will obviously be a biased education film. It would be a waste of money and time for everyone that would need to be involved.

This bill has more issues than can be addressed in one written testimony.

I am against HB 1469. I am against more government input for North Dakotans.

I am firmly against HB 1469. I am against any more government requirements for North Dakotans including not being able to receive your religious or philosophical exemption until you watch a government mandated module.

To Whom It Concerns,

I am opposed to HB1469.
This bill creates a situation which implies that a parent who disagrees with vaccination is guilty of a crime. Just as a person with a traffic violation may be required to be "re-educated" by watching videos on traffic laws, this bill puts a parent in the position of being punished with a "re-education" video. It is wrong for North Dakota to punish parents who have the right to claim a religious or philosophical exemption!
Vote NO on HB1469!

Frederick Pearson
Beach, North Dakota

To Whom It May Concern,

I am a wife, a mother, and a homemaker. As such, I am strongly opposed to HB1469.

The wording of HB1469 implies that parents who refuse to vaccinate are willfully uneducated. In fact, the opposite of this is true. In order to have a religious or philosophical opposition to vaccines, a parent must be educated in the topic as well as have a full understanding of their deep-seated beliefs. From what I have seen among parents in North Dakota, whether I agree with their opinion or not, I must say that they are overall educated and concerned about each topic that enters their life. They do not shirk off the work of research, and their faith plays a large part in their decisions. It would be wrong for North Dakota to imply that such good, upstanding citizens and faithful parents are so willfully ignorant! Instead, the North Dakota legislature ought to be applauding its citizens for their loyalty to providing their children with the best of both worlds – their religion and education.

I am opposed to HB1469 and I urge every lawmaker to vote against this bill!

Sincerely,

April Pearson
Beach, North Dakota

HB1469

Thank you for taking the time to read my written testimony. My name is Janelle Anderson and I am from rural Alexander, ND in District 39. I am a mother of 4 children, ages 9 months to 16 years old. My husband and I ranch together, as well as own/run multiple other businesses.

I am writing this today in reference to House Bill 1469, which deals with requiring parents/guardians to watch a Vaccine Education Module if they choose to use a Vaccine Exemption. I want you to know that I strongly **OPPOSE** HB1469. It is discrimination to require parents to take a vaccine education module that want to use a religious or moral/philosophical/personal belief exemption. HB1469 is putting a condition on my basic parental right to make medical decisions for my children.

HB1469 willfully submits that I as a parent am not capable of making medical decisions for my child and uses coercion tactics via the Vaccine Education Module to sway that decision. North Dakota has exemptions in place, so that parents can choose to use them if they have a religious or moral/philosophical/personal beliefs or medical exemptions, and we do not need any conditions added on top of those. I believe this is a clear government overreach and is not needed.

I ask you all as a committee, to give HB1469 a **FAIL.** This bill is coercion and discrimintaion and not needed.

Thank you committee members for reading my testimony, your time serving your constituents, and being open to hear why our family fully **OPPOSES** HB1469.

Sincerely,

Janelle Anderson
Rural Alexander, ND
District 39

HB1469

Thank you for taking the time to read my written testimony. My name is Paula Slow and I am from Arnegard, ND in District 39.

I am writing this today in reference to House Bill 1469, which deals with the Vaccine Education Module. I want you to know that I **OPPOSE** HB1469.

I ask you all as a committee, to give HB1469 a **FAIL.**

Sincerely,

Paula Slow
Arnegard, ND
District 39

Hello, I am the mother of four children. My three oldest have autoimmune disorders that are known side effects of multiple vaccines and were fully vaccinated up to ages 9, 4 and 2. Our youngest has not yet been vaccinated and does not have any health issues at all. I have always been a very healthy person and followed every recommendation of my doctors prior to conceiving, while pregnant and while breastfeeding all of my children. My oldest child has had 6 surgeries as a result of one of his autoimmune disorders. My 2nd child has had 4 surgeries and is so ill that we must homeschool to protect his health. My 3rd child has an extremely limited choice of foods that he can eat because of the pain caused by his autoimmune disorder. Again, each of their autoimmune disorders are listed as possible side effects due to vaccination on the package inserts that I was never once shown. When attempting to vaccinate my 4th child at a slower rate than the recommended schedule, we were met with extreme resistance. We were told that the only way we would be allowed to comply was to follow the exact same path that we had previously trod three times over. We chose not to vaccinate our 4th child because we were very tired of life-threatening fevers, hallucinations, loss of communication abilities, and seizures from age 6 months to age 9. We were also tired of being told that these things were entirely normal and being ridiculed by clinic and ER staff for our concern for the health of our children. After many years of healing, our children are better and their autoimmune disorders are mostly under control. As such, we are unlikely to find a physician who will risk their medical license, their medical practice insurance and ability to feed their own children to sign a statement that a vaccination would definitively endanger the life or health of them. We are even more unlikely to be able to get such a written statement for our youngest.

House Bill 1469 categorically denies the reality of the pain that we have lived through. It creates further isolation and irrational fear for families who have discovered that vaccines do indeed cause harm. It sentences untold scores of other children and families to the same fate. It is thoroughly unconscionable that our representatives would see themselves as so all knowing and all powerful as to remove the ability of a parent to make medical choices for their child. You are not the parent of my children and you do not know how difficult their lives are due to living with autoimmune disorders that are recognized side effects of vaccination. The hypocritic oath, requires that all doctors follow the mantra, “Do no harm.” Through the action of HB 1469, you will be taking the choice not only away from parents but also away from doctors who specialize in caring for children. You set up a standard where a social worker, a criminal justice major, a fire fighter and economist, a realtor, a retired sociologist and an attorney who have never met my children, have never read their medical files, nor consulted with their pediatrician have more say over what is injected into their bodies than either their parents or their doctor do.

1839 East Capitol Ave

Suite B

Bismarck, ND 58501

To whom it may concern…

In regards to HB 1469, I am AGAINST this bill.

I am already seeing excessive propaganda by the NDDOH to pressure and manipulate my health decisions. There is no mention to the risks involved with any of the procedures they promote. I know several parents of children injured by vaccinations and were never told the risks. I don't need to be "educated" by NDDOH.

Helping Create Health and Wellness,

Dr. Allen Rudolph

HB1469

Malinda M Weninger

701-527-8226

I write in complete opposition of HB1469. This is complete infringement of personal freedoms.

If YOU chose to get a vaccination, then YOU are SAFE. If your vaccines are so great, you then are SAFE and protected from others whether they vaccinate or not. Correct? So why is everyone so worried about what the other individual is doing.

My daughter suffered for four years after her vaccination in 2006. If people would do their research they would see the many many injuries that happen out there. Facebook group "Vaccine Injury Stories" is full of injury stories. The COVID vaccine injuries are already starting to pour in. People just need to do their research.

This is a total infringement of my rights. I own one thing in this world: MY BODY. And I should decide what goes on with it.

I have five grandchildren and as of now not one of them has had an ear infection or hardly even been sick. They are extremely healthy – unvaccinated. Vaccinated children get ear infections and illnesses much more often. SIDS deaths are almost always within a few weeks of a vaccination.

If you have not done your research you have no right to make mandates such as this – as remember this could affect one of your very own loved ones sometime in the future.

I urge a NO vote on this bill.

Malinda Weninger
701-527-8226

I am in opposition to bill HB 1469.
We should have our rights to choose what is best for our children's health without getting "fear" tactics thrown in our face.
We as parents know what is best for our child!

I support HB1468 which deals with providing more information to parents when their kids are getting vaccinated. When my child was vaccinate, the risks of them was greatly underplayed. More information and facts need to be given to parents before vaccination for them to make a more educated risk vs reward choice instead of them just telling the parents they are safe. In the case of my child, they were not safe at all.Thanks for reading.

Hi my name is Brady Lund from Watford City, ND and I am testifying in opposition to HB1469.

As a nurse I do not want to have to take care of children who are dying due to not having been vaccinated. Especially when it could have been prevented. I do not agree and think immunizations should not be exempt from schools.

Hello
My name is Marvin Lepp and I am writing to you today in regards to HB 1469 regarding re-education for vaccinations for school age children. I have dealt with the first hand pressure that is placed on individuals when it comes to vaccines and have dealt with the issues that arise after the fact.
My wife was convinced to receive the HPV vaccine in 2010 by her Doctor shortly before our marriage. It was when the vaccine first came out and she was told that it would help prevent all sorts of issues including cervical cancer and was pressured into taking the shots.

I cannot express how much I wish this never would have happened. What the vaccine actually did was make a very healthy young woman near infertile. We spent the better part of 6 years and thousands of dollars trying to conceive our little miracle. She developed Polycystic Ovary Syndrome, has had to endure surgeries for the pain related to it, and last emotional health issues as this “CURE” permanently damaged her body.

This same vaccine is now in our school systems and on the “required list”.

Moving forward after we finally had our little miracle we dealt with a ton of pressure from our pediatrician, “the best in the state” Kathy Anderson. She was the same doctor who led the CHI dr. revolt and the one that has been spearheading all the letters to the Governor regarding masks and vaccines. The amount of pressure being pushed onto parents who only want the best for their children is alarming. The Doctors, their nurses, everyone pushes this issue and it disgusting the tactics that are currently taken to convince us for the “appropriate” vaccines.

Why do you think the only people in favor of this are doctors and members of the State Health Department. You know the same people who helped coordinate statewide lock downs, quarantine measures, and letters of encouragement to the governor.

This bill if passed will see more children withdrawn from school systems by parents in flocks. The State Health Department has already created enough issues in our schools with unelected officials dictating the lives of our children. As far as I am concerned the state health officer and the director of human service should be an elected position just like the state superintendent so that they are held accountable for their actions.

There is no liability for vaccine damage. If there was it would not be a multi-billion dollar industry.
Thank you for your time.

