Association of Immunization Managers

Vaccine Access Cooperative Regional Meeting for Adults
Mid-Atlantic Region
July 22-24, 2024

MEETING NOTES

PowerPoint Slides: https://www.immunizationmanagers.org/content/uploads/2024/08/Mid-Atlantic-VAC-for-Adults-Vaccines-Meeting-presentation_July2024.pdf

OHE Article: https://www.ohe.org/wp-content/uploads/2024/04/Socio-Economic-Value-of-Adult-Immunisation.pdf

July 23, 2024

Agenda	NOTES
Setting the stage: Adult Vaccine Landscape in our Region	• Dr. Fiscus informed the group that tomorrow, teams will set meeting dates with people in their group. The survey said if teams went home and scheduled a meeting, 80% of them would continue the work and make progress. • We provided teams with the data profiles to help with planning in the jurisdiction. • The cost of adult-vaccine preventable disease is $26.5B annually. Most of that is influenza ($16B). • If we fully vaccinate adults, the ROI is nineteen times. • Paying for vaccinations is complicated and depends on insurance status and plan. • Someone asked if you could get shingles vaccine out of the pharmacy. Brent Ewig said yes. • 317 purchases vaccines for uninsured but limited funding. • Amber Tirmal, Philadelphia, said 317 is flat funded because of the higher price of vaccines and less money.

Agenda	NOTES
	• Pre-meeting survey results said Access is voted one in challenges to vaccinating adults. Funding is the number 1 solution. • Spend the next 2 days trying to answer the question. Where do you want to start? Population? Vaccine? • How do you build vaccine confidence?
Tony Yang Associate Dean for Health Policy and Population Science George Washington University School of Nursing ytyang@gwu.edu	Q: How is DC going to continue its work with CBOs? • Looking for funding opportunities for their staff (IZ program) to continue to help CBOs with vaccine admin. Working with pharmacy schools. • Connecting CBOs with Walgreens to provide vaccines. CBOs can use funding $ to purchase incentives. (Maryland) Q: Is there any data on co-admin of C-19 and Shingles vaccines? • Not aware of data. • Medicaid is always looking for ways to help pay for PH initiatives. Medicaid is paying FFS for CHWs now. Leverage that in your jurisdiction and see if providers even know that's a possibility. Are there CBOs that meet the qualifications for CHWs? PA is going to add CHWs to Medicaid rolls as a provider type. May be happening in other jurisdictions. CHWs are paid to talk about preventive services, including immunizations. Talk to Medicare and Medicaid providers. (PA) • Must build the evidence and political will to understand that we are not just talking about immunizations, we are working on disparities. Blending/braiding of funding, use of CHWs, use of trusted messengers. (Susan Farrell) • If looking for CHWs look at IPHI (Inst for PH Innovation). They have a PH CHW academy and training institute that works to expand that workforce (Heather Burris)

Agenda	NOTES
	• There is a lot of money out there in insurance reimbursement– clinics in schools. Net $0.5M/yr for 6 weeks of work in schools (Tiffany Tate) • Sustaining the partnership is extremely valuable, even without ongoing funding. CBOs are also crafty about getting funding. (Claire) Q: How can we understand the population of under-insured people in a jurisdiction? • No one was aware of the data source. Q: Do you have any data on administering shingles and COVID-19 vaccine data together? • None Q: How is DC planning to continue to fund CBOs to do this work? (Amber Tirmal (Phila) • One of their challenges is that CBOs were funded to do communications, messaging, etc. but they cannot buy vaccines. • D.C. has funded GW for the last year and will for an additional year. Looking at other opportunities, assessing who can reach people, etc. Trying to use the staff, they must continue to foster awareness and put people together. D.C. is hoping to continue to utilize academic partners (i.e., students working in the health department). (Heather Burris (D.C) ● They are working with community partners across the country. Working with Walgreens was successful – CBOs connected with Walgreens (Bridge Program and flu voucher program) to allow CBOs to access vaccines. (NMQF – MD) ● Medicare as of January 1 became Medicare free for service for community health workers. Several Medicaid states have added CHWs, so they are covered. Encourage people to talk to partners in states to see if billing for both Medicaid and Medicare and see if they can communicate the need for immunization. (Medicaid PA)

