OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

IMPROVING HPV VACCINE COVERAGE

a multi-disciplinary approach to achieve 80% Series Completion in Adolescents by 2020

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OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH (OASH)

ADM Brett P. Giroir, M.D.

- The Office of the Assistant Secretary for Health (OASH) leaders are dedicated to developing policy recommendations as they pertain to public health issues that cut across HHS agencies and operating divisions.
- The Assistant Secretary for Health leads development of HHS-wide public health policy recommendations, oversees 11 core public health offices — including the Office of the Surgeon General and the U.S. Public Health Service Commissioned Corps, which has approximately 6,500 uniformed health officers who serve in nearly 600 locations around the world to promote, protect and advance the health and safety of our nation and our world, and oversees three Presidential and 11 Secretarial advisory committees.

OFFICE OF THE

ASSISTANT SECRETARY FOR HEALTH

Leading America to Healthier Lives

- **Providing trusted data and information** to serve HHS, the federal government, states and localities, and the public in general
- **Convening partners**
  federal agencies, state and local, professional societies, non-profits, academia, patient advocates
- **Developing novel initiatives**
  Gaining situational awareness, identifying gaps, building teams, setting a common agenda**,** and supporting infrastructure

SELECT OASH PRIORITY INITIATIVES

- Infectious Diseases
  - Reducing new cases of HIV by 75% within 5 years
  - Increasing HPV vaccine coverage rates to 80% within 5 years
  - Incentivizing adult vaccination through reimbursement reform
  - Developing a national plan to combat STDs
- Meeting the Physical Activities Guidelines
- Digital Determinants of Health
- Chronic Kidney Disease
- Implementing the revised “Common Rule”

- Health Disparities
  - Developing Office of Minority Health programs that serve as a catalyst and new framework for change
  - Implementing public health “turn around teams” focused on zip codes suffering the worst health inequities
  - Improving sudden cardiac death and availability of CPCR
  - Developing exemplar initiatives.

NATIONAL VACCINE PROGRAM OFFICE (NVPO)

- Located in the Office of the Assistant Secretary for Health (ASH)
- Responsible for coordinating and ensuring collaboration among the many federal agencies involved in vaccine and immunization activities.

Core Functions	National Vaccine Program Responsibilities
• Ensure collaborative federal immunization activities are carried out in an efficient, consistent, and timely manner. • Develop and implement strategies for achieving the highest possible level of prevention of human diseases through immunization. • Implement strategies that ensure the highest level of prevention of adverse reactions to vaccines. • Support the National Vaccine Advisory Committee and its related activities. • Identify and bridge gaps in federal planning of vaccine and immunization activities.	• Vaccine research • Vaccine development • Safety and efficacy testing of vaccines • Licensing of vaccine manufacturers • Production and procurement of vaccines • Distribution and use of vaccines • Necessity and effectiveness of vaccines • Adverse events related to vaccines and immunization activities

OFFICE OF HIV/AIDS AND INFECTIOUS DISEASE POLICY

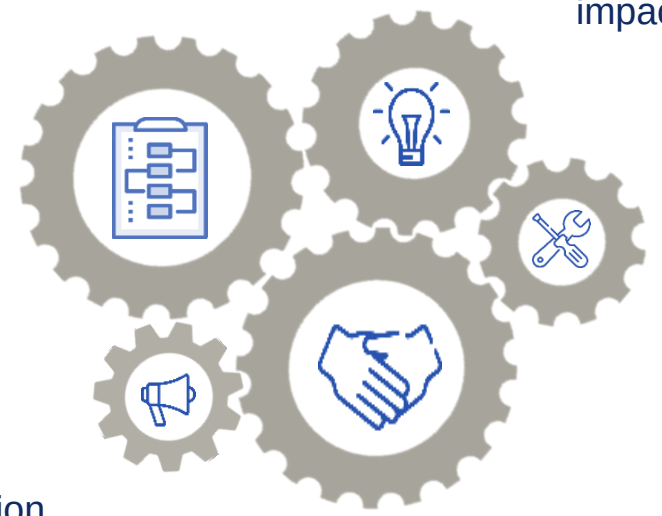
The mission of the **Office and HIV/AIDS and Infectious Disease Policy (OHAIDP)** is to advise the Secretary, Assistant Secretary for Health, and other senior U.S. Department of Health and Human Services (HHS) officials on health policy and program issues related to:

- HIV/AIDS;
- Viral Hepatitis;
- Other infectious diseases of public health significance; as well as
- Blood and Tissue Safety and Availability in the United States.

OHAIDP: FRAMEWORK FOR LEADING CHANGE

National Planning & Policy Development

OHAIDP leads the development and implementation of strategic policies and action plans to achieve our national goals.



Innovation

OHAIDP designs and tests innovative programs and strategies to improve efficiency, effectiveness, and impact of the federal response.

Systems Change

OHAIDP invests in pilot and demonstration projects that have the potential to transform the way infectious diseases are prevented, diagnosed, treated, and cured, and do so at a lower cost.

Communications

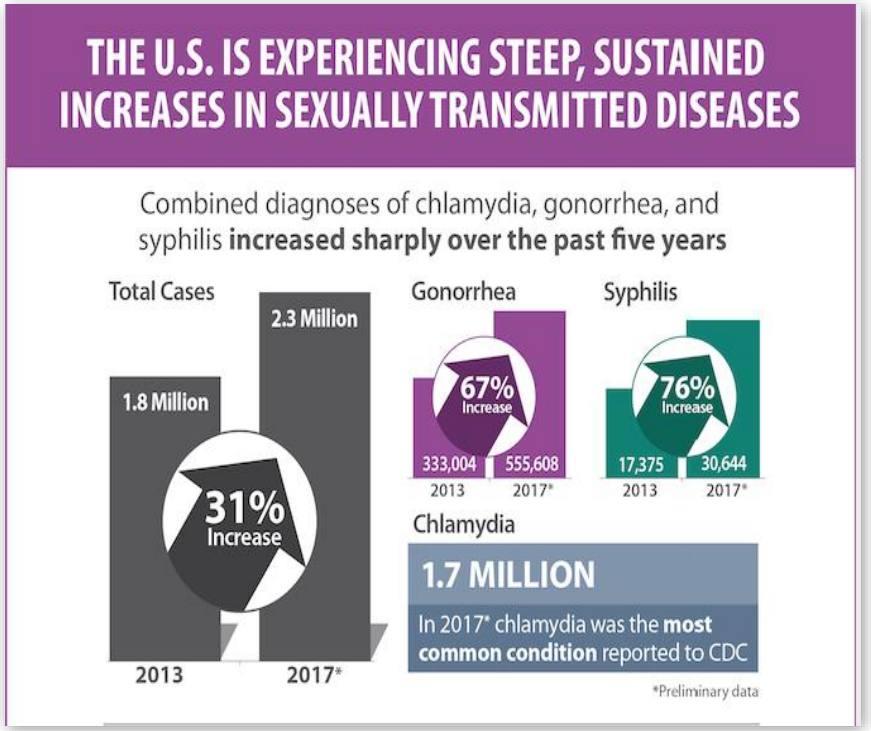
OHAIDP is a leading source of information, supports consistent messaging across HHS, and builds digital communications capacity to extend the reach and impact of our messages.

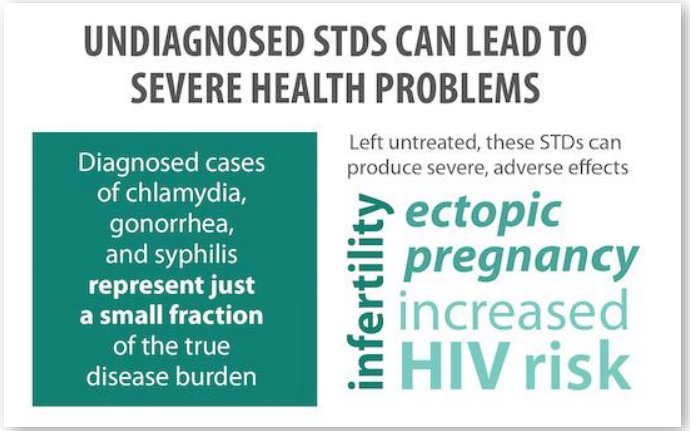
Strategic Partnerships and Collaborations

OHAIDP works within HHS, across the federal government, and with external partners to align response and create synergies to deliver the best result possible.

OHAIDP: PRIORITIES

- Ending the HIV Epidemic: A Plan for America
- National HIV/AID Strategy Update
- National Viral Hepatitis Update
- National Sexually Transmitted Disease Plan
  - First Federal Government Plan Addressing





HIV HAS COST AMERICA **TOO MUCH** FOR **TOO LONG**

700,000

American lives lost to HIV since 1981

$20 Billion

Annual direct health expenditures by U.S. government for HIV prevention and care

Without intervention and despite substantial progress **another**

400,000

Americans will be newly diagnosed over 10 years despite the available tools to prevent infection

Ending the HIV Epidemic

HHS Has Launched A New Initiative to End the HIV Epidemic in America

GOAL:

75% reduction in new HIV infections in 5 years and at least **90%** reduction in 10 years.

Diagnose all people with HIV as early as possible after infection.

Treat the infection rapidly and effectively to achieve sustained viral suppression.

Protect people at risk for HIV using potent and proven prevention interventions, including PrEP, a medication that can prevent HIV infections.

Respond rapidly to detect and respond to growing HIV clusters and prevent new HIV infections.