HB 1469
No

Chairman Weisz and Committee Members,

My name is Theresa Deckert and I am from Devils Lake. I spent 33 years as a home educator. All of my children have since graduated. One of those graduates had a severe reaction to an immunization when she was only 2 months old. Because of this, she was exempt from certain immunizations. She is now 34 years old, but in her early days there were not as many immunizations pushed on a child at one appointment. Because she had only received one immunization that day, it was easy to know what the culprit was.

If I were parenting young children today I would seriously consider spacing out or delaying some immunizations. I know many parents who opt for that. I also know parents who have religious, moral or philosophical objections to immunizations.

Our current state law allows parents to opt their child out based on those reasons. I am opposed to the **adding** of a "reeducation plan" (section 3, point b) for parents who choose to opt their child out of mandatory vaccinations, especially in the homeschool realm where children are not with age mates all day for five days each week.

Most parents who choose another path have studied the issue thoroughly and have educated themselves about the possible risks. It is insulting to insist they go through an education module.

30 years ago when my children were young, there were fewer requirements. With Covid and the adoption of a vaccine that does not have long term studies, I am afraid we are opening the door for other vaccines where the general populous will be the trial study.

I also write you because I personally suffer from chronic hives because of a reaction to a medication three years ago. My doctor feels like this will be a permanent issue for me. Basically my immune system has been compromised. I did not even know such a thing could even happen.

We need to be very careful when we start adding excess regulations that hamper an **individual's private medical decisions**. Please vote no on HB 1469.

Thank you,

Theresa Deckert
4631 76th Ave NE
Devils Lake, ND 58301 District 15
701-662-4790

To whom it may concern;

Good Morning, my name is Megan Martina and I have three beautiful kiddos that I would move mountains for. My oldest child, whom my husband tried for years to get pregnant with, was vaccine injured as an infant. She suffers from seizures, a tic disorder and brain damage that her neurologist has confirmed is a result of adverse effects from vaccines. I can only imagine how biased a module from the state would be when it comes to the topic of vaccines. I do not understand why this has to be such a hot topic and why parents are so incredibly pressured when it comes to vaccines. Children today receive many more shots than we received as children. The schedule is forever growing and has never been tested for safety. It is unfair and a violation of our rights to be forced to watch what I'm certain will be fear mongering propaganda. As the parent of a child who suffered as a result of vaccines, it is a slap in the face. Parents have the God given right to make medical decisions for their children, and should not be forced to watch biased videos. Vaccines can and do carry real risks and this bill is overstepping big time.

Thank you,

Megan Martina

Re: HB 1469 Testimony Human Services Committee
January 25, 2021 2:30 p.m.

Good afternoon, Chairman Weisz and members of the Human Services Committee. I am writing to testify to my opposition to HB 1469. I take my children's health very seriously and I have studied vaccines to a great extent. I studied my birth options when I was pregnant and I thoroughly look into many health aspects of my children's health from food to the type of medical care they get. I have a college degree and my husband is a Doctor. That in know way shape or form means people without an education are incapable of researching on their own as well. I believe if you would actually sit down with parents who have decided against vaccination or have an altered schedule you would actually find they have spent many hours researching vaccines and weighing out the pros and the cons of making such an important decision. VAERS is set up by the government to report vaccine injuries. Are you at all familiar with this? The government has paid out over $4 billion to families for vaccine injuries caused to someone in their family. It is not the governments role to decide what education they want me to have to make these important decisions for my children. A one-sided propaganda video is not going to change the minds of people who already spend hours and hours of time researching to make their decision. We as parents know what is best for our children and this bill would undermine our parenting rights. I urge you to vote no on HB 1469.

Sincerely,

Melanie K Paape

My name is Sara Williams, I am writing you today as a constituent of District 37 and as a concerned parent who opposes HB1469. Choosing to vaccinate or not vaccinate your children is an especially important decision and I believe a decision that does not come without hours of research and at times heartache regarding making the best choice for the health and safety of your child. As a parent I have found it difficult to have my concerns heard with our family medical provider about vaccinations and have felt pressure to consent despite the wealth of information on vaccines that is available and the many parents I know whose children have been harmed by vaccines. Telling your medical provider, you will not be following the schedule is difficult and I believe HB1469 is just one more hurdle to make it more difficult for parents to make medical decisions for their families. Thank you for your consideration.

Hello my name is Kim Huebner. I am testifying in OPPOSITION to HB1469. Thank you.

HB 1469: NO, OPPOSE

Chairman Weisz and the House Human Services Committee;

My name is Whitney Jeske, a resident of McKenzie County, ND. I am testifying in OPPOSITION of HB 1469. When a parent arrives at the decision not to vaccinate their child, countless hours have been spent scouring the websites of the CDC, WHO, FDA, and NVIC.org. Countless studies, and lack thereof, have been read on PubMed. Informed parents have read inserts, read books, connected with other parents and individuals who have been personally affected by vaccines. My point being, parents who have chosen not to vaccinate have done his/her due diligence in making an informed decision. They do not need a state funded, biased module. My question for you, will NDDOH and their "pro" vaccine propaganda course include lengthy information on vaccine risks, disclose that there have never been true double blind placebo studies done on childhood vaccines, or will it give information on what to do if an adverse reaction does occur? I'm guessing no. There must be transparency, there must be freedom! Again, I strongly oppose HB 1469.

Christine Miller
922 East Owens Avenue Apt 8
Bismarck, ND 58501

January 25, 2021

Regarding HB 1469 - A BILL for an Act to amend and reenact section 23-07-17.1 of the North Dakota Century Code,relating to exemptions from vaccine requirements before admission to school; and to provide an appropriation.

Dear Committee Members;

I am opposed to House Bill 1469. Instead of the State forcing parents to be "educated" about vaccines before they can file an exemption for their children, the State needs to make it unlawful for the medical community to administer vaccines to children without providing parents with proper and complete Informed Consent. Please refer to HB 1468.

Informed Consent is all parents need to make decisions regarding childhood immunizations!!

I believe this bill is discriminatory towards Christian and Homeschooling families and towards families with children who have health conditions which make vaccination risky or even dangerous.

As a homeschooling parent I have had to submit vaccine records to the school district and I have always wondered why. If my children are not in school, why does the school district need their vaccine records? I recently learned that North Dakota is one of only a few states that require home schooling families to submit vaccine records.

When I first moved to North Dakota I did not have children so home shooing was not something I was thinking about. When I did have children ready to enter the school system in 2007 I began investigating the state home schooling laws. I was shocked to find out that North Dakota was considered a "red" state, meaning a state with the highest state regulations for homeschooling. Had I known that before having children I would not have chosen North Dakota as my home. Fortunately, organizations like HSLDA (Home School Legal Defense Organization), and NDHSA (North Dakota Home School Association) along with many dedicated parents and legislators have made some much needed changes in the area of home school freedom in this state, and North Dakota is now an "Orange State." We need to and could do much better!

Due to the Covid-19 and our nation's school closings, mask mandates, and vaccine mandates in some states, Home schooling numbers have increased substantially since a year ago, and families in high regulation states with oppressive medical mandates are fleeing for freedom. North Dakota needs to work on making home schooling more free, not more highly regulated.

I can assure you as a home schooling parent and as a parent who files vaccine exemptions for my children, parents who choose these avenues research heavily before making a decision. We do not need, nor desire, nor should we be required to view a State propaganda video about vaccine safety.

Sincerely,

Christine Miller

HB 1469

Testimony of Thea Lee

01/25/2021

I am in opposition of House Bill 1469.

IT IS NOT WITHIN THE RIGHTS OR ROLE OF THE GOVERNMENT TO FORCE AN AGENDA UPON THE POPULATION THEY SERVE.

As has been demonstrated each time there is legislation relating to vaccinations or immunizations, the anti-vaccination population are anything but uninformed. They will spend hours telling you the mountains of information they have learned through days of research!

This bill essentially says "***We assume parents that opt out of vaccinations must be irresponsible or stupid, so we must force them to watch our informational video BEFORE WE WILL ALLOW THEM THE FREEDOM to make a medical choice for their family***."

If the group of citizens that have the belief that vaccinations are the best for the community want to launch an educational campaign in the community, **WITH THEIR OWN MONEY**, that is within their rights. However, **WE DO NOT SPEND GOVERNMENT FUNDING, TAX PAYER DOLLARS, TO FORCE AN AGENDA UPON THE POPULATION!** This cries of communist agendas, and WE DO NOT DO THAT IN NORTH DAKOTA!

Please do not let this precedence be set within our state!

Respectfully,

Thea Lee
8960 69th Ln NW
Powers Lake, ND 58773
(701) 339-1458

I STRONGLY oppose HB 1469 which would make parents watch an educational module before they are able to get a personal or religious exemption.

I have vaccine injured children and I, as are most people in my situation, are already fully aware of the risks vs benefits of vaccines. We don't need any more information to make our decisions.

Thanks for listening.

To whom it may concern:

I am in opposition to bill 1469 and I believe it would a horrible government overreach to require ND residents to put something in their body they do not want.

My son was vaccine injured when he received his kindergarten shot series. Approximately 4 days after being inoculated his personality changed and he has since been a different person. He is now 24 years old. He was happy, energetic, and had a quick sense of humor. On day 4 he became quiet, withdrawn, and introverted.

I have the right as a free American citizen to determine what goes in my body and the body of my child. Now that I know better I do better. If the committee members have not researched vaccine inserts and vaccine injury, I highly recommend they do before they determine others' fate and future health conditions.

Additionally, if vaccines are safe and effective, why do the vaccine companies need protection against lawsuits for adverse reactions? I think you know why.

https://www.youtube.com/watch?v=3lj5euanY4Y

I STRONGLY oppose HB 1469 which would make parents watch an educational module before they are able to get a personal or religious exemption.

I have vaccine injured children and I, as are most people in my situation, are already fully aware of the risks vs benefits of vaccines. We don't need any more information to make our decisions.

Thanks for listening.

Dear Committee Members,

Please recommend a ‘Do Not Pass’ on HB1469.

There should be no question on why you would recommend a ‘Do Not Pass’ on this atrocious piece of legislation and attempt to inject more propaganda into the citizens of ND. This bill is blatantly unconstitutional – it grossly infringes on my right to privacy and my freedom of religion. For those two reasons you MUST recommend a ‘Do Not Pass’ on HB1469.

