Vaccine Access Cooperative Regional Meeting for Adults
New England Region
July 17-19, 2024

MEETING NOTES

PowerPoint Slides: https://www.immunizationmanagers.org/content/uploads/2024/08/New-England-VAC-Adult-Vaccines-Meeting-presentation_July2024.pdf

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

July 18, 2024

Agenda	NOTES
Setting the stage: Adult Vaccine Landscape in our Region	• NE is great with flu vaccinations and long-term care. • NH is doing great with flu vaccinations in long-term care facilities. • CT is meeting the national rate for RSV. • Mass and Ct are going great with the COVID-19 vaccine. • Funding is the biggest challenge in this region followed by access, hesitancy, COVID fatigue, awareness, capacity, provider recommendation, cost to providers, changing guidance, Medicare Part D, education, politicization, etc. • Access is more effective at improving the vaccination rate than combating mis/disinformation.

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	• Solutions from this region were funding, VFA, education, payment providers, access, incentives partners

CBO Presentation
 	
Naomi Wolcott-McCausland, Bridges to Health, University of Vermont
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	• Bridges to Health- A seven-person Community Health Worker program team, covers 14 counties providing.
	  ○ Referrals to established health and social service organizations.
	  ○ Coordination of clinical outreach for everyone
	● Work with migrant and immigrant workers, which are currently living in Vermont.
	● Not otherwise supported by existing infrastructure
	● Are experiencing barriers to receiving health services.
	● Immunization outreach - community collaboration is required for this to be successful.
	  ○ The pre-covid immunization outreach is minimal due to the capacity of staff and funding.
	  ○ 2020 flu vaccine & TDAP
	  ■ UVM MC Volunteer MD willing to follow the team to sites for vaccinations.
	  ■ There was funding for education but not for vaccine outreach.
	  ○ 2021 COVID vaccine in spring; COVID-19, Flu, TDAP, in fall
	  ■ Targeted funding - 1 source for COVID-19, and 1 for other immunizations via EXCITE (CDC program)
	  ○ 2022 Community-based clinics and fall immunization outreach.
	  ■ Funding for CHWs to coordinate.
	  ○ 2023
	  ■ Funding for CHW to coordinate. Capacity diminished by an increase in a number of immigrant/migrant workers and children.
	  ■ Other health needs took priority as the needs of the communities changed.
	  ■ 689 vaccines
	  ● 50 farms/business/community-based clinics engaged with
	● Why we have been successful:

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	○ Building relationships with Employers who offer housing for folks is helpful in building trust, they will know the farm workers' schedule and understand that it's a priority to support their workers. ○ Creating connections and listening to the community needs, sharing knowledge during outreach ○ Tailoring outreach to community needs and composition. ■ In Vermont, it is very rural. Only a few events over the year that the population of migrant farm workers attend can host outreach. ■ Consider barriers to access when determining outreach strategy. ■ Include anyone onsite with interest (church member, farm owner, or passerby) ○ Scaling the team size depending on the site needs ■ 1 Immunization RN for smaller sites with an interpreter or coordinator ■ Consider tailgating. ○ Reduce time and paperwork barriers whenever possible. ■ Keep requests for information from the community partners, business owners, and members of the priority population to a minimum, ○ Planning ahead of time, coordinating outreach, keeping the harvest/farm schedules, be prepared to walk through locations that are convenient to those in need. ○ Making availability to both day and evening hours, to accommodate the availability of various workers ○ Customer service support, taking care of yourself and your needs throughout your day - bringing snacks, water, and a change of clothes. ○ Make yourself as comfortable as possible to be uncomfortable all day. ● Invest in community-based organizations. ○ Outreach is crucial to sustain relationships and continue to keep the connection with these organizations. Q+A

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	● Q: Could you talk about the acceptance of vaccines in your community? flu/Covid. How are vaccines received? ○ A: Jamaican farm workers, when they thought it was a requirement - everyone was getting vaccinated. Since the requirements have changed, there have not been many people coming to get vaccinated. On the farms, there's a general interest in flu, from the Mexican and Guatemalan farm workers. There is a lot of hesitancy. Tetanus is in high need due to the environment they work in. We are seeing a lot more people from South America who are in the service industry interested in HepB. Most folks do not have access to or knowledge of their vaccination records. ● Q: When you vaccinate them, do you report them to the IIS? ○ A: Whatever the partnership organization is vaccinating, with logging everything into the Vermont registry, sometimes it's a challenge to find the correct name to update their records ● Q: From a community health lens, trusting messenger, CHWs - what happens when you are not onsite? What is digital literacy with this population? How can we communicate if we are not physically there with them to help answer questions and they could receive this information? ○ A: At this point, the community we serve does have smartphones. I think the strategy would depend on what your population's needs are. If there is someone who can serve as a point of contact and has been at a site for a longer time, who people trust - you can communicate through them with the information you have. Another suggestion is to create a relationship with the farm owners or the manager who can share information directly with their workers. Figuring out who the individuals are to help you share the messages you are trying to get to the community. Sometimes food vendors are also crucial and unique. ● Q: are there sister organizations across the country? ○ A: No, we started this program because we didn't have any programs for community