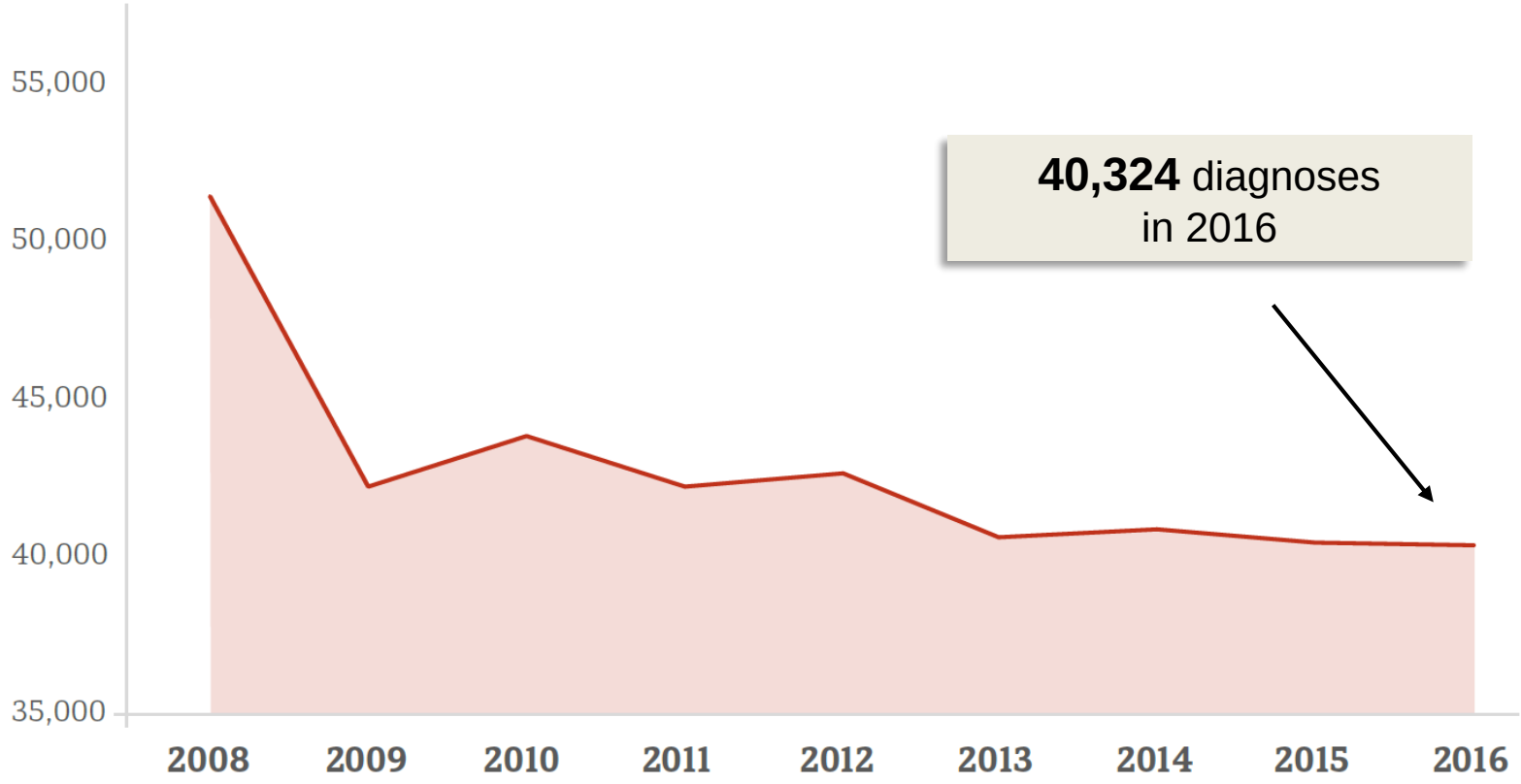
HIV HealthForce will establish elimination teams committed to the success of the Initiative in each jurisdiction.

STATE ★ of the ★ UNION 2019

NEW HIV DIAGNOSES HAVE DECLINED SUBSTANTIALLY BUT PROGRESS IS STALLED

MAJOR PROGRESS

- 1980s
  peak incidence near 130,000 annually
- 1985 - 2012
  interventions have driven infections down to <50,000 annually



www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-23-4.pdf

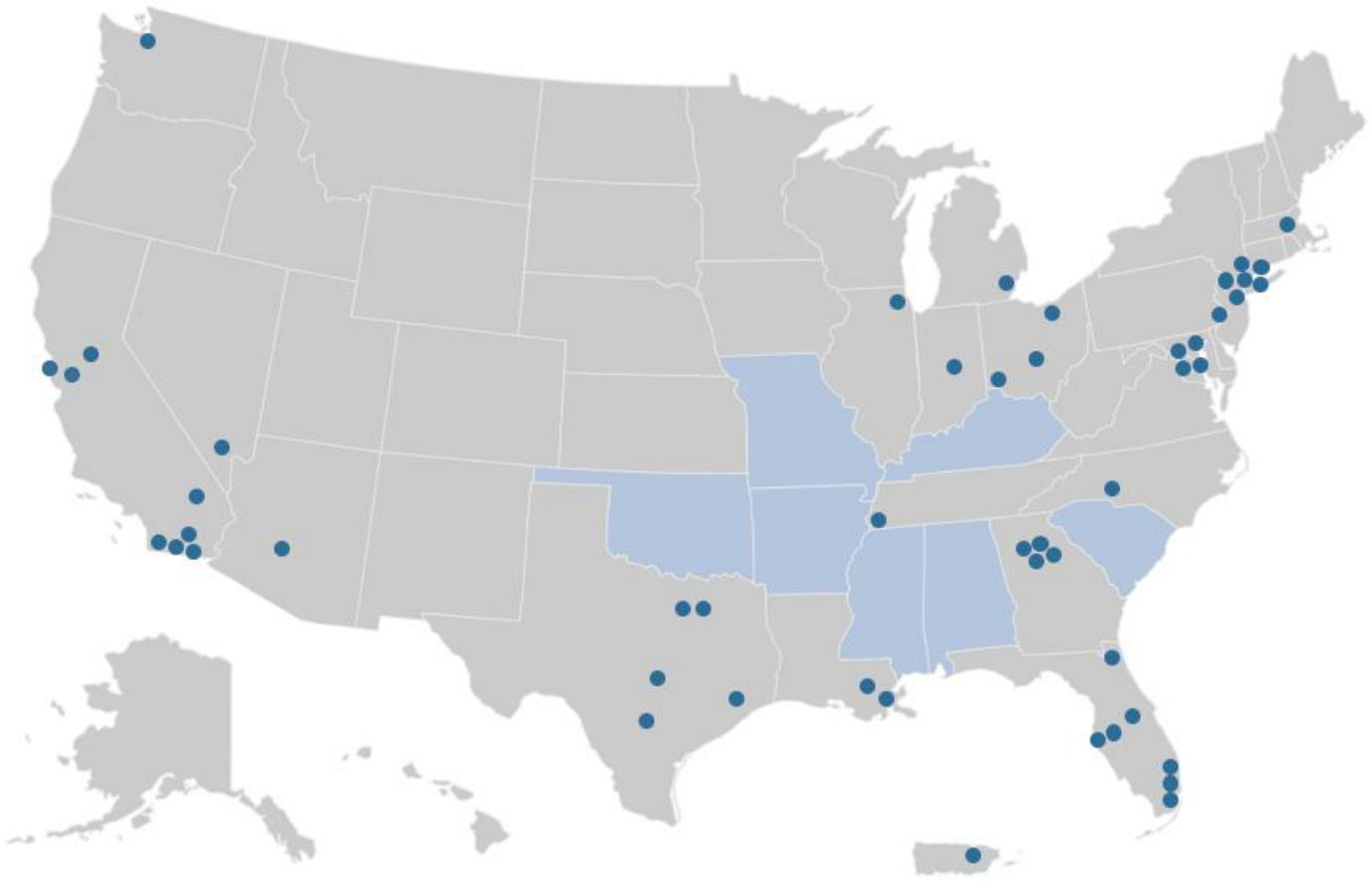
EARLY DIAGNOSIS IS *ESSENTIAL* TO END THE HIV EPIDEMIC

- **1 in 2** people with HIV have the virus at least **3** years before diagnosis
- **1 in 4** people with HIV have the virus at least **7** years before diagnosis
- **1 in 5** people with HIV are diagnosed with advanced disease (AIDS)
- **7 in 10** people with HIV saw a healthcare provider in the **12** months prior to diagnosis and FAILED to be diagnosed

87% of new HIV infections are transmitted from people who don't know they have HIV or are not retained in treatment

Daily et al., MMWR Weekly Report, 2017; Skarbinski et al., JAMA, 2015; Gopalappa et al., Med Decision Making, 2017

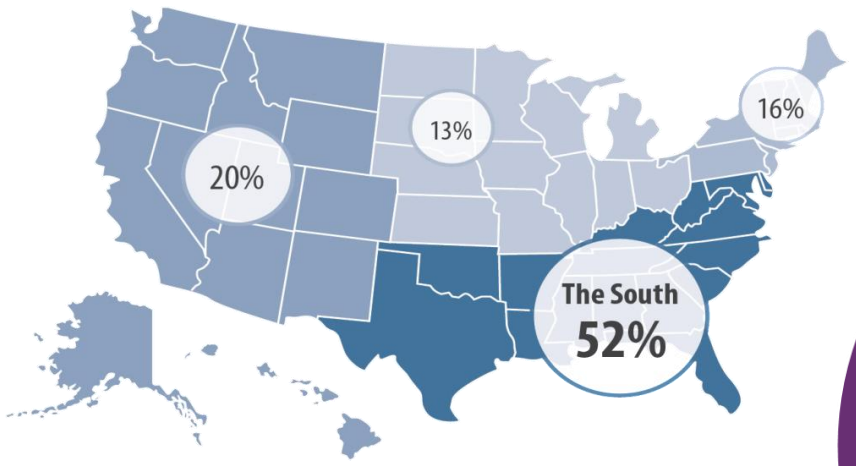
48 COUNTIES, 7 STATES WITH SUBSTANTIAL RURAL HIV BURDEN, DC AND SAN JUAN ACCOUNT FOR 50% OF NEW DIAGNOSES