Agenda	NOTES
	• Need to message that we are not just immunizing, but we are immunizing to end disparities. Strategies to think about utilizing CHWs, blending and braiding of funding, and trusted messengers. (Susan Farrel HHS) • A great partner and now a grantee of the DC program is the Institute for Public Health Innovation – they have a public health training institute. (Heather Burris DC) • There is a lot of money out there for reimbursement (i.e., getting reimbursed from insurance companies). (Tiffany Tate MD) • Other VAC speakers from the VAC meetings (P4VE members) emphasized the impact of strong relationships and continuing relationships and communication from IZ programs, keeping those massagers trusted, etc. (Claire Hannan AIM) Q: Where can we go to find the percentage of underinsured so we can get the true picture of how many are not getting vaccines? (PA) • No data that Dr. Yang knows of • Can AIM help gather data on who qualifies as underinsured? In Philadelphia, they were not talking about underinsured until the state of the Bridge Access Program. (Amber Tirmal Phila)
Overview of the Success Framework for Adult Immunization Partner Networks	• The partnership success framework's original intent was to help jurisdictions find CBOs to partner with AND fund with the supplemental COVID funds. • Post-pandemic the framework can still be used to facilitate partnerships even if non-funded. • Its strength is that it is very action-oriented and solutions-focused. • The various stages meet programs where they are in the planning. • Focus on informal partners as trusted messengers and advisors. • Formal partnerships can still be created through MOUs with support from the IP without necessarily financial support (like an MOA)

Association of Immunization Managers

Agenda	NOTES
	• Examples of partners: Government agencies/programs, tribes, and tribal entities, health-related entities, local entities i.e., schools, faith-based organizations, community centers • This list will be helpful as you work on your goals and tasks related to improving adult vaccine access in your jurisdictions. • The Success framework created by CDC in 'twenty-two to support you in determining the current strengths of your adult immunization partner networks and guide you in addressing areas for growth. • **Framework is a Question-based guide** that supports you in reflecting on your adult immunization partner networks' **current strengths and areas for growth or improvement**. • Supports you in **determining actions** to take to strengthen and sustain your partner networks. • Partner networks can focus on non-traditional community partners or smaller CBOs, which may be in specific communities or in a specific geographic area, like ways you will be asked to focus today, (e.g., around language/culture of racial/ethnic minority populations in a particular metro/rural area). So, I encourage you to color outside the lines. • There are four domains or phases which will help guide you through the framework activities to accomplish the phases of the partnership management lifecycle. • Defining goals and priorities, expanding organizational capacity, advance activity implementation, and evaluation and learning • Defining goals and priorities: Focuses on defining jurisdictions goals and priorities. • Expanding organizational capacity focuses on organizational capacity including staff, partners & funding. It highlights the sustainability planning guide as a resource for CBOs who may be losing funding. • Advanced activity implementation focuses on communications and outreach. The Team action plan template found in the resources section, can be used for these VAC groups to organize your future work – it is a simple tracking tool for goals, tasks and people. • Evaluation and Learning focuses on evaluation of the work and may pertain to long term goal setting for your group. Good resources for programs and CBOs to evaluate their

Agenda	NOTES

Team Report outs on discussions and developing strategies	work. This content is tied to the resources available from the DITA team at CDC.
	• If you do not know where to start, the success framework checklists and action plans can be a great launching pad for your adult VAC work that you started here.
	
	D.C.:
	
	Challenge
	• The health department cannot bill for service effectively to sustain itself.
	• Wards 7 and 8 are food and pharmacy deserts (3 grocery stores/150,000 people)
	• Pharmacies are small physically, and might not have resources to procure, store, and administer vaccines.
	• 800/2,200 Pharmacists are certified immunizers (some of that 2200 are non-practicing pharmacists though)
	• Collaborative Practice Agreements and some chain pharmacies do not want to codify the PREP Act (ACIP vaccinations provided by pharmacists)
	• The totality of vaccine providers is not sufficient to cover the populace.
	• Private claims data is expensive ($~40K), IQVIA for data -> (Might be able to obtain data from sharing)
	• 317 funding not going far enough.
	• Facing cliff with DOH vaccination program
	  ○ Home and Covid vaccination access
	  ○ Community likes the option, of convenience for homebound pts.
	  ○ ~500 patients seen during the last respiratory season.
	  ○ cost: $500K ($1000/person)
	  ○ possibly served insured patients but not able to collect from insurance companies to recoup the cost to extend the program)
	• Infrastructure and Regulation
	• Physicians