Sincerely,

McKenzie McCoy
Watford City, ND
District 39

I STRONGLY oppose HB 1469 which would make parents watch an educational module before they are able to get a personal or religious exemption.

I have vaccine injured children and I, as are most people in my situation, are already fully aware of the risks vs benefits of vaccines. We don't need any more information to make our decisions.

Thanks for listening.

HB 1469

My name is Selenna Bolanos-Reyes, I am resident of Williston,ND. I am testifying in **opposition of HB 1469.** It is the choice of the parent/ legal guardian as to whether to vaccinate their child/children. This Bill would put a condition on my parental rights to make a medical decision for my child/children. If one makes the decision to not vaccinate for any reason, there is absolutely no need for them to view a clearly biased education module. It is a waste of money. I OPPOSE THIS BILL.

House Bill 1469 categorically denies the reality of the pain that our family has lived through. It creates further isolation and irrational fear for families who have discovered that vaccines do indeed cause harm. It sentences untold scores of other children and families to the same fate. It is thoroughly unconscionable that our representatives would see themselves as so all knowing and all powerful as to remove the ability of a parent to make medical choices for their child. You are not the parent of our children and you do not know how difficult their lives are due to living with autoimmune disorders that are recognized side effects of vaccination. The hypocritic oath, requires that all doctors follow the mantra, "Do no harm." Through the action of HB 1469, you will be taking the choice not only away from parents but also away from doctors who specialize in caring for children. You set up a standard where a social worker, a criminal justice major, a fire fighter and economist, a realtor, a retired sociologist and an attorney who have never met my children, have never read their medical files, nor consulted with their pediatrician have more say over what is injected into their bodies than either their parents or their doctor do.

My name is Derrick Howry and I am voicing my strong opposition to HB 1469. I have a number of concerns with this bill, but I want to address two specifically.

The first is that true unbiased information about the vaccines is not provided to parents and families. Vaccine inserts are discussed with families, information about possible side effects is not discussed with families. Families are told that vaccines are safe and effective and made to believe that they are the only way. The concern is that these modules would be much of the same. Real information and conversation about the pros and cons of these vaccines are not being discussed.

The second concern I have is in relation to individual liberty and health freedom. We as parents and families have the right to research and make informed decisions for ourselves and our families. Choosing not to vaccinate is not a simple flippant decision that is made. It is accompanied by hours and hours of research, talking to medical professionals, and trying to obtain all the information. Parents care deeply about their children and their health; we have the right to decide what should be put in our bodies and in our family's bodies. We do not need permission to make that decision. It is rather insulting to think that we are so mis-informed that a simple video module would be the deciding factor. We have done the research we have followed the advice of 100's of doctors around the country that do not follow the vaccine schedule in their practices. We know both sides, and we have the right to make our decisions.

HB 1469 – "vaccination exemption burden"

Good afternoon Chariman and committee members. My name is Rena Rustad and I reside in McLean county.

I am strongly opposed to several amendments of House Bill 1469. Section 1, paragraph 3, leave 'Any' to begin the sentence, end the sentence after the word form. Period, that's it. There is no need to view a vaccination module online and submit an educational certificate to the 'institution authorities.' Leave the 'and' condition out of the century code.

I am also opposed to the wording in paragraph 6 "the exemptions from immunization against such disease may not be recognized and children not immunized must be excluded from an institution….." refers to an epidemic of communicable disease for which immunization is required.

Paragraph 8 – more money and time and personnel hours spent on something that is not needed.

Section 2 Appropriation - $50,000 to create a video? Useless waste of tax payer dollars.

This is why I am so strongly opposed to this bill. In researching I found an article from April 1, 2019 written by Andrew Horn stating that (in part) the ND Dept. of Health says the "personal believe" exemptions were up nearly a percent (actually .8 of a percent) or approximately 400 students exempt from immunizations.

The public school enrollment for 2018-2019 in ND was 110,842. If 400 students had exemption forms that is .36% of the enrollment for that school year, less than 1/2 of 1%! *I would give some consideration to the idea that perhaps several of these 400 were home educated, therefore NOT making public school population vulnerable.*

Jenny Galbraith from the department was quoted as saying "Increasing exemption rates leave North Dakota schools vulnerable to outbreaks caused by vaccine preventable diseases such as measles, mumps, or pertussis."

First of all I looked into the rate of infection from these 3 diseases. There has been one case of measles in ND since 2004 and that was in 2010, 10 years ago! according to the NDDoH website, (which was last updated 2/20/2020). Mumps has had a steady decline since an outbreak of 49 cases in 2016, with 2020

showing 0. Pertussis, or whooping cough, had only 3 in 2020 after an outbreak in 2012 of 214 cases.

As the charts on the ND Immunization Information System website clearly show, vaccine uptake is on the rise or flat per adolescents 13-17 years, depending on the vaccine, even in the 3rd quarter of 2020. Vaccine uptake in children 19-35 months has been on a slight decline, especially during 2020 but according to the charts of reportable diseases, the disease occurance has NOT INCREASED.

In 2019, 400 children made up the 'personal belief' exemptions. Also listed for exemptions are history of disease and medical.

According to the charts from the ND Immunization Information System, the 'personal belief' exemptions have dropped about ½% from 2019 in the infants 19-35 months, increased in children 4-6 by less ½% and increased about ½% in teens 13-17.

Now let's just think about this. All of these changes are around ½%! Not 1%, not 5%, not 10%, around ½ %!

If a parent has chosen a 'personal belief' exemption, then you can be rest assured that they have done some, if not a plethora of research into vaccinations. They don't need to watch a vaccine propaganda video and turn in verification that they watched it to the district. This is just nonsense. The ND DoH wants $50,000 to create this online video and the documents that go with it again, a waste of taxpayer money.

The 3 forms I was able to print off from the DoH website have inconsistencies regarding vaccination exemptions. The wording is not the same on any of them.

One item on the Certificate of Immunization that needs to be addressed is the sentence above the exemption box that states: "In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility." The children who are sick with the disease should be the ones excluded from school, not a healthy, unvaccinated person. This sentence should be removed from this form and SHOULD be an amendment to the bill.

And as it pertains to the current medical emergency we are in with Covid-19: As stated in the ND Vaccination for Covid-19 Plan which is on the dashboard website, it clearly states:

COVID-19 VACCINES DISTRIBUTED UNDER EMERGENCY USE APPROVAL CANNOT BE MANDATED. Therefore, these vaccines cannot be mandated for school entrance or day care either.

As I close, let's remember the facts. The incidence of flu in the ND schools was at least an emergency level in 2019-2020. The incidence of measles, mumps and pertussis was none to extremely low.

There is NO NEED for a parent or guarding signing a personal exemption from vaccine to have additional burden put on them to view informational vaccine videos. The ND legislatures should not spend $50,000 to create such a program. I am opposed to this bill.

Personal belief exemptions for vaccinations increase in North Dakota

By Andrew Horn
Published: Apr. 1, 2019 at 10:14 AM CDT

Vaccination rates in North Dakota are holding steady for school kids, but the North Dakota Department of Health says personal belief exemptions are up nearly a percent. – less than 1%

NDDoH says the percent of North Dakota parents claiming an exemption due to reasons of personal belief increased from 3.1 percent to 3.9 percent, leaving approximately 400 students exempt from immunizations.

"Increasing exemption rates leave North Dakota schools vulnerable to outbreaks caused by vaccine preventable diseases, such as measles, mumps, or pertussis," said Jenny Galbraith, epidemiologist with the NDDoH. "An MMR coverage rate of 95 percent is recommended to maintain herd immunity in schools and prevent cases and outbreaks. Outbreaks have become more commonplace in the United States due to low vaccination rates and the ease of travel."

Before entering school in North Dakota, children must have five doses of DTaP, four doses of IPV (polio), three doses of HBV (hepatitis B), two doses of MMR, and two doses of varicella vaccine. Students entering seventh through twelfth grade need one dose of Tdap, which protects against tetanus, diphtheria, and pertussis (Tdap). Students in grades 7 through 10 need one dose of meningococcal conjugate vaccine (MCV4) and students entering grades 11 and 12 need a second dose of MCV4. (19 total)

Public School Enrollment 2018-2019 110,842

400 students = .36% of total students claiming an exemption

For a list of exemptions, see the attached link.

Documents

School Requirements 19-20 Final.pdf

North Dakota Administrative Rules 33-06-01 requires the reporting of certain conditions to the North Dakota Department of Health (NDDoH). The NDDoH Division of Disease Control uses this information to monitor, control, and prevent the occurrence and spread of reportable infectious diseases and outbreaks. The data on this website is a summary of reportable conditions in North Dakota. In an effort to protect the identity and health information of North Dakotans, numbers smaller than five can be released statewide or

Select a Condition

Measles

Select a Year

2020

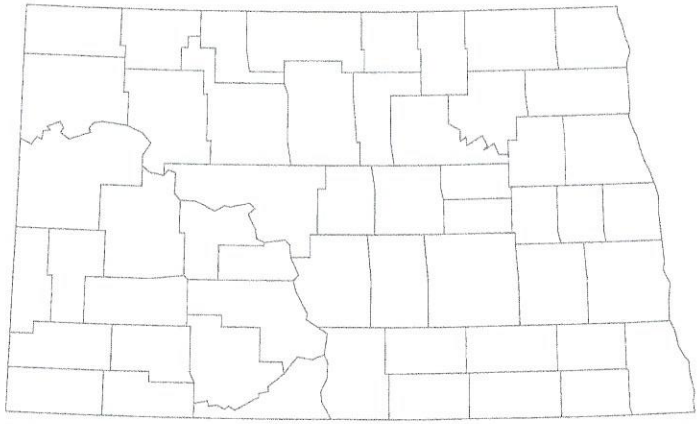
For more information:

http://www.ndhealth.gov/Disease/Documents/faqs/Measles.pdf

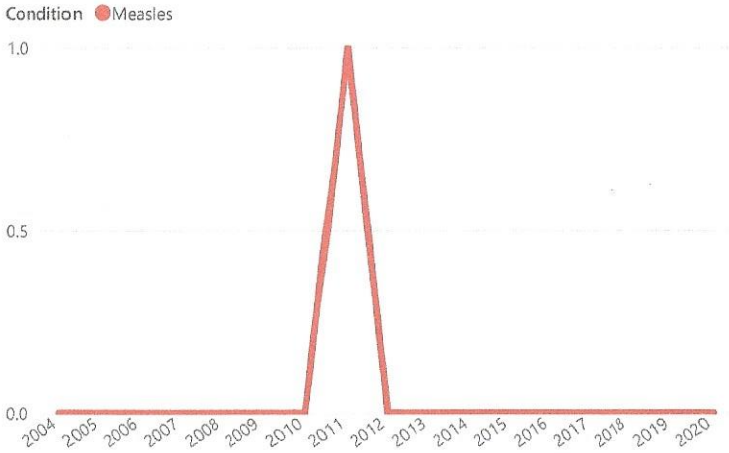
Previous Page

County Total Cases Rate Per 100,000

Total Cases by County *



Total Cases by Year



Total Cases *

0

Measles is a highly contagious virus that starts with fever, runny nose, cough, red eyes, and sore throat, followed by a rash that spreads all over the body.?Measles is highly contagious and spreads through coughing and sneezing.