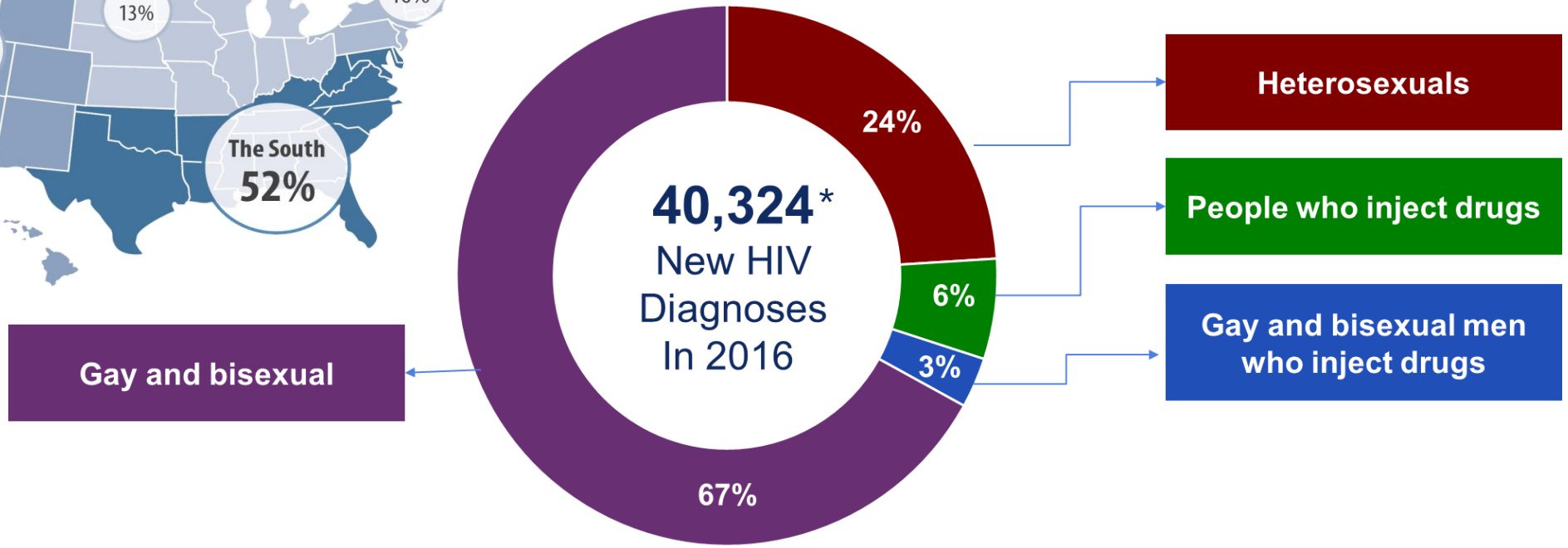


County contributing to 50% new HIV diagnoses in 2016 / 2017

State with disproportionate rural burden in 2016 / 2017

HIV DIAGNOSES ACROSS SPECIFIC GROUPS





In 2016, **African Americans** accounted for 44% of HIV diagnoses, but comprised 12% of U.S. population

From 2012-2016, HIV diagnoses among **Hispanic/Latino** MSM age 25-34 years increased 22%

From 2012-2016, HIV diagnoses among **American Indian / Alaska Native** MSM increased 58%

* www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-23-4.pdf, all other data from https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2017-vol-29.pdf

ACHIEVING THE GOALS

DIAGNOSE

All people with HIV as early as possible after infection

TREAT

The infection rapidly and effectively to achieve sustained viral suppression

PROTECT

People at highest risk of HIV with potent evidence-based interventions

RESPOND

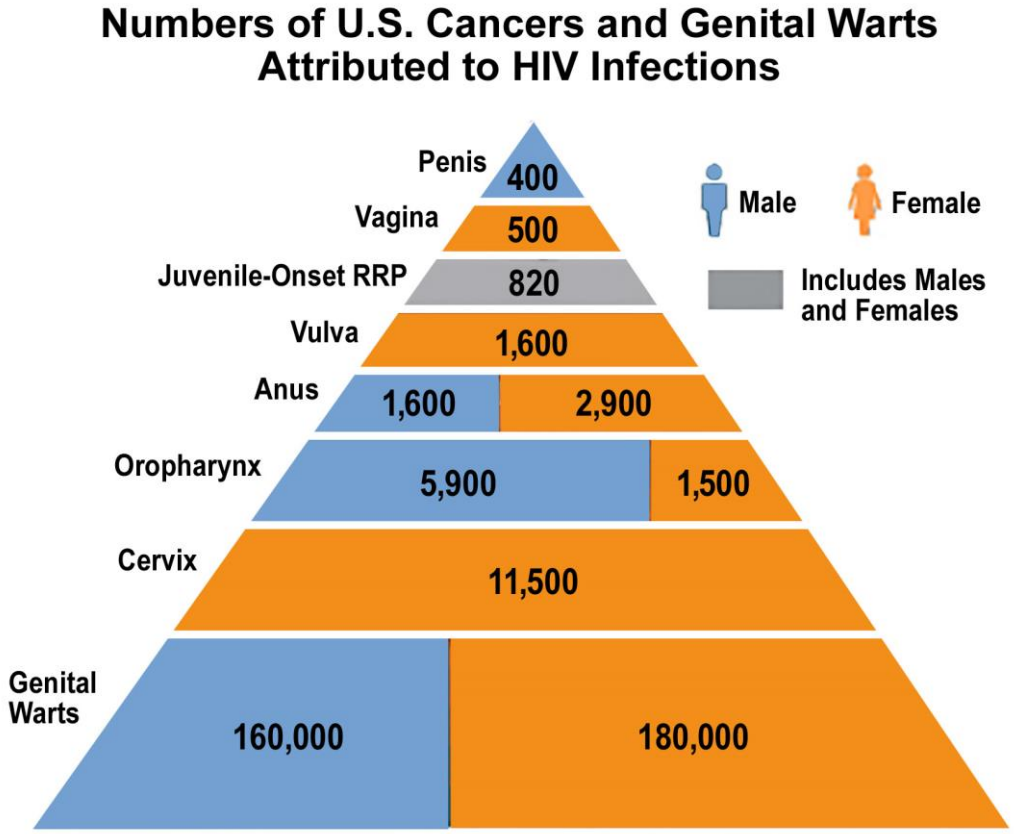
Rapidly and effectively to clusters and outbreaks of new HIV infections

HIV HEALTHFORCE

A boots-on-the-ground team that ensures implementation of HIV elimination plans

HPV: AN URGENT PUBLIC HEALTH ISSUE

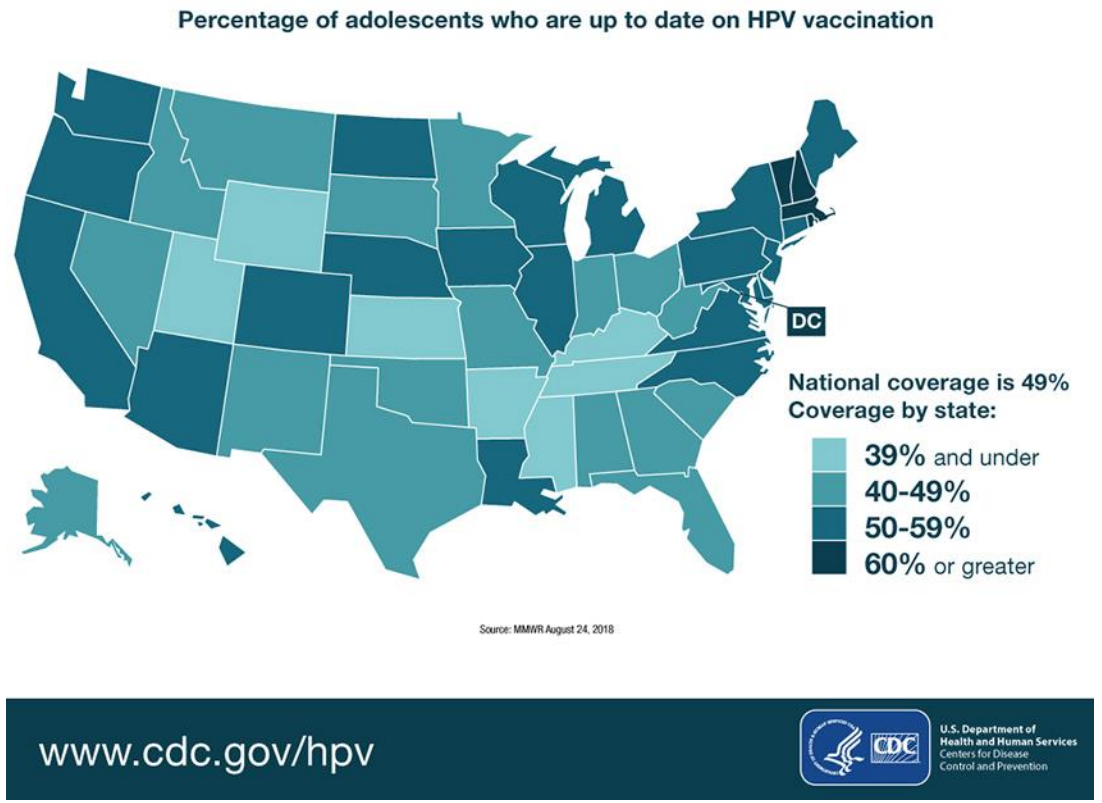
- Almost every American will be infected with HPV at some point in their life
- Each year more than 30,000 Americans will develop cancer caused by HPV



Source: President's Cancer Panel 2018 Report on HPV

HPV: AN URGENT PUBLIC HEALTH ISSUE

- Despite a safe, effective vaccine not enough people are getting vaccinated.
- HPV vaccination rates in the United States remain too low — only **half (49 percent) of U.S. adolescents** were up to date in 2017.
- There are also significant disparities — for example, the percentage of adolescents living in rural areas who have received the first dose of the HPV vaccine series is 11% lower than for adolescents living in urban areas.