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	health promotion. ● Q: Do you get a sense/have thought on the rate at which this population will be vaccinated this year? ○ A: it's going to be tricky because the symptoms aren't particularly impactful for this group of workers. COVID-19, there was initially a fear and now the physical impact has been minimal. We haven't seen the transition and will continue to share information and the benefits with the community. Anytime there's an impact on the ability of people to work and get paid, they will avoid getting sick.
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. ● Informal partners are trusted messengers who can help you create useful messaging. Will disseminate info to the community. ● 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) ● A rich network pulls together both formal and informal partners. ● Examples of partners: Government agencies/programs, health-related entities, tribes and tribal entities, local entities ● The Success framework created by CDC in '22 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**.

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	● 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, similar to ways you'll 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 4 domains or phases that will help guide you through the framework activities to accomplish the phases of the partnership management lifecycle.
	● Domain A: Focuses on defining jurisdictions' goals and priorities.
	  ○ This is the gap analysis or needs assessment phase.
	● Domain B focuses on organizational capacity including…
	  ○ Staff, partners & funding
	  ○ It highlights the sustainability planning guide as a resource for CBOs who may be losing funding.
	● Domain C: 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's a simple tracking tool for goals, tasks, and people.
	● Domain D: 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 work.
	  ○ This content is tied to the resources available from the DITA team at CDC.

Team report outs on discussions and	

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developing strategies	**Maine** **CHALLENGE:** ● Getting FQHCs buy-in ● LTCF staff have COVID-19 fatigue. ● Misinformation and the effort required to engage with that. ● National guidance about the latest booster was misinterpreted as needing the C-19 vaccine every 4 months (from a partner) ● Lack of communication from CDC to states/agencies (specific to COVID) ● Financing– can't get a straight answer. Bridge program ending. ● Not reading program updates d/t fatigue around C-19 ● Constantly changing CDC guidance ● Had state funds to deliver flu vaccinations to everyone– funding got reallocated and relationships with partners suffered. ● High turnover with partners ● Mandate for HCW lifted. ● Can't afford to get COVID-19 vaccines at LTCF to stock (flu is cheap) ● Procurement/contracting issues with the state **SUCCESS:** ● Offering all ACIP vaccines for adults through 317– twice a year pre-book to providers. Primarily FQHCs but any provider can enroll. ● Requesting and receiving an additional 317 funding ● Raised Bridge admin fee from $50 to $100. ● CBO relationships have persisted (but now they feel ignored) -- worked with Somali population, and targeted communities that needed trusted messengers.

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	● Individuals at LTCFs can get a small stipend to champion vaccines (specific to COVID and flu) -- federal COVID money. **GOALS:** **Short-Medium** ● Find a way to get Maine Primary Care Assn to work more on immunizations. ● 79 LTCFs in Maine– ● ME Health Care Assn– fall conference. Could talk about the importance of immunization and maybe a peer-peer program. ● Look into the medical liability companies for ME LTCFs– possible to give a small incentive to improve vaccination rates? ● Look at designing an emergency preparedness event at a college and using 317 funding. Partner with campus life/Greek system to promote. Reach out to the CDC about their additional funding request. ● ME HCA has quarterly calls with the Maine CDC ongoing. The immunization program has calls with MAs or nurses who vaccinate but could invite the LTCF staff. **Long** ● Universal purchase for adults **New Hampshire** **CHALLENGE:** ● Providers do not know where to send patients to get vaccines if they don't have insurance. Practices are having major staffing issues with community partners.

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	• Patients don't know where to go to get access to vaccines. • Lack of awareness on types of adult vaccines. • There are too many barriers to be able to provide vaccines. FQHC's don't have the staff capacity to schedule vaccine clinics. No hosted events anymore. • There is a cost to providers to give a vaccine to an uninsured patient. The internal policies on cost, where to send patients who are uninsured are all barriers to getting. • Political climate is a big issue. Can't even say the word COVID. • No national VFA program. State gets 300,000 only. Series of questions are asked before vaccines can be administered. • Onboarding providers have been good. Reporting has been difficult with providers who get vaccines privately because there was requirement. • Impossible to get accurate adult vaccine coverage assessments. Only a small subset of data is coming in because NH has to get explicit consent from patients to report their data. • Support- Tip sheet that would help providers- What vaccines are covered by what insurance- cheat sheet. • State support provided: Vaccine finder - providers given the tool to understand which providers were close to them and what vaccines had offered them. • All the work being done on vaccine hesitancy has been very helpful to give providers. AIM support and CDC support are very helpful. Research on best practice coming out is huge. • Tailor education based on patient population served- younger group uses QR code. • Overcoming barriers in funding, staffing capacity, and political climate **SUCCESS:** • Established and engaged in partnership with LTCF. • Being able to use the COVID Bridge program for the first time to give adult vaccines was a huge success, but now funding is gone.