** Due to Health Department policy, data may not be released for conditions in years with fewer than 5 cases.*

*** Numbers for current year are preliminary and subject to change.*

****The data presented in this report are current as of time of publication. However, the data may be variable as new information is received and may differ from other*

Last Updated

2/20/2020

North Dakota Administrative Rules 33-06-01 requires the reporting of certain conditions to the North Dakota Department of Health (NDDoH). The NDDoH Division of Disease Control uses this information to monitor, control, and prevent the occurrence and spread of reportable infectious diseases and outbreaks. The data on this website is a summary of reportable conditions in North Dakota. In an effort to protect the identity and health information of North Dakotans, numbers smaller than five can be released statewide or

Select a Condition: Mumps

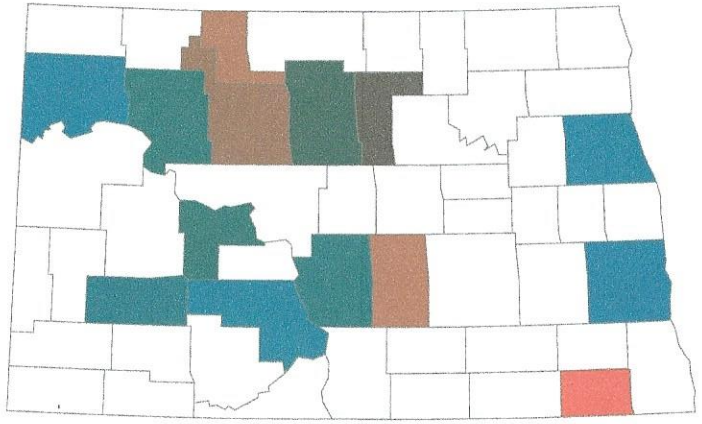
Select a Year: 2016

For more information:
http://www.ndhealth.gov/Disease/Documents/faqs/Mumps.pdf

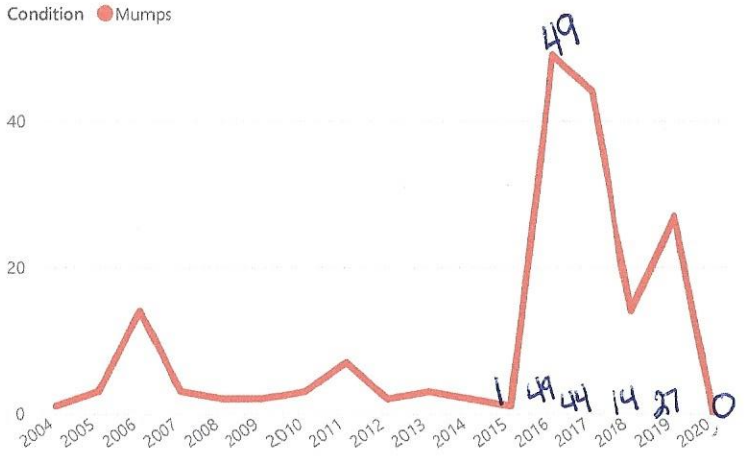
Previous Page

County	Total Cases	Rate Per 100,000
Sargent	2	51.44
Kidder	1	40.39
Renville	1	39.71
Ward	24	34.55
Pierce	1	23.71
McHenry	1	16.76
Mercer	1	11.60
Mountrail	1	9.78
Burleigh	8	8.46
Stark	2	6.48
Total	**49**	**9.03**

Total Cases by County *



Total Cases by Year



Total Cases *

49

Mumps is a highly contagious, vaccine-preventable disease caused by an infection with a virus. Infection with the mumps virus results in tenderness and swelling of the salivary glands in the cheeks and neck.

** Due to Health Department policy, data may not be released for conditions in years with fewer than 5 cases.*

*** Numbers for current year are preliminary and subject to change.*

****The data presented in this report are current as of time of publication. However, the data may be variable as new information is received and may differ from other*

Last Updated

2/20/2020

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Select a Condition: Pertussis

Select a Year: 2012

For more information:

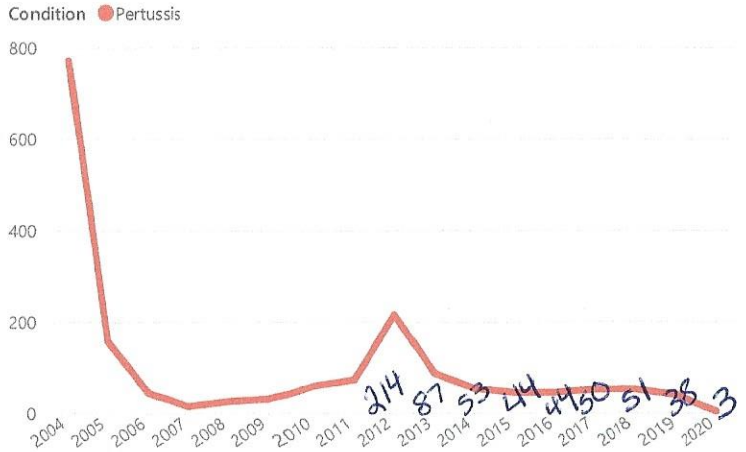
http://www.ndhealth.gov/Disease/Documents/faqs/Pertussis.pdf

Previous Page

County	Total Cases	Rate Per 100,000
Billings	2	217.63
Rolette	14	97.21
Ward	60	92.52
McHenry	5	86.22
McIntosh	2	72.73
Walsh	8	72.60
Foster	2	59.17
Morton	16	56.98
Dunn	2	50.54
Williams	13	48.63
Total	**214**	**34.78**

Total Cases by County *

Total Cases by Year



Total Cases *

214

Pertussis, or whooping cough, is a very contagious respiratory disease caused by bacteria. It is a vaccine preventable disease that is usually mild in vaccinated children and adults, but can be serious in infants. All children attending child care facilities and entering schools are required to be immunized against pertussis

** Due to Health Department policy, data may not be released for conditions in years with fewer than 5 cases.*

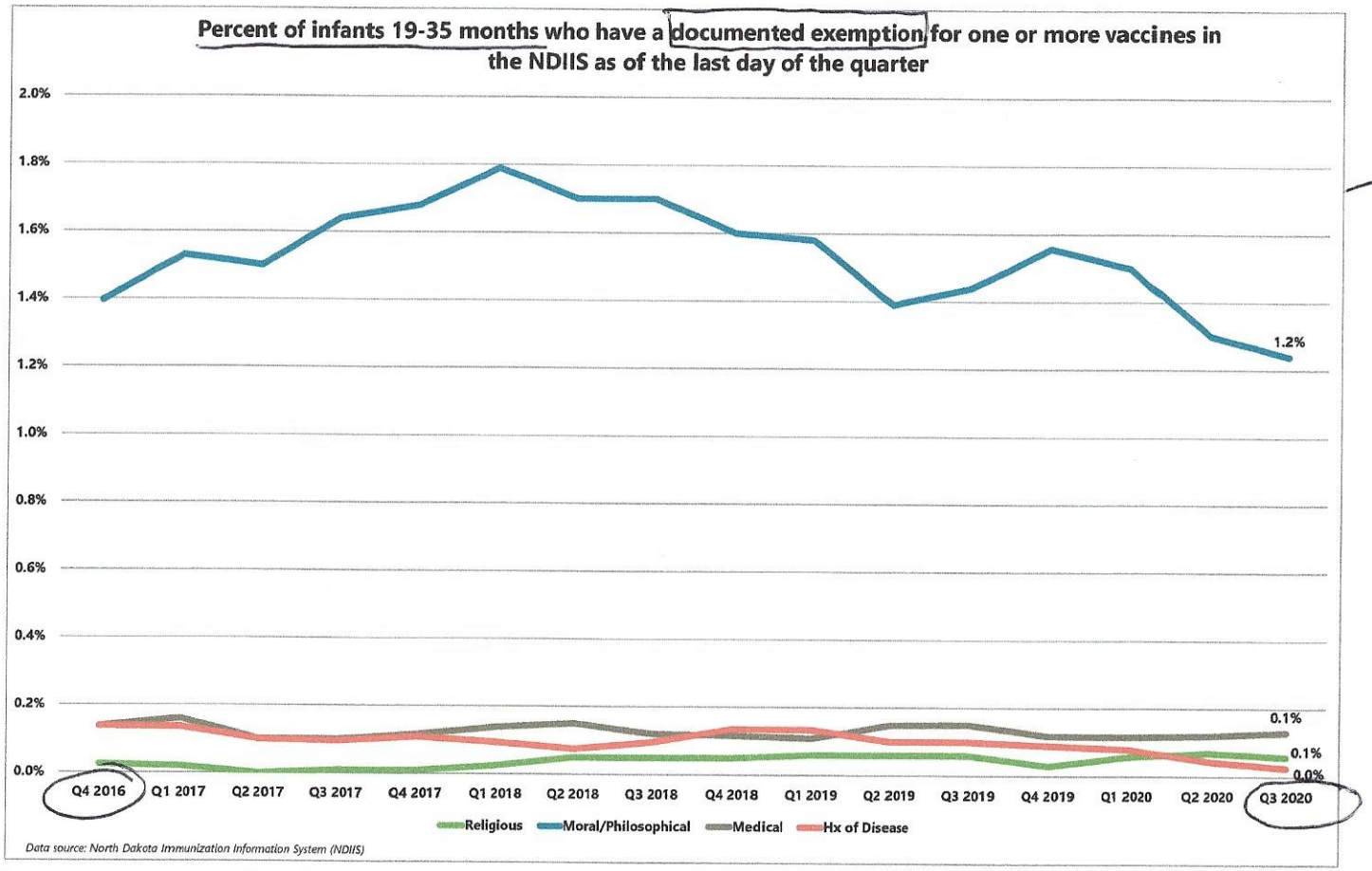
*** Numbers for current year are preliminary and subject to change.*