Association of
Immunization
Managers

<table>
<tr><th>Agenda</th><th>NOTES</th></tr>
<tr><td></td><td>

LTCF residents being vaccinated, however, the provider is potentially unknown or unreported, and working to find a linkage.
Trying to narrow focus on which vaccines

Success

Vaccination rates better than the national average (better than Florida)
Alleviating red tape in the district to administer ACIP vaccines down to the age of three in pharmacies
Grubs Pharmacies are about to become VFC providers. They are well-known and respected in the pharmacy community. But infrastructure support for funding applications, etc. is a challenge.
Tried to eliminate some of the red tape and make permanent some of the COVID flexibilities. Codified Prep so pharmacists can vax down to age 3.
The numbers are above the national average.
Sharing coverage status in LT care facilities and making ppl report that info. There are privately owned facilities and there are always issues. Better data was coming in because they had to report to their LT care systems during COVID-19. Now, it is sometimes challenging for us to identify. Jacob is working on trying to understand who the provider is and that they report to us. Identifying them with PIN so that we can measure their coverage better.

HEDIS - you cannot find that info until next year.
Shelley: in TN, made providers aware of being in the lowest quartile for vaccinations through HEDIS.
Heather: we did certificates of excellence in schools, and they loved it. And then the education agency also reprimanded those who did not do as well.

Goals

Explore Universal purchase.

</td></tr>
</table>

Agenda	NOTES

	• Flavor - LTCF awards (carrot/stick)
	• Want to understand why the health department cannot bill for direct services (like AZ who has a company handle it for them)
	• Would love to do a universal purchase. Learning why DC has not been historical?
	  ○ RI has done it across the age spectrum. VT has done it for adults under sixty-five.
	  ○ KidsVax has an economic case for doing it.
	  ○ Even with VFC, to get Medicaid to mandate providers to participate.
	  ○ Who do we need to talk with?
	• Challenging to identify vaccines to focus on - based on age, geography, and risk.
	  ○ 317 based mostly on cost.
	  ○ in VT, they allow providers to choose what vaccines they want - everyone has access to a certain amount of 317 funding. DC did this last year.
	  ○ Exploring DOH's ability to bill direct service, LT care QI, and universal purchase
	  ○ Meeting LT QI people
	• In LT care space, identifying which pharmacists are doing it, where they are connected, are they billing.
	• universal purchase would mean pharmacy involvement in VFC.
	  ○ DOH can do another webinar encouraging pharmacies to enroll in VFC (with Grubs as a new use case)
	• Population of focus
	  ○ How well are colleges helping people get vaccinated?
	
	Maryland:
	
	Challenge
	• Demand for vaccines
	• CBOs - biggest challenge is access.

Agenda	NOTES

	• Pharmacy perspective - Access is an issue. We must order the flu vaccine so far in advance. Challenge because once flu season starts, there is no flu vaccine available. Purchasing pieces is hard. Already received small amounts of flu vaccine. If the buying group says they are going to buy 10k doses vs. 50k doses, you may get a better negotiating rate.
	• MD - Maryland gets their flu vaccine end of August.
	• Greg - fluctuation of demand (i.e., no one wants to get a COVID vaccine) → no consistent demand to Congress to make sure there is *consistent* funding.
	    ○ Insurance companies getting off "Scott free" - PH has taken this one but we struggle to find funding.
	    ○ PH vaccinating 60% of insured individuals.
	• Tiffany - Would make sense to partner with insurance companies to bill.
	• Christine - Contract with employer companies to go in and vaccinate.
	• NMQF - the better message is to have people bring their insurance so not giving free vaccines to those with insurance.
	    ○ Solution: Walgreens can bill
	• Tiffany - lack of community immunizers awareness
	• Greg - PH lacks billing infrastructure to bill insurance companies so they can recoup some of their vaccines.
	• Tiffany - education
	• Christine - get reimbursed $16/vaccine, different billing prescription vs. medical.
	