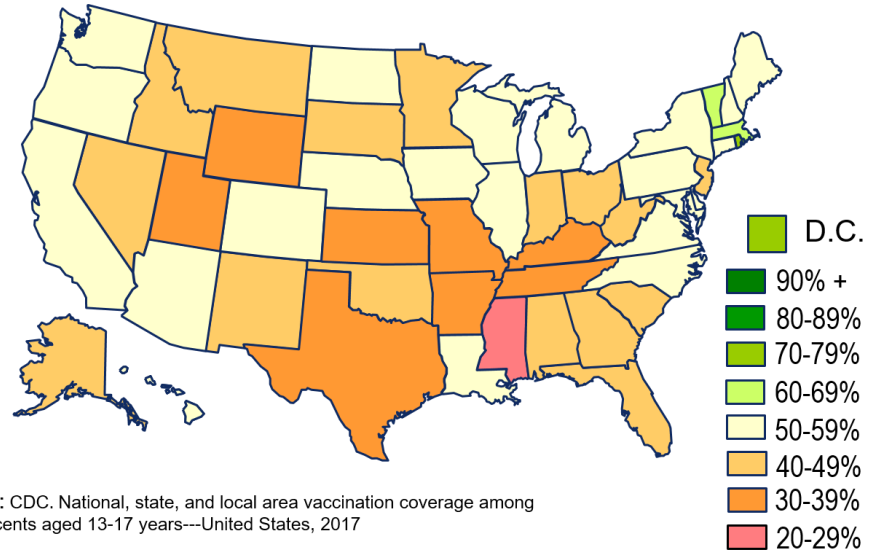
HPV VACCINATION: WHERE WE ARE

- HPV vaccination series completion could prevent up to 30K new cases of HPV related cancer in the U.S. per year *
- However, despite the efficacy of the vaccine, coverage remains substantially lower than that for other vaccines recommended for the same age group.

* MMWR August 25th, 2017 66(33); 874-882

ESTIMATED UP-TO-DATE HPV VACCINATION COVERAGE AMONG ADOLESCENTS, 2017

National Coverage = 49%

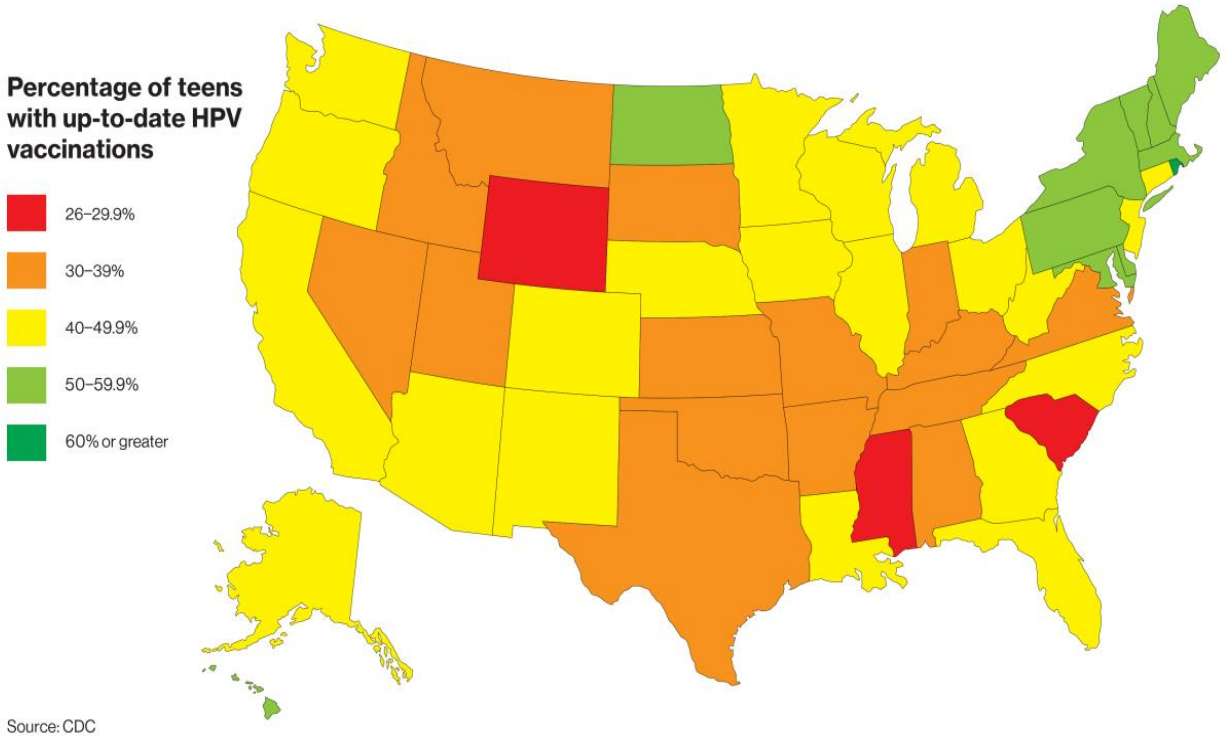


Source: CDC. National, state, and local area vaccination coverage among adolescents aged 13-17 years---United States, 2017

Contributing Factors to Low HPV Vaccine Coverage
NVAC report, 2018

1) **Providers not giving strong enough recommendations for HPV vaccine compared to other adolescent vaccines**
2) Missed opportunities: preventive care
3) Parents refusing HPV vaccination
4) Lack of HPV vaccination mandates
5) Rural challenges

HPV VACCINATION IN RURAL COMMUNITIES



Rural Challenges

Rural vaccination rates remain lower than those in Urban areas

- Coverage disparity: 11% lower for adolescents living in rural communities compared to those living in urban areas for receipt of first dose in HPV vaccine series (NIS-Teen, 2017)
- Shortages of primary care physicians and pediatricians
- Less access to supply, vaccination sites
- Less community based vaccine and immunization education for providers

HHS STRATEGY TO IMPROVE HPV VACCINATION COVERAGE

- A future without HPV cancers is within reach, but urgent action is needed to improve HPV vaccination rates
- In 2018, the Assistant Secretary for Health charged the National Vaccine Advisory Committee (NVAC) with developing recommendations for strengthening federal, state, and local HPV prevention efforts
- NVAC's final report provided the foundation for HHS' HPV strategy

Reports and Recommendations

Public Health Reports

Strengthening the Effectiveness of National, State, and Local Efforts to Improve HPV Vaccination Coverage in the United States: Recommendations From the National Vaccine Advisory Committee

SAGE

Approved by the National Vaccine Advisory Committee on June 25, 2018

Abstract

In February 2018, recognizing the suboptimal rates of human papillomavirus (HPV) vaccination in the United States, the assistant secretary for health of the US Department of Health and Human Services charged the National Vaccine Advisory Committee (NVAC) with providing recommendations on how to strengthen the effectiveness of national, state, and local efforts to improve HPV vaccination coverage rates. In the same month, the NVAC established the HPV Vaccination Implementation Working Group and assigned it to develop these recommendations. The working group sought advice from federal and nonfederal partners. This NVAC report recommends ways to improve HPV vaccination coverage rates by focusing on 4 areas of activity: (1) identifying additional national partners, (2) guiding coalition building for states, (3) engaging integrated health care delivery networks, and (4) addressing provider needs in rural areas.

Keywords

National Vaccine Advisory Committee, human papillomavirus, immunization, coalition, health systems, rural health

Introduction

In June 2015, the National Vaccine Advisory Committee (NVAC) issued the report, "Overcoming Barriers to Low HPV Vaccine Uptake in the United States: Recommendations From the National Vaccine Advisory Committee."[1] The report provided recommendations to the assistant secretary for health (ASH) on strategies to increase human papillomavirus (HPV) vaccine uptake among adolescents by reviewing the current state of HPV immunization, exploring the root causes for low vaccine uptake in both initiation and series completion, and identifying some of the best practices currently in use to attain high immunization coverage. The NVAC endorsed, among other recommendations, the recommendations of a report issued by the President's Cancer Panel, a federal advisory committee of the National Institutes of Health's National Cancer Institute, *Accelerating HPV Vaccine Uptake: Urgency for Action to Prevent Cancer*.[2]

Since the 2015 report, a range of policy and program changes and advances in research have resulted in progress on HPV vaccination.[3] In 2016, the Advisory Committee on Immunization Practices updated its HPV vaccination guidance to routinely recommend a 2-dose schedule for males and females aged 9-14, while maintaining a 3-dose schedule for those aged ≥15.[3] Shortly thereafter, 2 existing Healthcare Effectiveness Data and Information Set measures that assessed the receipt of adolescent vaccines were modified and combined. Specifically, in 2017, the Human Papillomavirus for Female Adolescents measure and the Immunizations for Adolescents measure were combined to report receipt of all recommended vaccines (meningococcal, tetanus–diphtheria–acellular pertussis, and HPV) for both male and female adolescents.[3,4] The 2-dose schedule and updated Healthcare Effectiveness Data and Information Set measure may increase vaccine uptake among adolescents.