****The data presented in this report are current as of time of publication. However, the data may be variable as new information is received and may differ from other*

Last Updated

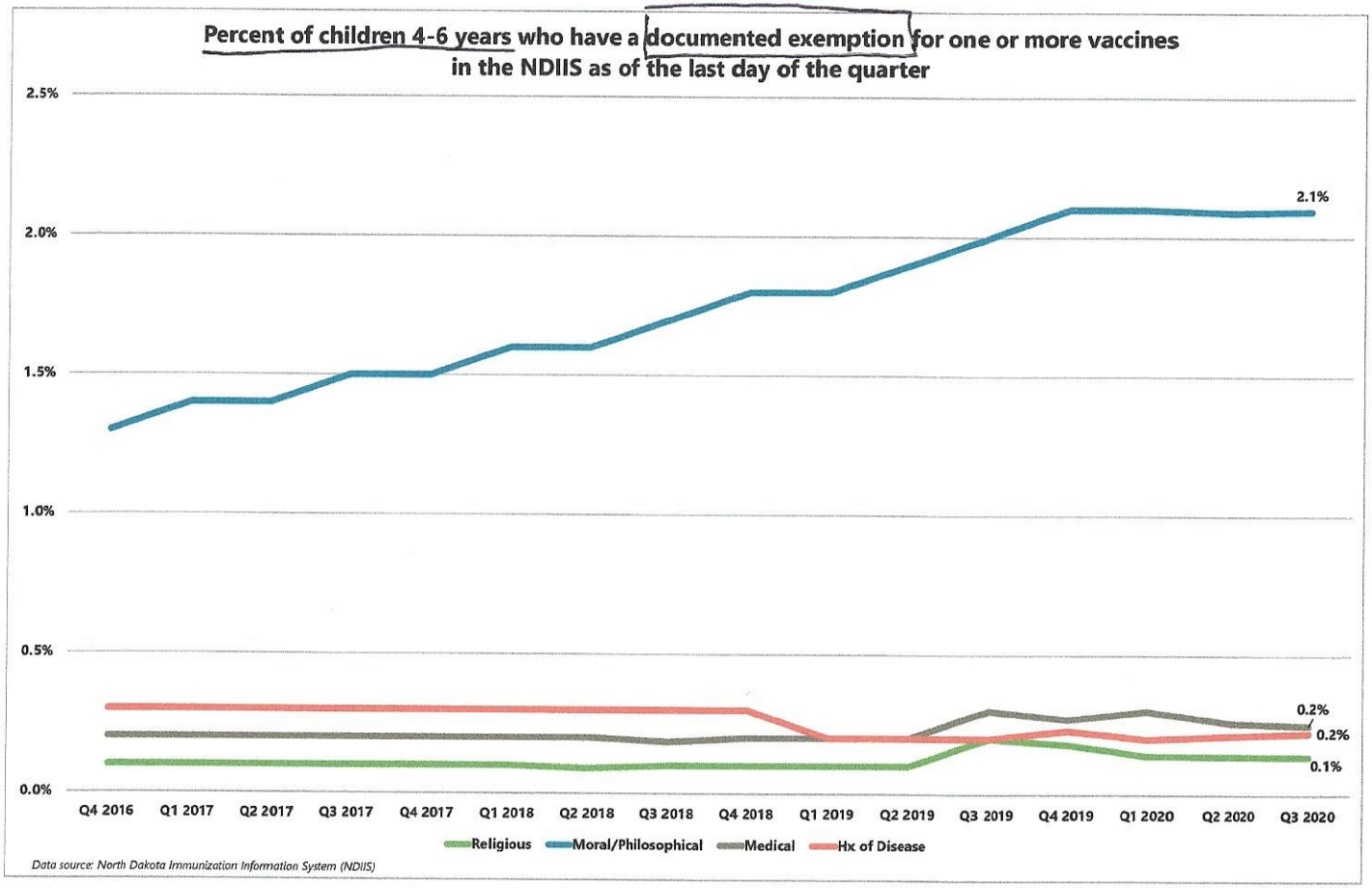
2/20/2020

ND shows decrease or "flat" in exemptions for 'toddlers'.
Only for moral/philosophical reasoning was it elevated in 2018.



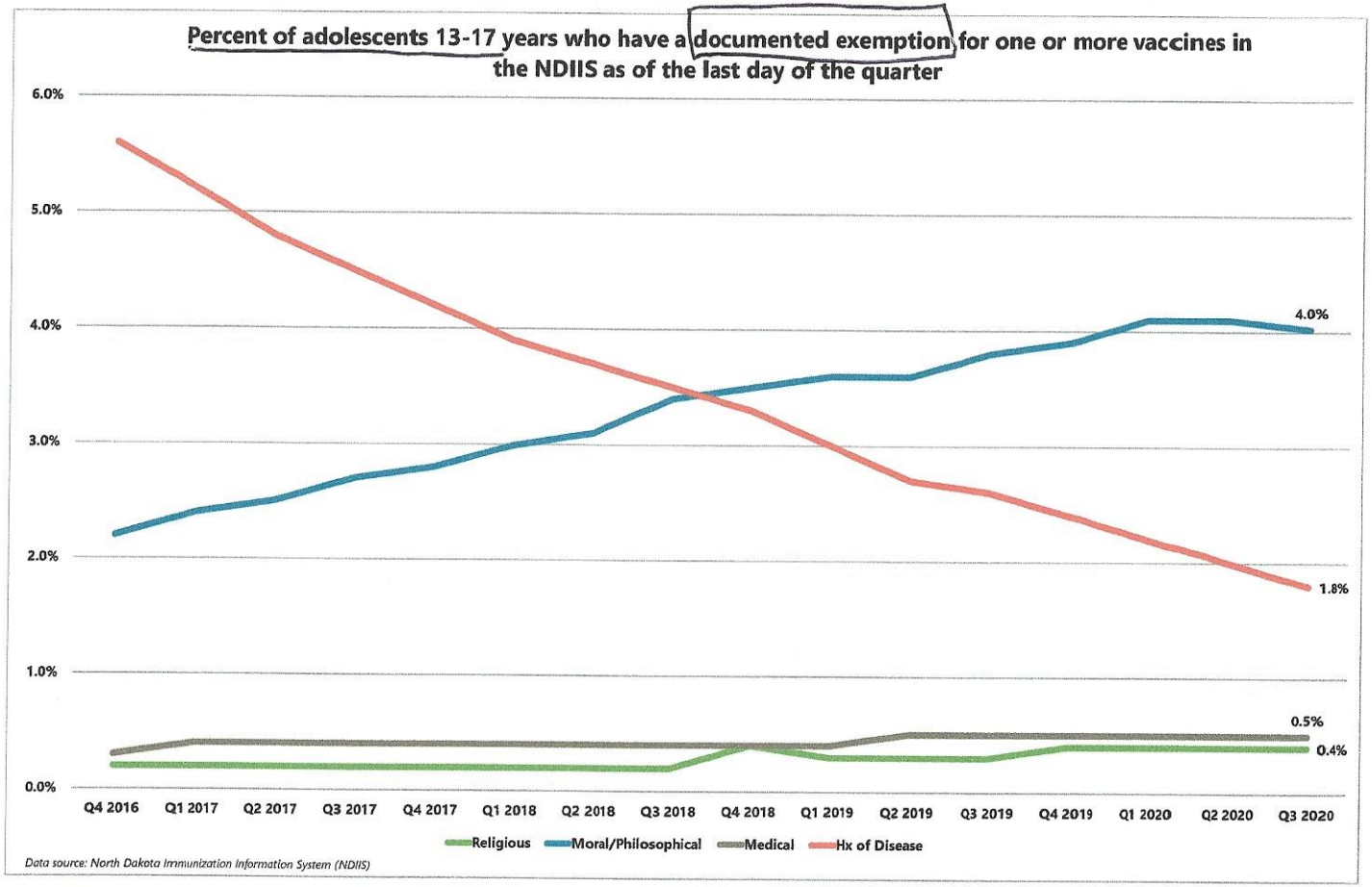
1.2%
.1
.1
1.4% total of children 19-35 months

ND shows increase or "flat" in exemptions for 4-6 yr olds.