	<u>Summary of challenges:</u>
	• Access
	• Fluctuation of demand
	• Not billing insurance
	• Education (provider, PH, community)
	
	Success

Agenda	NOTES

	• vaccinating adults when we are doing SLVs.
	• A Short-term solution might be back-to-school vaccines in communities and churches to also bring adult vaccines and offer parents vaccines.
	• Flavor of conversation - Billing and how we are dependent on handouts and administration and should be looking at more sustainable funding.
	
	• Pharmacists are interested and have a vested passion.
	• Christine - vaccinated 24k adults through grants mostly in LTCF/assisted living
	  ○ Preference to vaccine vs. fill tons of vaccines
	  ○ But will give the vaccine to you.
	• Tiffany - school-based campaigns vaccinate kids and staff (staff are more eager than the kids) and bill + reimbursed; going to large employers to go into every school and vaccinate.
	• Greg - pharmacists' ability to handle vaccinating during the pandemic; need to keep pharmacy model active and engaged beyond kudos and thank you; how do we keep it funded?
	• Have infrastructure to bill - Tiffany: received money for 80% of those that are billed.
	• Only giving vaccines to providers that were interfaced into IIS → good data/reporting.
	• Huge uptake with RSV vaccines last year because doctors were telling their patients to get the vaccine (need pharmacists to have these conversations)
	• How to shift the needle for those 35-45
	• Church event vaccinated three hundred people after 1 church service.
	
	Goals
	
	Short
	• Making back-to-school campaigns into whole-family campaigns
	• Public health partnering with pharmacists who bill.
	• Educating on billing among partners and network groups/P4VE recipients

Agenda	NOTES
	• Education or program around business/economics of vaccinating • Partnering with LTCF and going in to vaccinate on their behalf • Chicago - model to vaccinate in congregate living settings used during measles. Medium • Working on vaccinating in congregate settings (i.e., homeless shelters, etc.) • Partnering further with pharmacies • partner with medical provider. Long • Partnering with AHIP to push billing • Insurance companies to establish incentives when vaccinating. • Pharmacies going to large employers. • Performance measures based on adult vaccination coverage. New York City and State: Challenge • Demand, targeted messaging to audience and breaking through the noise. • Vaccine access for older adults is an issue since a lot of elders cannot leave their homes due to fear of getting sick or transportation. • Reliable data sources are missing in part of the messaging, combining the data and statistics, and promoting this on the local TV. • A large population of older adults listen to what is on TV and believe everything that is publicized on the news. • Data gaps, there is no IIS reporting registry requirement in VFC, and there are two reporting. • There is no appetite in legislation to provide data for adult vaccines.

Agenda	NOTES
	Success • NY state Vaccines for Adults program. • Received double the state dollar investment to supplement 317. • We have 200 providers enrolled for uninsured and underinsured possibly room for growth, most of the budget is eaten up by COVID, RSV, and Mpox, but we're able to offer all adult vaccines under CDC contract, and all the vaccines on the recommended list from the CDC are on that list for access • Online adult immunization toolkit and state IZ website has translation in ~12 languages to increase accessibility. • There is great pharmacy data, pharmacies are very good at providing the coding for tracking registry data. • NYS DOH has a person dedicated to social media outreach and messaging. • Podcasts, to discuss Medicaid and health services. • 6 Fall regional meetings with NYSACHO (New York State Association of county health officials), providing state updates, CDC updates, and joint Q+A, information to each other and disseminating information. • The existing adult program, 70%, 1.6 million 317, matched with 1.6 million for the state, with another 1.6 million. • Local DOH, 2018-2019 contracted a Health care system program, • Working alongside the University of Albany School of Public Health, the school can support webinars and live webcasts, doing this with a school can help provide data to review and provide adult education programs. • We have an immunization advisory council that meets, this is a combination of pediatricians and doctors. • Local health departments will bring vaccinations to county jails.