Primary care providers deliver most vaccinations in practice-based settings in the United States, but there is a

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EXAMPLE RECOMMENDATIONS INFORMING STRATEGY

- **1.1** Encourage **further development, dissemination, and implementation of evidence-based practitioner**
- **3.1** Work with state health officials and local health departments as key immunization leaders to **engage with regional and local health systems and integrated delivery network (IDN) executives to prioritize HPV vaccination** as an effective means for cancer prevention and to develop accountability mechanisms to track and incentivize performance.
- **4.1** Further research be conducted to **better understand the needs of rural providers** in supporting the administration of or referral to vaccination services in rural environments and to identify and determine barriers to accessing vaccination services for patients in rural settings.
- **4.3** Stronger **HHS-wide social media presence to improve the reach of communication strategies** and engage parents and adolescents to build trust and recognition directly about the importance of HPV vaccination and how to best engage patients in rural communities.

IMPLEMENTATION: 3-PRONGED STRATEGIC APPROACH

Objective: Foster and facilitate efforts to strengthen system-wide focus on HPV vaccination as recommended by the Advisory Committee on Immunization Practices

1 ENGAGEMENT & COMMUNICATIONS
Sharing Evidence-based Practices

- Communications working group
  - Key/unified messaging and dissemination of evidence based practices
  - Communications and social media strategy
  - Engagements around Cervical cancer awareness month and HPV awareness day
- HPV Roundtable State Coalition and Task Force regional summit in SE States 7 States
- Infectious Disease Focal Point, Public Health Advisor

2 INTEGRATED DELIVERY NETWORKS
and Health Systems Engagement

- Engage IDNs
- HPV Learning Collaborative Quality Improvement Project
- Quality measures
  - Provider level “report cards”
  - eCQM

3 Determining RURAL & FAITH BASED NEEDS

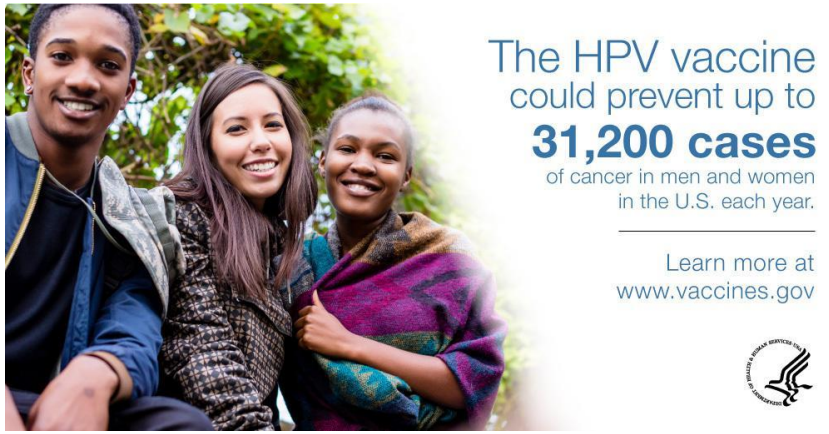
- Needs assessment for rural communities
- Identify federal programs with footprints in rural communities that can be key partners to deliver HPV vaccination messages
- Explore distance learning (e.g. Project Echo-AAP) as a vehicle for delivery of evidence-based practices in rural communities
- Engage faith based community through HHS Faith Based and Community Initiatives Office

Engagement with federal, state, national, private partners

COMMUNICATIONS

AWARENESS CAMPAIGN: WORKING TOGETHER TO END HPV CANCERS

- **Objective:** Partner to raise awareness of the importance of HPV and share evidence-based practices to ensure every 11 and 12 year old completes the HPV vaccination series
- **Primary Audience:** Parents/guardians with children recommended for HPV vaccination and immunization providers
- Talking points, social media messages and graphics, web tools and other materials are available on www.hhs.gov/nvpo
- **Timeline:**
  - **March 4:** International HPV Awareness Day (Kick-off Activities)
  - **March through April:** Continued push for HPV awareness and evidence-based resources



KEY MESSAGES

- Because the HPV vaccine prevents cancer, we have an obligation to protect our youth by improving HPV vaccination rates.
- We can prevent over 30,000* new cases of cancer in the United States each year by increasing HPV vaccination series completion in adolescents to 80% by 2020.
- Despite the availability of safe and effective HPV vaccines, vaccination rates for adolescents remain low — leaving them susceptible to several types of cancer.
- Boys and girls need the HPV vaccine at age 11 or 12 to take advantage of the best immune response. Teens and young adults who have not been vaccinated can get catch-up vaccines.
- HHS works with diverse partners to improve HPV vaccination coverage rates, reduce missed opportunities to prevent HPV-related cancers, and address disparities — especially in rural areas.

*CDC MMWR

HHS ACTIVITIES

International HPV Day

- It's Time to #EndHPVCancers
- Twitter Chat with the Surgeon General

Select April Activities

- Daily @HHS_ASH Tweet on HPV Evidence-Based Resources
- **April 15:** World Vaccine Congress

Future Promotions

- NAMCP Medical Directors Institute Collaboration on HPV educational effort in May
- WHO/PAHO Global Elimination of Cervical Cancer
- Possible Rural Health Monitor piece in fall and spotlight views on the Rural Health Information Hub

MULTI-PRONGED APPROACH: ENGAGING NATIONAL ORGANIZATIONS

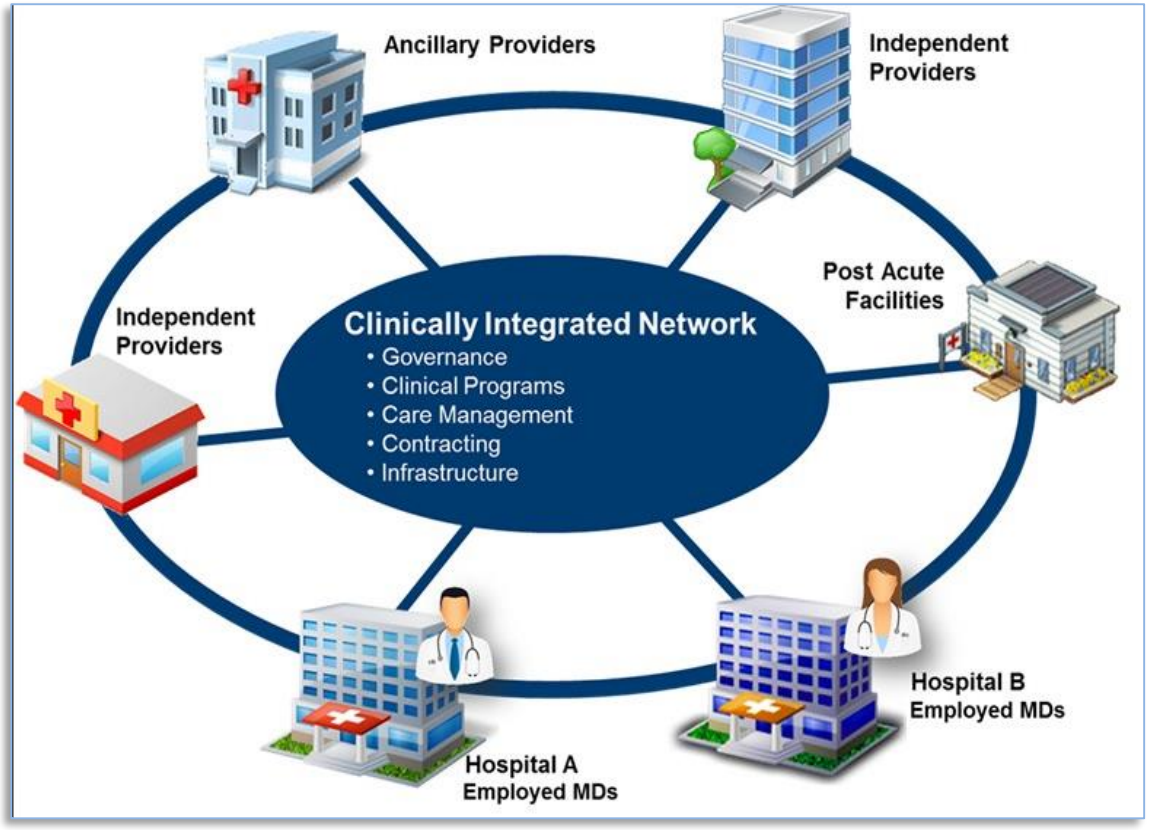
COMMUNICATION AND SHARING EVIDENCE-BASED PRACTICES

- HPV Vaccination Roundtable
  - Wide range of partners (over 75 organizations)
    - American Cancer Society and CDC
    - American Dental Association
    - American Association of Public Health Dentistry
    - Healthcare organizations
    - State Level coalitions
    - State and Federal agencies
  - Successful at promoting HPV vaccination through clinical guidance and EB interventions
- Association of State and Tribal Health Officials
- Cancer Advocacy Groups
- Faith Based Community
- State Level Coalitions
- AMGA
- National Vaccine Coalition
- Federal Partners
  - OASH
  - CDC
  - HRSA
  - CMS