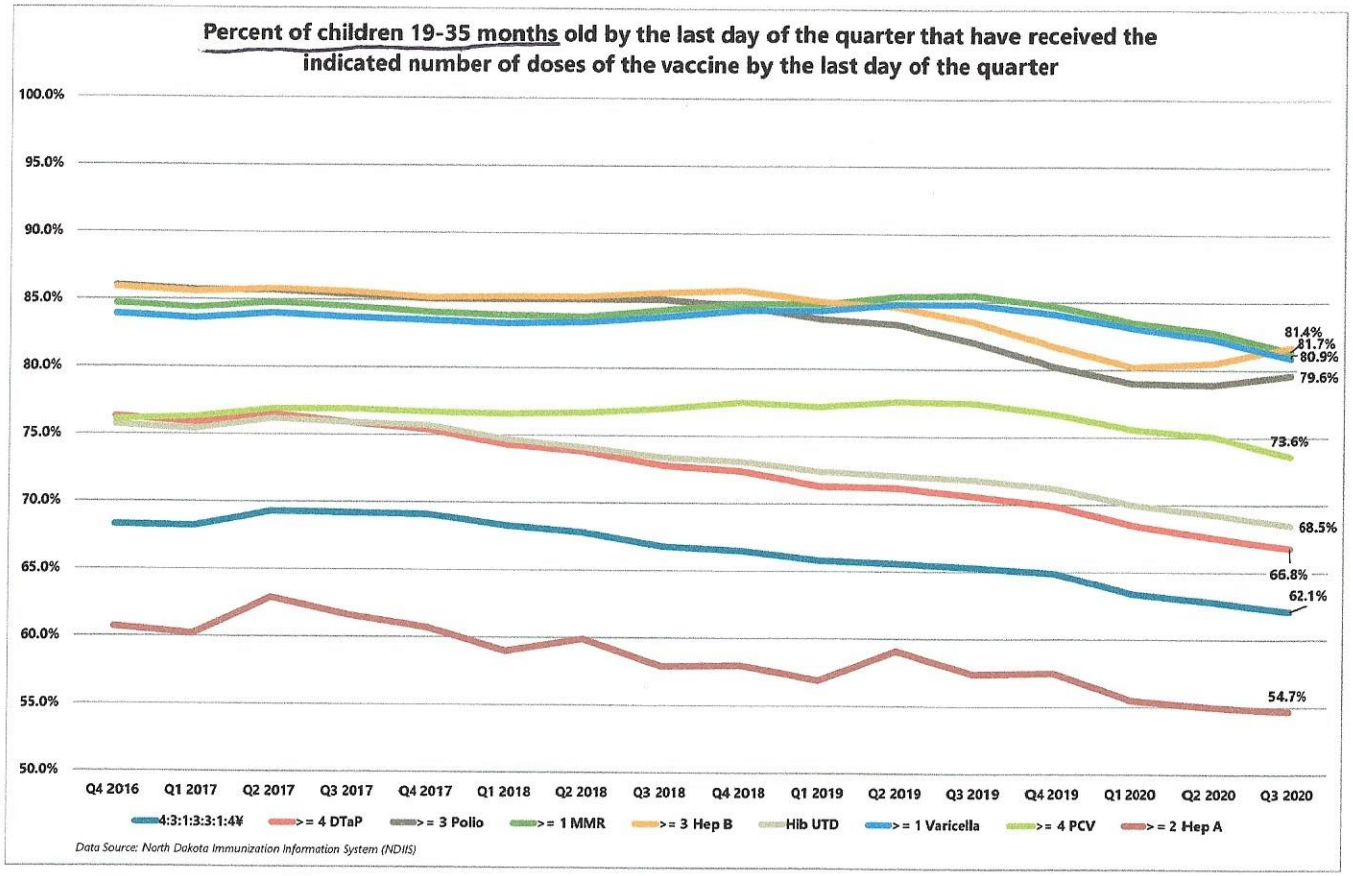
2.1%
.2
.2
.1
2.6% total of children 4-6 yrs

ND shows mix of exemptions in 13-17 yr olds.



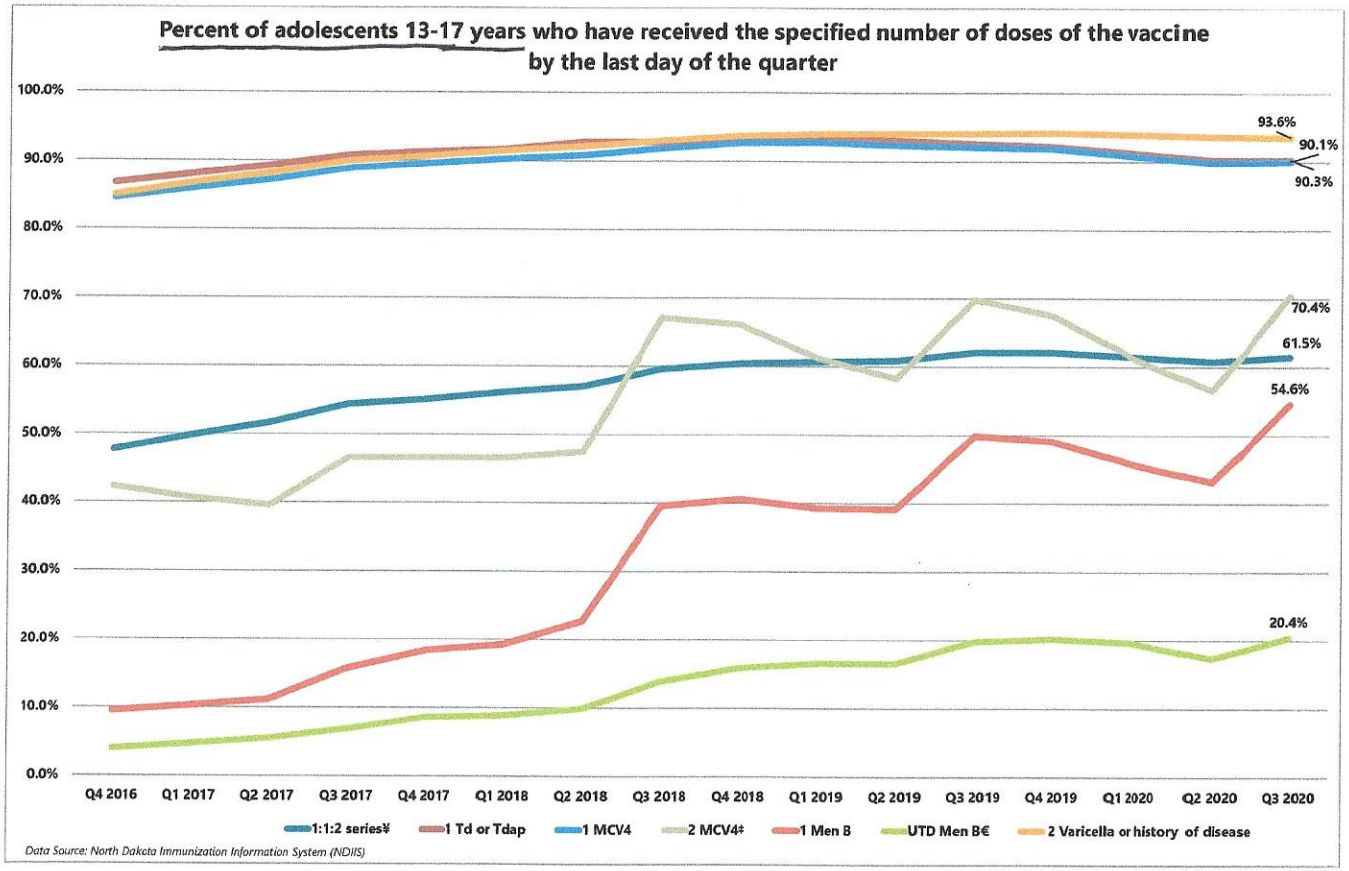
4% or less
1.8
.5
.4
6.7%
total of
'teens'

ND shows decrease of vaccine uptake in 'toddlers.'



¥: infant vaccine series includes >=4 doses of diphtheria, tetanus and acellular pertussis (DTaP) vaccine, >=3 doses of polio vaccine, >=1 dose of measles, mumps and rubella (MMR) vaccine, >=3 doses of hepatitis

ND shows increase of vaccine uptake in 'teens'.



¥: 1:1:2 adolescent vaccine series includes >=1 dose of Td or Tdap vaccine, >=1 dose of meningococcal conjugate (MCV4) vaccine and up-to-date with either 2 or 3 doses of human papillomavirus (HPV) vaccine

‡: rate for >=2 doses of MCV4 vaccine was assessed only for adolescents 16-17 years of age.

€: rate for series start and series up-to-date with Meningococcal B vaccine was assessed only for adolescents 16-17 years of age.

CERTIFICATE OF IMMUNIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 16038 (Revised 01-2018)

Division of Disease Control
2635 East Main Ave. PO Box 5520
Bismarck, ND 58506-5520
800.472.2180 or 701.328.3386

Child's Name (Last, First, Middle Initial):	Date of Birth:
Parent's Name:	Telephone Number:

Vaccine Type		Exemption Type*	Enter Month/Day/Year for Each Immunization Given				
Hepatitis B	Hepatitis B						
Rotavirus	Rotavirus						
Hib	*Haemophilus influenzae* type B						
PCV	Pneumococcal conjugate						
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis						
IPV/OPV	Polio						
MMR	Measles-Mumps-Rubella						
Varicella	Chickenpox						
Hepatitis A	Hepatitis A						
Td/Tdap	Tetanus-Diphtheria (and Pertussis)						
MCV4	Meningococcal ACYW-135						
HPV	Human Papillomavirus						
Men B	Meningococcal B						
Other							

To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.

Physician, Nurse, Local/State Health:	Title:	Date:

If additional doses are added after initial signature, please initial dose and sign below.

Update signature #1:		
Physician, Nurse, Local/State Health:	Title:	Date:
Update signature #2:		
Physician, Nurse, Local/State Health:	Title:	Date:

My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) and to submit a signed Certificate of Immunization.

Parent/Guardian Signature: Date:

Statement of Exemption to Immunization Law

In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

☐ ***Medical (Med) Exemption:*** *(Indicate vaccine above, requires physician signature)* The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

☐ ***History of Disease (HD) Exemption:*** *(Indicate vaccine above, requires physician signature)* To the best of my knowledge, the above named person has had prior infection as indicated by prior diagnosis or laboratory confirmation.