Agenda	NOTES

	• NYSACHO (New York State Association of County Health Officials) went out to survey local farm workers, then brought this information to the local health departments to roll out vaccinations of flu to farmer workers and their family.
	  ○ Mobile or pop-up clinics and local health departments have migrant health departments specific for the people who are in need in certain rural zip codes, daily report outs to review how sites were running.
	  ○ State-run sites were operating well.
	• Successful translation across all web pages in multiple languages, diversity, equity, and inclusivity is important
	
	Goals
	
	Short
	• Outreach around healthcare vaccination, healthcare needs to show other vaccination needs.
	• vaccine access PowerPoint to communicate to the public and medical professionals as messaging.
	• Applying lessons learned from COVID to a targeted seasonal flu vaccine for farm and migrant workers.
	• Exploring options to increase adult IIS reporting
	Medium
	• Leverage the NYS Immunization Advisory Council (IAC) to expand and include adult vaccines and representation from FQHCs and pharmacies.
	Long
	• Applying lessons learned to targeted seasonal vaccine campaigns for frameworks and migrant farmworkers. Need to make sure to at least have seasonal vaccines in arms.
	• Exploring options to increase adult IIS reporting. Do not have an adult reporting mandate in NY state, makes it difficult to measure successes.

Agenda	NOTES
	• Enrolling pharmacies in our VFA program, right now LHJs and FQHCs New Jersey: Challenges • 317 limited to FQHCs, a few non-profits • currently offers all ACIP recommended vaccines for adults but with new products - Monkeypox, Jynneos, COVID-19 vaccines and RSV for adults - challenging to continue due to increased pricing. • Some 317 programs serve the underinsured as well, ours is just uninsured. There is still a gap for this population. We have a separate 317 program coordinator. The Adult coordinator, Rafia, does more health promotion partnerships and awareness. The 317 coordinators and Rafia will be working together to flush out what the adult IZ framework will be in NJ. • HRSA funding was there for COVID but now it is gone. For pharmacies that were billed during that period, claims were a big mess. Medicaid claims are also a mess. • many years ago, pharmacists were defined as HCPs but that never included any kind of payment model. They are considered providers, but Medicaid has not moved in that direction [payment model]. Successes • COVID was implemented on the commissioner level and worked with all state partners and met with folks to make that happen on the governor level. • Our campaigns for pregnant people, healthcare workers and flu campaigns, priority populations, health advocacy and information or health education; risk communicators sending out messaging for those populations. Our IP was never about vaccinating the entire state of NJ, and the COVID program was.

Agenda	NOTES
	• identified great team members, and received a bit of funding for vaccines, but is that sustainable? Increased funding for FQHC, LHJs, non-profits, but it was very minor on who we could extend our 317 programs too, we have had to pull that back some. We had some expansion because of the bridge, but that has gone away. We were successful but that is an orange and an apple. • State hired Rutgers to look at our vaccine purchase policy; VFC program and uninsured program. Looking at Universal; doing a study. Lots up in the air. • Our IPOM has chapters on priority populations to outreach to. Pregnant people and healthcare workers were part of our priorities and part of our cooperative agreement. Next CoAg, CDC is re-evaluating how they want to structure the program. • part of the supplemental for COVID was funding LHJs, and this energized local public health. They were able to do mobile vaccination units, they were able to get out there and vaccinate homebound. Vaccine was universally available. They got funding from us for operational use. Proud of the work they have done as a success story, now that the funding is gone, they are energized and excited, but we do not know how to maintain it afterwards. • Transportation • strengthened relationships with adult vaccination partners - FQHCs, LHJs, and tribes. Goals Short • Call internally with colleague Jennifer about what is going on in both Hot for Tots and MCHs programs to discuss the idea of home visiting education for adults. • see if there could be a relationship between federal Hot Shots for Tots and our Hot Shots for Tots campaign with childcare facilities. Identify who the contact for federal head start is and see if local department of education is head start and determine if they should be included.

Association of Immunization Managers

Agenda	NOTES
	Delaware: Challenges • people are walking into the pharmacy asking for vaccines that are more expensive, there are underserved folks who do not have access. • We have the same challenges. It is a big challenge to identify who exactly is underinsured and get resources for them. • underinsured, you have insurance, and your vaccine is not covered, or the administration fee is not covered, that is two different challenges. If you are not being reimbursed for an administration fee, folks are being turned away. Pharmacists and patients do not want to pay the differences. • We are still paying the 2009 administration fees. Working to change from the federal limit. • Important to connect between pharmacists being recognized to provide for service and paid for service. Medicaid is a state-based decision but for Medicare. Physicians cannot bill D pharmacists cannot bill B and patients do not understand it. AIM is good because when they see those discrepancies, somebody must speak up and make those changes. • pharmacist - Not getting reimbursed so I have pulled back from underserved places. Successes • They passed a law where pharmacies must be paid the same as other providers. COVID helped make that happen. The champion needed to spearhead it. Legislators got to see my face [Kevin, pharmacist] and we worked on a collaborative care agreement but that does not do well if it does not get paid for service. The payment parity bill went through unanimously. Insurance companies tried to put a fiscal note on it to delay implementation. Used APhA to help us with the wording, which is why our bill is more well written. Anybody could take their vetted language and put their state's language on it. • Had FQHCs and division public health would take care of communities, but they no longer could do that after COVID. People had better access before COVID. Now [public health?]