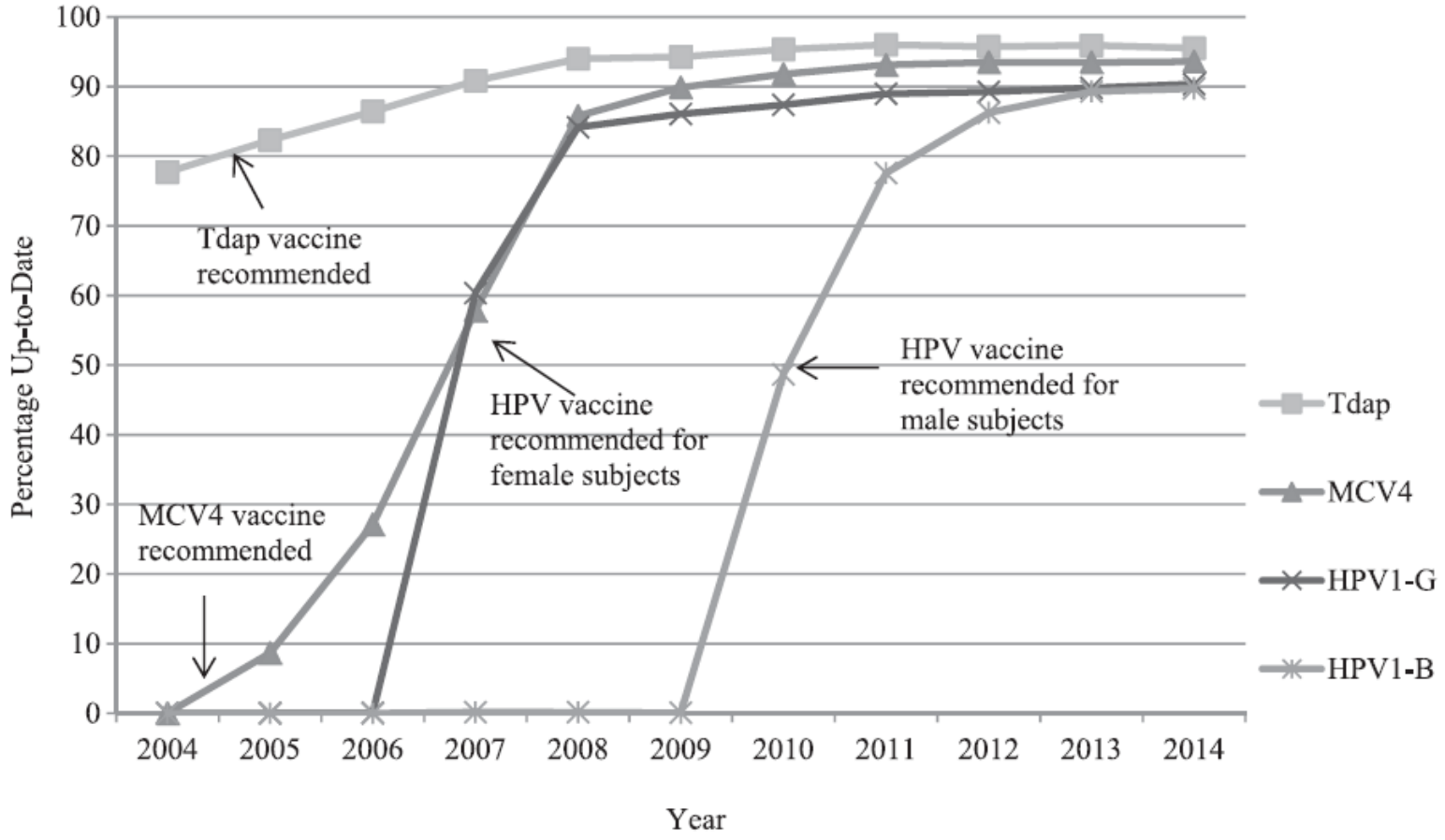
HEALTH SYSTEMS

INTEGRATED DELIVERY NETWORK: ENGAGEMENT

- Evidence-Based Practices to increase HPV Vaccination Rates
- Engaging IDN CEOs
- Learning Collaborative
- Sharing EBPs
- Measuring Results
- In collaboration with CDC



IMMUNIZATION RATES FOR ADOLESCENTS
DENVER HEALTH, 2004-2014



Farmer et al, Pediatrics 2016

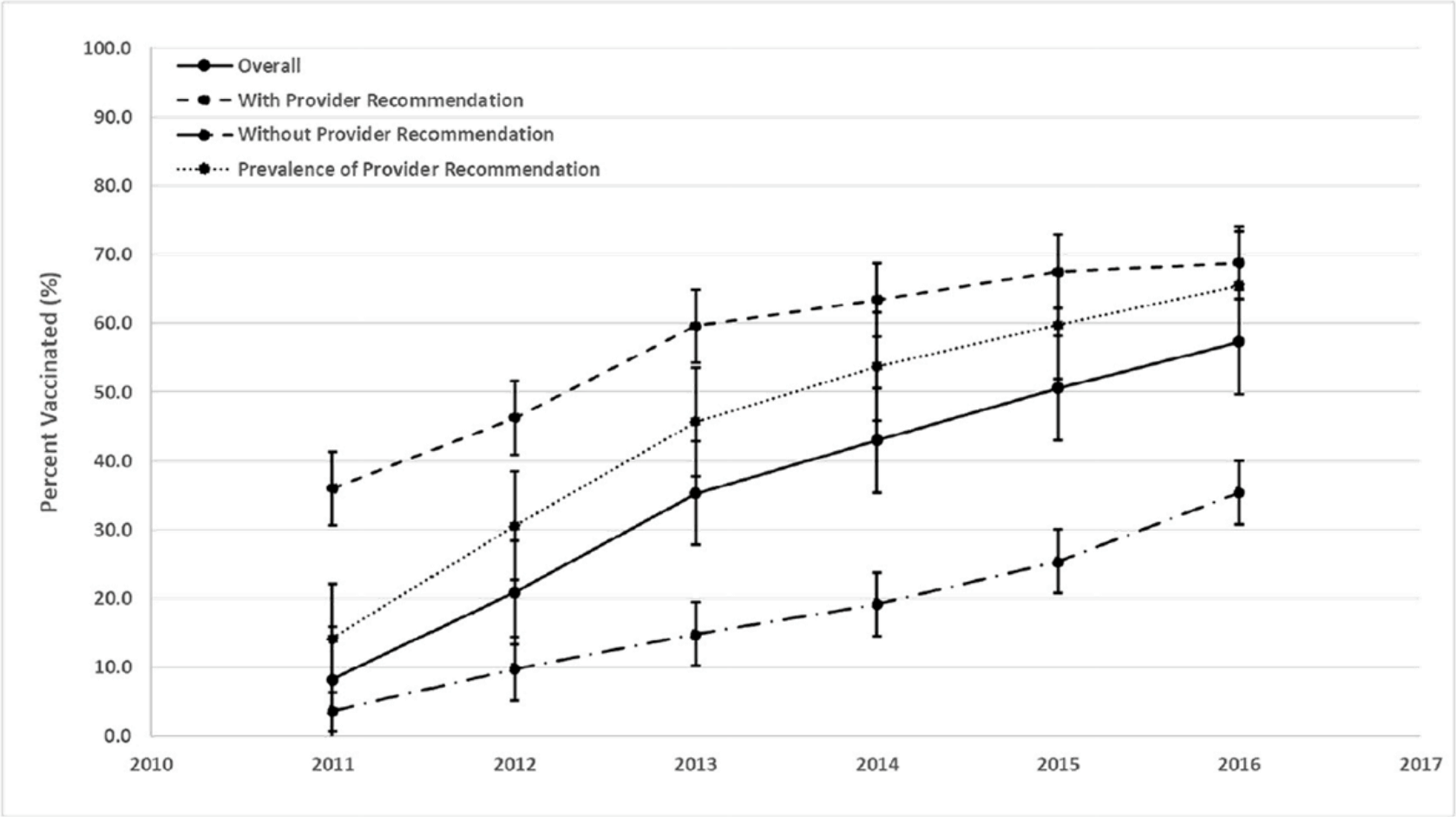
IDNS: EVIDENCE-BASED INTERVENTIONS

TACTICS FOR SUCCESSFUL HPV VACCINE DELIVERY: DENVER HEALTH

- Routine use of a robust immunization registry for multiple functions, including recording vaccine history and recommended needed vaccines at every visit
- Medical assistants check vaccine registry for recommended vaccines at every visit
- Standing order for routine immunizations
- Vaccines are given early in the visit when possible
- Education for providers to present Tdap, MCV, and HPV as a standard “bundle” of adolescent immunizations
- Provider-level “report cards” with adolescent vaccination coverage rates
- Vaccination drives at school-based health centers

Farmer et al, Pediatrics 2016

Figure. HPV vaccination coverage and prevalence of provider recommendation among male adolescents 13-17 years, United States, 2011-2016. Source: National Immunization Survey-Teen, 2011-2016.



Lu, et.al. Journal of Pediatrics. March, 2019.