Physician Signature:	Date:

Religious (Rel), Philosophical/Moral (PBE) Exemption: *(Indicate vaccine above, requires parental signature)*

Parent/Guardian Signature:	Date:

*** Medical =Med, History of Disease = HD, Religious = Rel, Philosophical/Moral = PBE**

NORTH Dakota | Health

Be Legendary.™

2019 – 2020 School Immunization Requirements

18

Vaccine Type	Number of Required Doses			
	Kindergarten-6	Grades 7-10	Grade 11	Grade 12
DTaP/DTP/DT/Tdap/Td*	5	5	5	5
Hepatitis B	3	3	3	3
IPV/OPV†¥	4	4	4	4
MMR	2	2	2	2
Varicella (Chickenpox)+	2	2	2	1
Meningococcal¶	0	1	2	2
Tdap Θ	0	1	1	1

* One dose of DTaP (pediatric diphtheria, tetanus, and acellular pertussis) vaccine must have been given on or after the fourth birthday. Only four doses are necessary if the fourth dose was administered on or after the fourth birthday. Three doses of Tdap (adolescent/adult tetanus, diphtheria, and acellular pertussis)/Td are required for children ages seven or older who were not previously vaccinated. Tdap should be used as the first dose followed by two doses of Td for children age seven or older not previously vaccinated.

† For polio vaccination, in an all-IPV or all-OPV schedule: one dose must have been given on or after the fourth birthday. The final dose in the series should be administered on or after the fourth birthday and at least six months after the previous dose. If four doses are administered prior to age four, a fifth dose should be administered on or after age four. Only three doses of IPV are required if the third dose is given on or after the fourth birthday. Children born before August 2005 only need four doses separated by at least four weeks. These children do not need a dose after the age of four.

¥ Any doses of OPV administered after April 1, 2016, should not be counted as valid, because it was bivalent or monovalent vaccine, rather than trivalent. The child should be revaccinated with IPV vaccine, accordingly.

+ For the 2019-2020 school year, two doses of varicella (chickenpox) vaccine are required for kindergarten through eleventh grade. One dose of varicella vaccine is required for twelfth grade.

¶ One dose of meningococcal conjugate vaccine (MCV4) must have been given on or after the tenth birthday. The second dose of MCV4 must be given on or after the sixteenth birthday. If the first dose of MCV4 is given after the sixteenth birthday, then only one dose of MCV4 is required for eleventh and twelfth grade.

Θ One dose of Tdap must have been given on or after the eleventh birthday.

Exemptions

Students may be exempt from immunization requirements for the following reasons:

- **Medical Exemption:** Requires a certificate signed by a licensed physician stating that the physical condition of the child is such that immunization would endanger the life or health of the child.
- **Personal Belief or Religious Belief Exemption:** Requires a certificate signed by the parent or guardian whose sincerely held philosophical, moral or religious belief is opposed to such immunization.
- **History of Disease Exemption:** Requires a certificate signed by a physician stating that the child has a reliable history of disease. History of disease exemptions may only be claimed for hepatitis B, varicella, measles, mumps, or rubella.

Exclusion

All children must be up-to-date according to the school immunization requirements or have claimed an exemption by **October 1st** of each school year or they must be excluded from school. Children enrolling in school after October 1st have 30 days to be up-to-date or claim an exemption or they must be excluded from school.

Updated: 01/14/2019

No mention of childcare

NORTH DAKOTA
DEPARTMENT of HEALTH

Child care Facility Immunization Requirements

23

Vaccine Type	Minimum Number of Doses Required Per Age						
	2-3 Months	4-5 Months	6-7 Months	8-11 Months	12-17 Months	18-24 Months	2-5* Years
MMR (Measles-Mumps-Rubella)					1	1	1
Varicella (Chickenpox)					1	1	1
HAV (Hepatitis A)					1	2	
Rotavirus#	1	2	2 or 3¥				
Hib§ (*Haemophilus influenzae* type b)	1	2	2 or 3	2 or 3	3 or 4	3 or 4	3 or 4
HBV (Hepatitis B)	1	2	3	3	3	3	3
IPV (Polio)	1	2	3	3	3	3	3
PCV¶ (Pneumococcal)	1	2	3	3	4	4	4
DTaP/DT (Diphtheria-Tetanus-Pertussis)	1	2	3	3	4	4	4

§ If a child receives immunizations late, fewer doses may be required. Contact your local public health unit or the North Dakota Department of Health (NDDoH) to determine the appropriate number of doses. Children ages five and older are exempt from the Hib requirement. Depending on vaccine brand the child may receive a series of three or four doses.

¶ If a child receives immunizations late, fewer doses may be required. Contact your local public health unit or the NDDoH to determine the appropriate number of doses. Children ages five and older are exempt from the PCV requirement.

Children who do not receive the first dose by 15 weeks of age can no longer receive this vaccine and are exempt from the Rotavirus requirement. Children ages eight months and older are exempt from the Rotavirus vaccination requirement.

¥ Rotavirus vaccine may be given as a two or three dose series depending on the brand of vaccine. The third dose of rotavirus vaccine may not be necessary depending on the brand of rotavirus vaccine given.

* Children attending kindergarten may require more doses, but these immunizations are not required to attend child care.

Exemptions

Children may be exempt from immunization requirements for the following reasons:

- **Medical Exemption:** Requires a certificate signed by a licensed physician stating that the physical condition of the child is such that immunization would endanger the life or health of the child.
- **History of Disease:** Requires a certificate signed by a physician stating that the child has a history of disease. History of disease exemptions may be claimed for measles, mumps, rubella, chickenpox, hepatitis A, or hepatitis B.
- **Personal Belief or Religious Belief Exemption:** Requires a certificate signed by the parent or guardian whose sincerely held philosophical, moral or religious belief is opposed to such immunization.

Exclusion

All children need to be up-to-date according to the child care immunization requirements or have claimed an exemption within 30 days of enrollment or be excluded from child care.

01/01/2018

Note: updated form from 1/14/2019 wording is not the same

of the capabilities are similar to PrepMod but lack a few functionalities that we gain with PrepMod. Also, North Dakota has been interested in purchasing an electronic registration system for facilities to use for all vaccinations including back to school and influenza. VAMS will only be used for COVID-19 vaccine administration. VAMS may be used by providers in North Dakota once it is available but most likely facilities will use their own systems or PrepMod.

Vaccination Mandates

It is not expected that the state will enact any mandates requiring vaccination for COVID-19. However, specific institutions or businesses may choose to mandate the vaccination of employees as a condition of employment. A requirement that health care workers and long-term care workers have mandated vaccination should be discussed by applicable institutions. Many institutions have mandates in place for influenza vaccinations. It is unknown at this time what impact COVID-19 vaccination will have on the need for ongoing testing and use of PPE, but it is anticipated that vaccination may lessen the requirements for testing, visitor restrictions, and use of some PPE. Therefore, there may be incentives that will encourage COVID-19 vaccination. COVID-19 vaccines distributed under EUA cannot be mandated.

Regulatory Considerations for COVID-19 Vaccination

The provisions of an EUA requires that persons receiving the vaccine know that the vaccine has not completed full approval, but that it is being offered due to an emergency. Potential recipients would need to know the risks and benefits of receiving the vaccine or of refusing the vaccine, any alternatives that they have to the vaccine, and an assurance of their right to refuse the vaccine. In the event that NDDoH needed to administer vaccine under an EUA, the agency would expect to receive substantial information from Department of Health and Human Services detailing the following:

- Target recipients;
- FDA conditions for use;
- Information regarding risk and benefit of use;
- Additional information to be collected (in addition to contact information and information collected as part of the vaccination process for a non-EUA vaccine);
- Guidance regarding enhancements to adverse event reporting and case investigation that would need to be implemented as additional safeguards.

Chairman Weisz and the House Human Services Committee

RE: HB 1469

NO, OPPOSE

My name is James Jeske, a resident of McKenzie County, ND and a practicing optometrist. I am testifying in OPPOSITION of HB 1469. There is no need for one-sided propaganda to influence individuals one way or the other. Without providing all the possible adverse effects and study information it would be nothing more than a biased view aimed at steering decisions.

Again, I oppose HB 1469

HB 1469 Testimony

Human Services Committee

January 25, 2021

Chairman Weisz and Esteemed Members of the Human Services Committee,

My name is Danielle Pinnick. I am a public health professional, who for the last several years has focused on immunizations, maternal and child health, and health policy. I was born and raised in Minot, and have lived in Fargo since 2005, where I currently reside with my husband and two children. Today, I would like to address you as a mother and as a North Dakotan.

I want to keep my remarks brief. I don't need to go into depth about the numerous health benefits of immunizations, or even the health dangers of not being vaccinated, as many of my colleagues have spoken about these already, at length. I believe in legitimate exemptions to vaccines, for the reasons of health and strongly held personal beliefs. My concern is, however, focused chiefly on parents who may be objecting to vaccination on the basis of convenience. As a parent who is well-educated on immunizations (both the diseases they prevent, and their components, since my background is in chemistry, as well), I choose to vaccinate myself and my own family, and would like to share my knowledge with you, today.

I would like to address one of the more practical concerns that is posed by vaccine exemption. In Minnesota, during the spring of 2017, a decline in vaccination coverage facilitated the spread of measles in a community of children, throughout the Twin Cities. Through the incredible work of the health department, this outbreak was contained to only 75 children. Thanks to the North Dakota's incredible health departments, clinics, and local health units, this outbreak did not spread to our neighboring state – although it easily could have.

Of those 75 cases, nearly half were hospitalized and suffered needlessly. Measles is an incredibly infectious disease – 5 to 10 times more infectious than COVID-19. Each of these cases led to a contact tracing investigation, and in the event that a contact had no immunity to measles through vaccination, each subsequent exposure to the incident case resulted in a quarantine of that contact of up to three weeks. These were mainly children exposed, which means parents staying home for that entire duration. Many of you are likely parents or caregivers, of children – do you have a 3-4 weeks of family leave banked? I certainly do not.