Agenda	NOTES
	feels they should go to a community pharmacy. • We have a county coalition that identifies our underserved and we [pharmacists] go to them. We have been doing some this summer, and are sad bridge is going to end. Goals Short • Have a discussion at the staff meeting next week about home visits as well. Medium • Figure out where people can get vaccinated if we are able to start doing education for adults during these home visits. Build on your matchmaking to find a partner who can go into that area. Long • Develop a curriculum care plan, do training, and be able to push it out. Philadelphia and Pennsylvania: Challenges • Access - LTCF does not have in-house pharmacists and must rely on staff to vaccinate the patients. • Funding - limited, 317 funds space, cost issue, OBGYNs do not' want to carry expensive vaccines because of cost. • Cost-value for uninsured, if the uninsured walks into the pharmacy and cannot vaccinated, other FQHCs have a waiting period. • Billing - lots of billing issues, hard for pharmacies and providers to get properly reimbursed. Pharmacists do not know how to properly bill vaccines. Must pay out of pocket. Pharmacy, bill for medical, vaccines will not be covered. Missed opportunity to focus on insurance different coverage and reimbursement rates for vaccines.

Agenda	NOTES
	• Policy - Philadelphia this will happen soon, but in PA we do not have a universal standing order for providers and pharmacists to follow to vaccinate patients. Pharmacists must work hard to get the standing orders. Success • PA and Philly - rates for populations 65+ are above the national average. By the end of this fiscal year in PA all the pharmacists will be required to report to IIS. • Philly - vaccinated over 10k through breeze program (?), developed resources in ten different languages, and IZ website can be in fifteen different languages. • Focus Areas • Developing standing orders so administrative workload will be less on the pharmacist's side. • Webinars so pharmacists know how to properly bill. • Matching process where we can help match pharmacies with CBOs to host off-site vaccine clinics like they did during pandemic. • Contact insurance commissioner to talk about vaccines needed and ROI. Data presentation and present to DSH Leadership and how vaccines can lower total cost per head in our state. • Pharmacy to make their pharmacy patient assistance program so more people can benefit. • Talked about potentially forming an adult vaccine coordinator workgroup among those who are here to regularly meet to share resources and ideas.

July 24, 2024

Agenda	NOTES

Adult Immunization Program Q&A What would you like to know from other programs?	• Philadelphia - The visitors were able to identify that it is difficult to make action plans at the action level. There are multiple counties in need of help, making it difficult for one person to manage, there is a need for more people to help. • AIM is a collaborating partner funded by the CDC to look at QI for adults. Johns Hopkins leads evaluation. Will share lessons learned along the way. • New Jersey - prior to the pandemic, always had 317 and VFC wrapped together. Through covid that was transitioned to 317. Now 317 teams will go out and do site visits for field operations. Waiting for a tool from CDC, since it did not come, they needed a way to track and so it was decided VFC was used as a base and covid nineteen red cap survey as a guide. Currently has a separate team to go out to adult providers. The field operations team does both VFC AND 317. • (NY) DEPT OF HEALTH – what kind of plans are there for vaccines for migrant farm workers? Local health dept have done migrant farm worker clinics in the path. Survey of data on the success of that. Is there anything that is being done and successful in getting migrant farmers vaccinated for flu? • Burlington Vermont, speaker workers with farm workers and her organization has done all the vaccination efforts, making them trusted and meeting the needs of the community. Listening to the community and having their presence of them for their needs. • Are there federally qualified health centers that go beyond the needs of vaccinating farmer workers? • Webinar on the farm workers coming up. • A lot of interest nationally – adult programs – how long ago were the programs set up and was there a legislative authorization prior to setting that up? • 2015/2016 – state investment to match 317 funds. Trying to target campaigns for migrant clinics, std clinics, substance abuse clinics, under insured individuals. • VFC obligations – VFA MMR REQUIREMENTS. Enrollment is like vaccines for child enrollment. Can order any vaccines on the CDC contract. Having them participate in a program where reporting is necessary. Not a lot of off-site visits because providers are part of VFC. Not a legislative appropriation. • Universal purchase – (317 vaccine purchase funds)