HPV VACCINATION COVERAGE OF MALE ADOLESCENTS BY PROVIDER RECOMMENDATION

Table II. HPV vaccination coverage of male adolescents aged 13-17 years in the US, by parental report of provider recommendation status, demographic, and access-to-care variables—NIS-Teen 2016

State	Sample size, n	Prevalence of provider recommendation for HPV, % (95% CI)	HPV vaccination coverage, % (95% CI)			
			Overall	With provider recommendation	Without provider recommendation	Percentage points difference*
National	9712	65.5 (63.7-67.3)	57.3 (55.5-59.1)	68.8 (66.8-70.8)	35.4 (32.1-38.7)	33.5 (29.6-37.4)†
Wyoming	186	45.9 (37.4-54.5)	36.5 (28.5-45.4)	51.5 (39.2-63.6)	23.8 (14.5-36.7)	27.7 (10.9-44.4)†
Mississippi	180	48.4 (38.9-57.9)	45.4 (36.1-54.9)	65.7 (52.1-77.2)	26.3 (16.5-39.2)	39.4 (22.3-56.6)†
South Carolina	150	52.0 (42.0-62.0)	38.7 (29.7-48.6)	54.4 (40.5-67.7)	21.7 (11.7-36.6)	32.7 (14.0-51.5)†
Kansas	149	52.4 (42.6-62.2)	43.1 (33.8-52.9)	63.2 (50.7-74.2)	20.9 (10.8-36.6)	42.3 (24.7-60.0)†
Kentucky	162	52.7 (43.3-62.0)	42.3 (33.4-51.7)	53.1 (40.7-65.1)	30.2 (18.3-45.6)	22.8 (4.2-41.5)†
Texas	939	52.8 (47.4-58.2)	46.0 (40.7-51.4)	64.0 (56.6-70.9)	25.7 (19.2-33.6)	38.3 (28.1-48.5)†
Oklahoma	137	53.4 (42.7-64.1)	51.2 (40.6-61.6)	66.0 (52.9-77.1)	34.2 (20.3-51.4)	31.8 (11.6-52.0)†
Missouri	168	54.3 (44.5-64.2)	49.2 (39.5-58.8)	71.7 (59.7-81.2)	22.3 (12.2-37.3)	49.3 (32.7-65.9)†
Alabama	155	54.5 (45.0-64.1)	51.2 (41.7-60.6)	76.1 (63.1-85.6)	21.2 (11.5-35.8)	54.9 (38.3-71.5)†
West Virginia	149	56.2 (46.6-65.9)	51.6 (42.0-61.1)	69.3 (56.5-79.6)	29.0 (16.9-45.0)	40.3 (21.7-58.8)†
South Dakota	167	56.2 (46.8-65.5)	50.5 (41.3-59.7)	74.2 (62.7-83.1)	20.1 (10.6-34.7)	54.1 (38.3-69.9)†
Montana	173	57.0 (47.4-66.5)	43.5 (34.6-52.9)	56.5 (44.4-67.9)	26.3 (15.3-41.4)	30.2 (12.3-48.1)†
Arkansas	190	58.0 (49.7-66.3)	54.9 (46.5-63.0)	67.8 (56.8-77.1)	37.1 (25.5-50.4)	30.7 (14.3-47.0)†
Utah	151	60.2 (50.8-69.6)	42.1 (33.1-51.6)	54.4 (42.4-65.9)	23.5 (13.3-38.1)	30.9 (13.6-48.2)†
Florida	183	61.1 (51.9-70.3)	53.8 (44.5-62.9)	62.1 (50.0-72.8)	40.9 (26.8-56.6)	21.2 (2.0-40.5)†
Indiana	173	61.3 (52.2-70.4)	39.0 (30.5-48.2)	48.5 (37.3-60.0)	23.8 (13.2-39.1)	24.7 (7.3-42.2)†
Idaho	178	61.3 (52.5-70.1)	54.2 (45.2-63.0)	63.6 (51.8-73.9)	39.4 (25.9-54.7)	24.2 (5.6-42.7)†
Tennessee	144	61.7 (52.1-71.2)	58.2 (48.5-67.3)	68.0 (55.9-78.1)	42.5 (27.7-58.7)	25.5 (5.9-45.1)†
Georgia	158	74.8 (66.6-83.0)	57.7 (47.7-67.2)	66.8 (54.8-77.0)	30.8 (17.0-49.2)	36.0 (16.0-56.0)†

Lu, et.al. Journal of Pediatrics. March, 2019.

BOTTOM LINE

- Receiving a provider recommendation for vaccination was significantly associated with receipt of HPV vaccine among male adolescents, indicating that a provider recommendation for vaccination is an important approach to increase vaccination coverage

- Using evidence-based strategies should be implemented to increase coverage
  - Strong recommendations
  - Standing orders
  - Provider reminders
  - Reduce missed opportunities (sick visits, sports physicals)

Lu, et.al. Journal of Pediatrics. March, 2019.

RURAL + FAITH-BASED

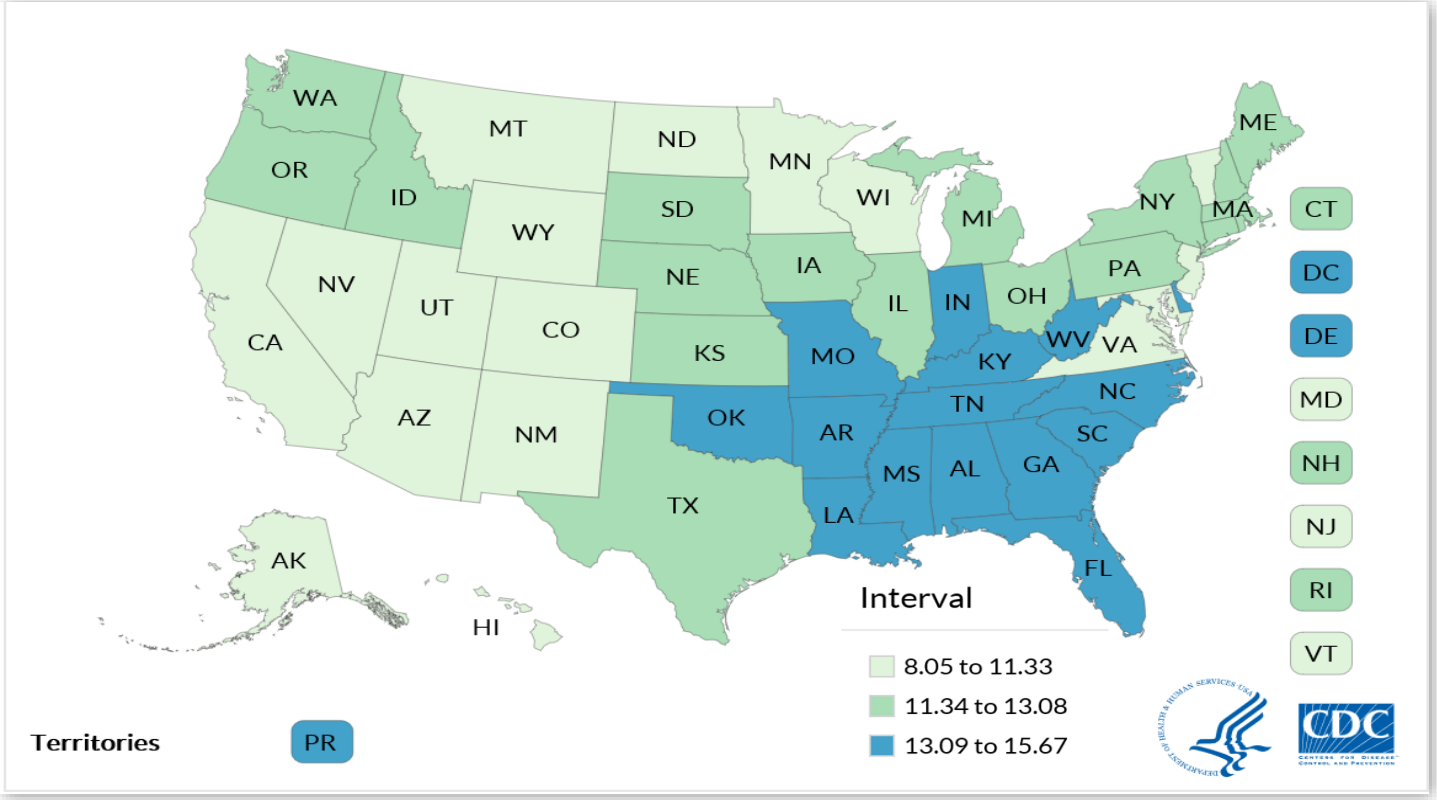
NVPO COMMISSIONED STUDY

RURAL PROVIDER NEEDS ASSESSMENT FOCUSED ON HPV

- Mixed methods approach to:
  - (1) understand procedures and protocols for assessing immunization status
  - (2) understand barriers and motivators for recommending and administering HPV vaccine
- Qualitative groups to be held in **KY, MS, MO, WY**
- Online survey for broader dissemination and input
- Final report insights aid:
  - State Coalitions
  - Health Officials
  - Healthcare Systems
- Complementary to CDC 3-year cooperative agreements.