While parents have the right to refuse vaccination, they also deserve to know the consequences of non-vaccination, and how it will affect their lives. Many of the families involved in this Minnesota outbreak lost their pay, or their jobs, due to this unexpected outcome. The measles outbreak cost the state of Minnesota over $2 million in public health cost, and that does not even account for direct medical costs, or the lost days of work. Quarantine is necessary to keep people healthy and safe, and to prevent larger outbreaks of disease. This protects people who are unvaccinated, whatever the reason.

Non-vaccination has large, fiscal consequences. Parents deserve the right to know this, in addition to the risk they pose to their families, by refusing immunization.

Thank you for your time and I would be happy to answer any questions.

Sincerely,

Danielle Pinnick, MPH

Minnesota measles outbreak to cost state $1 million | CIDRAP (umn.edu)

WHO_SurveillanceVaccinePreventable_11_Measles_R1.pdf

HB 1469

Dear Representatives of House Bill 1469,

I am writing in direct opposition to 23-07-17.1.3.b as well as 23-07-17.1.8

I am in full support of the 1468 bill proposed, as well as the 1377 bill.

As a practicing clinician in a chiropractic and health center where our focus is on health restoration, we are often the last resort for very sick children. I am trained in removing triggers that lead to malfunction of the human body (as opposed to using drugs and surgery to control function) and to help to restore homeostasis.

Upon consulting, we ask about vaccination history, and if relevant, inquire as to whether they have concerns about safety. Most have significant concerns however report they have been scared, intimidated, and were never told about their options to opt out or what risks are.

I get about 1-5 contacts per month asking if we write exemptions because they cannot find a doctor willing to write them for their children or for their work. We don't write them. Parents are afraid because of how they are treated. They are intimidated, told that there are no risks, and when they express concerns about prior inoculations causing harm, they are very often flippantly dismissed.

Unfortunately, in giving my patients the time they deserve, I have not had the opportunity to thoroughly express why I am directly opposed to forcing biased information onto patients.

The NDDOH has been shown to minimize publicity of adverse events. Frankly, I do not trust them to put out unbiased information free from Industry (drug company) influence.

I had previously submitted a research study comparing fully inoculated individuals, partially inoculated, and those that had not had inoculations, and their likelihood of being diagnosed with various health problems. There ARE physiological mechanisms that cause these problems. However parents are grossly undereducated on the risks. They are taught to never question.

In regards to 1377, I am in full support, as exemption should be available whenever the producers of said product are considered free from any liability for damages. Drug companies, hospitals, and prescribing/administrating doctors are all exempt from liability if and when damage occurs. For that reason alone, no one should be forced/coerced for not wanting it or penalized for denying being injected with said product. **I don't know of any other product in the world that is free from manufacturer liability and at the same time, people are coerced into using it or penalized for not using it. The same companies that are free from liability are often convicted felons, some even hiding research causing damage from medications (avandia) from the public eye to continue to profit.**

For this reason, I believe 1377 would PROTECT people from impending mandates by companies influenced by drug industry lobbyists and pressure.

Thank you for your time and I apologize that this is not better formulated. If you have questions or would like further explanation, you may call me or email.

Dr. Steve Nagel

180 Health Solutions

I STRONGLY oppose HB 1469 which would make parents watch an educational module before they are able to get a personal or religious exemption.

I have vaccine injured children and I, as are most people in my situation, are already fully aware of the risks vs benefits of vaccines. We donÕt need any more information to make our decisions.

Thanks for listening.

Stephanie Becker

Please note, I tried sending this through the website and was not successful.

Thank you for considering my opinion. I am Kim Sheldon from Washburn, ND.

In regards to House Bill 1469, I am in opposition to this bill.

As most parents who reflect the need to opt their child out of vaccination, they have already had good reason to do so. Whether it be a previous reaction their child had, or even their own decision based on weighing the facts....they should not have to be subjected to the programming of pro-vaccination classes.

As parents, everyone should have the right to decide what is best for their child without having to go through formalities to guide them to a certain decision.

Thank you for your consideration.

Kim Sheldon

2356 2nd St. SW

Washburn, ND 58577

701-462-3563

HB1469

Malinda M Weninger

701-527-8226

I write in complete opposition of HB1469. This is complete infringement of personal freedoms.

If YOU chose to get a vaccination, then YOU are SAFE. If your vaccines are so great, you then are SAFE and protected from others whether they vaccinate or not. Correct? So why is everyone so worried about what the other individual is doing.

My daughter suffered for four years after her vaccination in 2006. If people would do their research they would see the many many injuries that happen out there. Facebook group "Vaccine Injury Stories" is full of injury stories. The COVID vaccine injuries are already starting to pour in. People just need to do their research.

This is a total infringement of my rights. I own one thing in this world: MY BODY. And I should decide what goes on with it.

I have five grandchildren and as of now not one of them has had an ear infection or hardly even been sick. They are extremely healthy – unvaccinated. Vaccinated children get ear infections and illnesses much more often. SIDS deaths are almost always within a few weeks of a vaccination.

If you have not done your research you have no right to make mandates such as this – as remember this could affect one of your very own loved ones sometime in the future.

I urge a NO vote on this bill.

Malinda Weninger
701-527-8226

HB1469:

Good afternoon, I am in opposition of this Bill and here is why.

This is ND and I was shocked to see this even trying to be pushed through; this is something you expect to see in CA! I have a daughter and I will raise her to use her voice. Her YES will be a YES and her NO will be a NO and she will do so based on research, knowledge, and common sense; just as I was raised.

I know my body and my health and if I say, NO to a Dr. or anyone else, I expect it to be respected. I have a functioning brain and I am fully capable of learning, researching, and asking questions and if something is not right for me or my family and we say NO, I do not need some propaganda video telling me I am wrong. Nor do I need a certificate proving I watched said propaganda video.

I will not accept anything from any company that blatantly refuses to back their own "product (s)" and if it is not right for ME, then I will say NO and I do not need to prove that to anyone.

Please read with a tone of passion and not anger, because that is exactly what it is.

Thank you for your time, Amy Winkelman

District 32 voter

1469

Hi my name is Hilary Lund and I am testifying in opposition to bill HB~~169~~. Parents should have the freedom to claim vaccination exemptions no questions asked. It's the parent's right to make medical decisions for their children. These exemptions are personal and private and are solely up to the parent, not the health department. The government has no business deciding what is best for a child especially when they no nothing about said child and they're medical history. Parents have undoubtedly done their research and have a reason for their exemption. No child should be denied an education because they have an exemption. Again that is personal and private and is up to the parent.

My testimony for HB 1469:

I am writing in strong opposition to bill HB1469. I have done hundreds of hours of research on vaccinations, much of it being reading through each individual vaccination insert and researching all ingredients and how it can affect developing brains and bodies, and also the CDC information. By having to take a "vaccine education module" in order to claim a religious or philosophical exemption, this bill not only puts limitations/conditions on what I believe to be the best medical decisions that I make for my children, it also infringes on my First Amendment right of freedom of religion because as a Christian, I believe in the sanctity of life and that our bodies are temples that we are supposed to treat as such. Aborted babies are used in the development of many vaccines and some still contain human diploid fibroblasts from these aborted children. Also, vaccines contain many carcinogens, preservatives, heavy metals, and neurotoxins that I believe are very harmful to my or my children's "body temple". Taking a class with information that does not directly line up with Biblical teachings will in no way sway my or many other parents decision to claim an exemption, and it only tries to limit my religious liberties and beliefs further. Thank you for your consideration.

Thank you,
Kylee Ybarra

#4249

Vote no to HB 1469

Dear Legislators,

Good afternoon! Thank you for listening to my take on this important bill. Please vote NO to this bill for this simple reason, "If it ain't broke don't fix it".

Currently, the requirements for exemption Have been working smoothly and been cost effective for years. I have personally and faithfully filled out a philosophical exemption form every year for 20+ years. This additional requirement has never come up before. It is purely unnecessary and it will involve the creation of a video and a system for tracking and logging the material. This would definitely be an extra expense for us tax-payers.

Any parent who takes the time to prepare and submit their current required exemption form, in my estimation, proves by their very act, that they are already diligent and informed.

I don't think that an uninformed parent would choose to take an exemption. Only ones who have taken their time would come to that decision simply because it differs so much from that of the majority. These parents have already weighed their options and have already researched the facts on both sides of the issue regarding the safety and efficacy of vaccines.

I strongly believe that to require well informed parents to watch state funded educational videos, (obviously biased toward vaccination), would be a major turn off to the parent choosing an exemption! Moreover, this may even open a perfect door for further requirements for the state to require them to prepare and fund videos for (possibly trusting and potentially uninformed?) parents who do decide to vaccinate. Those parents would likely need to view a mandated video to meet their requirement for full disclosure of the vaccine risks as well as options for exemption, and here we create a circular predicament!

Please say no.

Sincerely,

Alida Arnegard

ND Freedom Defenders

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1469
1/27/2021

Relating to exemptions from vaccine requirements before admission to school; and to provide an appropriation

Chairman Weisz opened the committee meeting at 4:05 p.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Educational components
- Better informed consent
- Advanced practice registered nurses and physicians assistants addition

Rep. Bill Tveit made a motion for **Do Not Pass.**

Rep. Matthew Ruby seconded the motion.

Representatives	Vote
Representative Robin Weisz	Y
Representative Karen M. Rohr	Y
Representative Mike Beltz	Y
Representative Chuck Damschen	Y
Representative Bill Devlin	Y
Representative Gretchen Dobervich	N
Representative Clayton Fegley	Y
Representative Dwight Kiefert	Y
Representative Todd Porter	Y
Representative Matthew Ruby	Y
Representative Mary Schneider	N

Representative Kathy Skroch	Y
Representative Bill Tveit	Y
Representative Greg Westlind	Y

Motion carried 12-2-0

Bill Carrier: Rep. Matthew Ruby

Chairman Weisz adjourned at 4:12 p.m.

Tamara Krause, Committee Clerk

REPORT OF STANDING COMMITTEE

HB 1469: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (12 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). HB 1469 was placed on the Eleventh order on the calendar.