	• NJ – covers all ACIP vaccines, but 317 providers can order once every 4 months (now closed since there is a lack of capacity to provide vaccines) • Two collations one is regional, and one is six county, AAP support through grant. Get funding through the health services grant team & other interested stakeholders. • Intern – look at what the priority is among the tip vaccines (summer study to determine what should be more available) running against 317 so they would borrow, now there is nothing to borrow, so the approach changed to 4 months three times a year. Most people order a minimum dose. What would like to be done is like what was done during covid. COVID was on bridge supply until recently, the intern is helping determine that supply and demand. • PHIL – not sustainable to offer all vaccines, using the allocation approach, providers can order monthly and there are thresholds set every month. Run out often, based on demand and supply. Every year apply for 317 funds, approved, sending out the vaccines to providers who most need them. July – September stop supplying. 317 only works about 9 months of the year. Will not be adding (two hundred doses of COVID-19, only Novavax, because it was the cheapest) cut what will be able to be offered for HPV. • Experience in coalition building – partnerships with community-based organizations. CBO's and building investments. AIM is working on a coalition toolkit. Collab with consultants with those who have a collation, structure, how it is run, funding, working together moving forward. • PA – LOCATION aspect – gathered data from hospitalization – create a map using data and uninsured pop. Based on map there will be priority on who gets the 317 vaccines. Private health care systems do not want to be a part of it, they would have a lot of left over and would use that to those who were not insured – uninsured. FQHC will be prioritized.
Brief team	Maryland:

<table>
<tr>
<td>report outs on plans and next steps</td>
<td>

will meet at 2pm on August 22.
They have the task of working to incorporate engagement and partnerships with independent pharmacists and identified key partners and stakeholders.
They will work with pharmacists with vaccination efforts in the community and schools in order for the state and tech partners to be successful. Establish meetings/webinars and identify stakeholders. Invite them to the meeting in August and become engaged.

Goals

Short

Meeting with key partners -

Reaching out to set up meeting with Deena Speights-Napta (Maryland board of pharmacy)
Christine reaching out to CPESN (clinically integrated network of independent pharmacies) which has forty-two independent pharmacies to see if they can partner with the state.

Working with Chrstine to identify those other independent pharmacies who are interested in.
Christine to partner with the local health department to vaccinate VFC kids + their parents in schools/communities.
Educating on value of billing
Christine to contact MPHA Aliyah Horton

Medium

Christine - partner to APIC and HFAM to figure out who needs services and/or if there is the opportunity.
Webinars with independent pharmacists
Put APIC and AFAM in

Long

increasing opportunity for pharmacists to vaccinate populations that need it.
Publish that these partnership work.

</td>
</tr>
</table>

	• Utilizing Tiffany Pennsylvania/Philadelphia: • The goal is to raise the population focus of 52 to 64. • They will be focusing on vaccinating COVID-19, flu, and meningococcal vaccines. The first meeting is August 22 from 9 to 10 am. • Stakeholders will meet to discuss vaccine-preventable diseases. For the long term – increase vaccination rates, work with coalitions, focus groups, webinars for pharmacists, work with state MCUs and family physicians to increase strong recommendations to patients. • Use a long-term reminder, recall system, and incorporate it in IIS. Will invite pharmacists to have opportunities to present to their policy committee. Vaccine Coordinator group creation to meet regularly. Goals Short • Collect and organize existing data on influenza showing the impact of influenza and low vaccination on the age group 50-64 years old. • Set the age bands for data collection (look at NCQA age bands) • Dr. Waller to present on what people see in the PA DOH dashboard. Amber to present on the Philadelphia dashboard. • Automated order sets within EHR for age bracket - prompts for ordering or recommending vaccinations. • For the upcoming COVID season, MCOs are refreshing their plans. • Messaging for this upcoming COVID and flu season: Philly comms to work with PA on messaging, outreach and using social media influencers. • Educate pharmacies about vaccine counseling code. Pharmacies working through state pharmacy association to continue outreach and education on billing - also instruction on how to bill as a medical benefit (PA to share NAIIS, and Philly to share bulletin on billing with Sophia