HPV VACCINATION IN RURAL COMMUNITIES

AVERAGE ANNUAL INCIDENCE OF HPV-ASSOCIATED CANCERS, 2011-2015

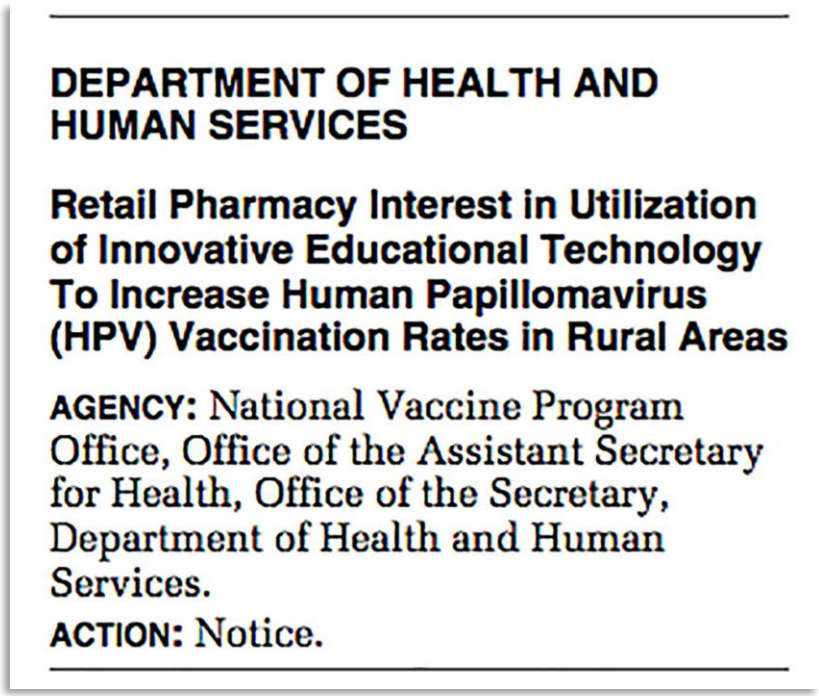


NVPO Commissioned Study
(Sept 2018)

- Online rural immunization needs assessment tool
  - Current procedures and protocols to assess immunization status
  - Barriers to and motivations for recommending HPV vaccination
  - Patient and caregiver motivators
- Plan to guide engagement with State Coalitions, Health Officials, and Healthcare Systems

POTENTIAL ROLE OF RETAIL PHARMACIES

FEDERAL REGISTER
February 15, 2019



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retail Pharmacy Interest in Utilization of Innovative Educational Technology To Increase Human Papillomavirus (HPV) Vaccination Rates in Rural Areas

AGENCY: National Vaccine Program Office, Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.

ACTION: Notice.

Request for Information:

- NVPO requests information from retail pharmacies (with greater than 100 stores in rural areas) to assess interest in using innovative educational models, for both providers and customers, to increase HPV-vaccination rates in rural areas
- Specific interest in corporate experience among responders in developing and/or implementing innovative educational models for retail pharmacy providers, and customers as part of health messaging, with a specific focus on increasing vaccination rates
- Response Deadline: March 15

https://www.federalregister.gov/documents/2019/02/15/2019-02548/retail-pharmacy-interest-in-utilization-of-innovative-educational-technology-to-increase-human

UTILIZATION OF TECHNOLOGY

OPTIONS TO EDUCATE PATIENTS AND PROVIDERS

- Options to influence behaviors of patients and providers through multiple technological modalities:
  - Smartphone educational applications
  - Electronic Health Record (EHR) alerts
  - Health and wellness engagement platforms (e.g. Sharecare)
- OASH exploring engagement with retail pharmacies in rural areas to utilize such technologies to positively influence HPV vaccination rates
- Further intent to expand to include faith-based communities

FEDERAL PARTNERSHIPS

- HHS Partnership Center
  - Engaging community leaders and communities to destigmatize HPV vaccination
  - Developing informational materials (1-pager, content for newsletters, messaging at meetings and events)

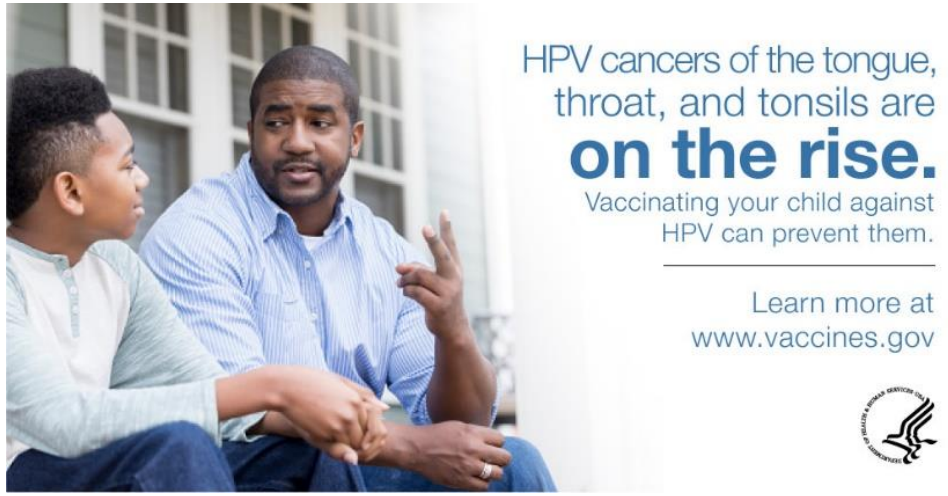
- Federal Office of Rural Health Policy
  - Newsletter piece highlighting HPV as urgent public health issue
  - Reaches 40,000+ subscribers
  - Potential longer piece in *Monitor*

- Other Potential Partners

HHS ACTIVITIES

Get Involved!

- **Join the Twitter Chat**
- **Share resources from the Vaccines.gov HPV Partner Toolkit**
  - Promotional graphics
  - Social media posts
  - Available in English and Spanish
    - ✓ View the toolkit: www.vaccines.gov/HPV-Partner
- **Spread the word on social media:**
  - **Official hashtag:** #EndHPVCancers
  - Retweet HPV messages from @HHS_ASH, @HHSVaccines, @Surgeon_General

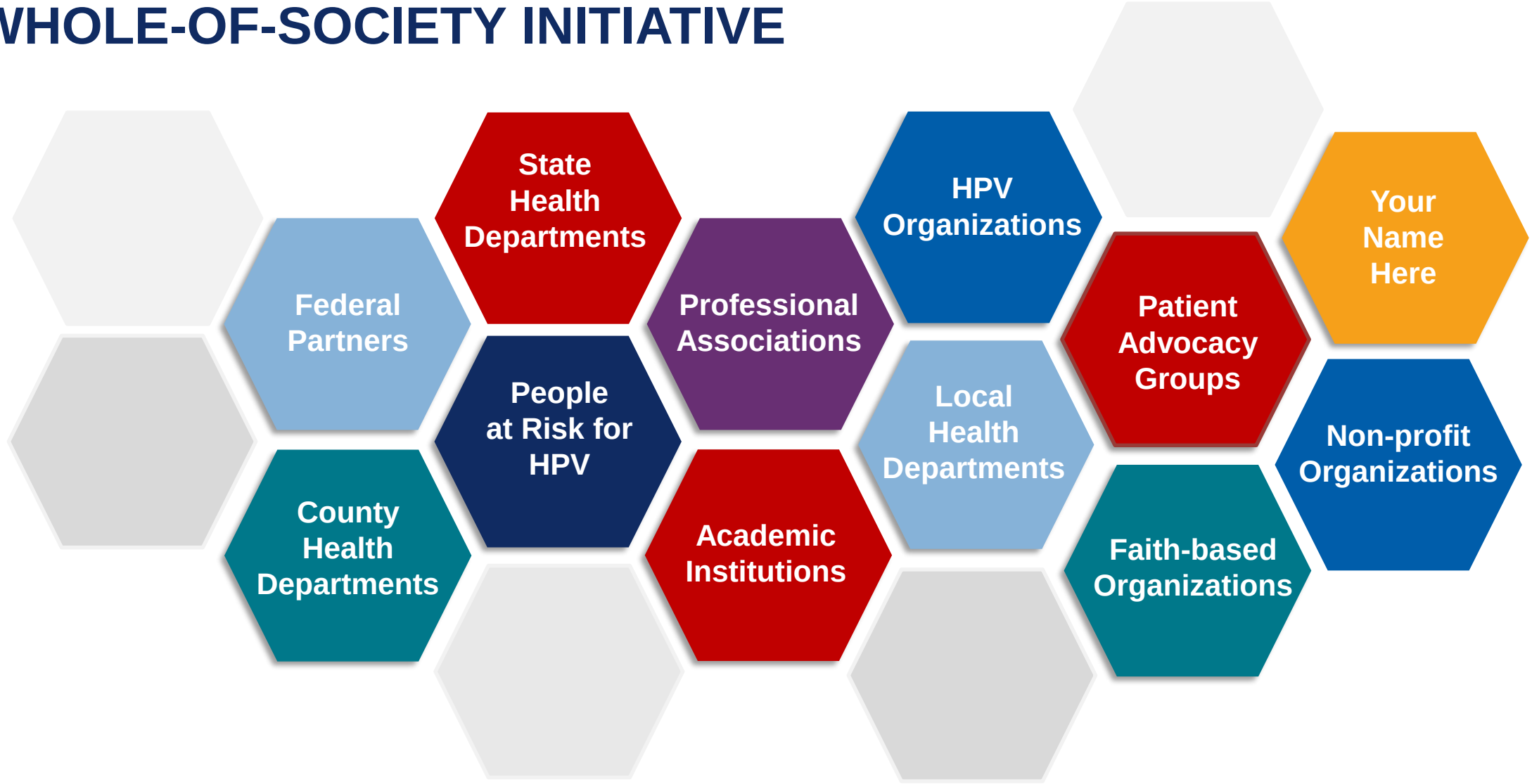


Key Messages

- HPV vaccines prevent cancer — we have a societal obligation to protect our youth and their future by improving HPV vaccination rates.
- We can prevent up to 30,000* new cancer diagnoses in the United States each year by increasing HPV vaccination series completion in adolescents to 80% by 2020.
- Despite the availability of safe and effective HPV vaccines, not enough young people are fully vaccinated against HPV, which makes them susceptible to several types of cancer.
- Boys and girls need the HPV vaccine at age 11 or 12 to take advantage of the best immune response. Catch-up vaccines may be given to adolescents and young adults that have not been previously vaccinated.
- HHS works with diverse partners to improve HPV coverage rates, reduce missed opportunities to prevent these cancers, and address disparities -- especially in rural areas.

* CDC MMWR

WHOLE-OF-SOCIETY INITIATIVE



Office of HIV/AIDS and Infectious Disease Policy
Office of the Assistant Secretary for Health
Department of Health and Human Services

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