	Herbert, state pharmacy association) • AIM to check on economic analysis of vaccinating adults (Claire to check with AVAC • Pharmacy "blasts" and MCO "blasts" via email to remind patients to get flu and COVID vaccine. • Get Philadelphia MCOs – chief medical officers and community health choices to meet with the immunization programs. Medium • Develop ROI – information showing the return on investment for vaccination and the cost/impact of influenza on the specific age population. • Adult education Mid-Atlantic working group Long • Set up reminder/recall in PA IIS for adults. • Raise rates for the specific age bracket (such as 50-64) by five percentage points — focus on flu, COVID, pneumonia (in one year) New Jersey: • looking at childcare health educator – promotion of childhood vaccines. Reach out to the in-house health coordinator. They will also reach out to Maternal Child Health home visits to reach adults. Goals Short • By October 1, Rafia can do an outreach to Jennifer Smith, Health Educator, to assess hot shots for tots' folks. • They are not sure about equity but just try to be realistic and attainable.

	- Rafia will also reach out to the Maternal Child Health home visiting team to discuss adults. They will talk to childcare workers and parents being the lens for adults. - Katelyn suggested Rafia and Felicia set up a meeting in September. Medium - If the October outcome went well, do a home visiting outreach to the sister division to see if they can collaborate on home visiting by December as the next step. - If the Maternal Child Health home visiting team has quarterly meetings, Rafia can speak at their meetings and discuss resources they have about adult immunization and access their resources. Katelyn suggested March 1st, to be more specific. Long - The end of the CoAg is June 30, 2025, and priorities will change. Funders drive a lot of things so they do not know what the Adult Immunization promotion will be. - NJ might have maternal promotions already. In 12 months, if there is a VFA program, then they can have a robust program for adults. It might depend on the election. For now, they need to focus on education. Funding is so limited for 317. Ordering vaccines every four months is hard. Pharmacists should be brought in. Federal policy might overrule state policies. Delaware: Goals Short - is the same with maternal child health home visits. Vaccinate the household. - Have discussion at staff meeting next week about home visits as well. Information awareness is

	a challenge. New York/NYC: Goals Short • Meeting on August 20 from 3 pm to 4 pm. Focus on flu campaign for migrant farm workers. • Talk to partners like migrant farm programs and work with rural health centers. They will talk to someone well-connected with the community to ask her for help. • Independent pharmacists might be able to go on-site. The farmer will only allow vaccines if all can be vaccinated. Medium • Immunization Advisory Council – asks coordinator to review bylaws to see if they can bring in adult immunizations. • Create a one-pager. • Create adult Vaccine 101 for vaccine providers. • Connect with the Office of the Aging to have the commissioner plug for seasonal vaccinations for older adults. Long • Bring Universal variance to NY (Brent will send an email and resources about how other states have done it). • billing program for HDs • Create a universal purchase program. • Provide an educational PowerPoint to public health departments pending approval. • Brent to send IIS purchasing resources.

	D.C.: Goals Short • Reach out to DC Health Care Associations and DC Coalition on Long Term Care. • Heather to do webinar for pharmacies about enrolling in VFC (October 3) • Connect with director's office re: universal purchase. • Connect with DC Alliance - working with them to make the vaccines for that population universal. For underinsured (17k individuals, who do not qualify for Medicaid) • Understand lessons from other states with UP programs - AIM and NASHP can support. • Determine barriers to billing. • Speak with LT care QI people (APHa will reach out) • Define what you would call a long-term care facility - SNFs. • Jacob - connect with CPPE re: HEDIS measures. • Work with Adult Vaccination Workgroup that DOH runs to pull in external partners. Medium • Acquire HEDIS data and ID providers of vaccinations in LTCFs. • Identify the vaccinators in those facilities (DOH) • Providing some sort of certificate to those who are in the top quartile - Mayor's social media potentially. Long • Dept of Health Adult Vaccination Workgroup. The meeting is going to be the last Tuesday of every month going forward starting in August. • billing program for HDs • Create a universal purchase program.

Association of
Immunization
Managers