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	● The mentality of people getting vaccines has been hard. Too much distrust with health care providers, leaning more toward social media influencers. ● Hearing about side effects and death also has a negative effect and does help in building confidence in vaccines. ● Providers continuing to build trust, become that trusted messenger. Improving their motivational skills will be the skills to build on. ● Using grants to provide CHW training. **GOALS:** **Short** ● leverage partnership with LTCFs, there is hesitancy in LTCF workers, and they do not always have best practices in place. ● Dissemination of information is key-Send out monthly communication with a long-term care facility. ● social media, emails ● Quarterly conference calls with providers **Medium** ● Refining media campaigns ● Assessing previous strategies and preparing for new fall season **Long** ● reduce outbreaks in long term care facilities. ● 139 assisted living facilities in NH ● 20 long term care facility outbreaks as of 7/19

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	Vermont
	
	CHALLENGE:
	
	● Vaccines access for 65+ is a challenge.
	● access - Medicare Part B vs Part D
	● some vaccines only under Part D, while other vaccines only under Part B
	● Not all Medicare recipients have Part D coverage.
	● COVID, flu, pneumococcal, Tdap in some circumstances – Part B
	● most pharmacies can do Part B billing.
	● Hesitancy and anxiety
	● Pneumonia vaccination schedule going to change.
	● Wind down of COVID funding - staff capacity at VT IZ program.
	● Homebound population People expect to get vaccine free in many, many locations (EMS did homebound) because of COVID and we don't have funding to do that.
	● Some VNAs have disenrolled because their funding has been cut and they don't have funding to support homebound vaccination.
	● RSV supply challenging - didn't get supply of Abrysmo until January
	● COVID schedule complicated for forecasting algorithms and pharmacy prompt systems (pneumococcal might be next)
	● LTCF
	  ○ LTCF - outreach to umbrella of LTCF and it's a mix between purchasing and administering and using pharmacies.
	  ○ Looking at CMS rates - we have higher than average, but still low (in the 30s and in the teens or staff)
	  ○ different approaches for flu and COVID - requirements for flu
	  ○ most SNF have a relationship with a long-term care pharmacy.
	  ○ most offer staff vaccination clinics

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	○ high turnover in staff ○ challenge getting rates per SNF or LTCF but do look at the rates as we can and want to potentially do IQIP visits to them. currently partnering with other groups to add immunization education to existing partner visits **SUCCESS:** ● Universal state for adults ● The state has an adult program for adults under age 65 (VFA) ○ pharmacies can enroll but have not - but they did enroll for COVID. ○ have over 95% of adult providers enrolled. ○ both insured and uninsured can get vaccine through the program ○ insurers contribute. ○ no admin payment ○ some providers choose to privately purchase vaccine for 65 and over and bill Medicare; some refer to pharmacies. ○ Separate inventories ○ main complaint from providers who don't enroll - it's a lot of work, we would have to keep separate stocks. ○ VT Vaccine Purchasing Plan (VVPP) - ○ Statewide requirement for providers to report doses to IIS. ○ Conduct site visits - adult and childhood IQIP – many providers in VFC and VFA – combined. ○ no hospitals enrolled (but birthing hospitals enrolled in VFC) ● for hospitals inpatient discharge process - COVID and flu vaccinations ● great program for homebound with VNA nurses and EMS providing vaccine in homes for homebound. but this is not happening like it did in COVID because funding for VNA nurses has been cut.

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	GOALS: **Short** ● Adding the immunization program to the QUIN monthly call. Creating education about where to get vaccine. ● VT was accepted as a head model extending VFA to include 65 and older. ● Send notes and follow up with QIN-QIO representative. ● Find out about vaccinations at pharmacy outpatient facilities? ● Educate pharmacies and Medicare recipients about cost-sharing and how to access vaccines. ● Can health centers bill Part D? ● Ask for an increase in VFA admin funding to make up for loss of COVID funding. ● Get a list of OB-GYN offices (not just providers) ● Messaging for RSV vaccine for pregnant people - Pharmacy (Lauren) wants to know if pharmacies are not willing to vaccinate pregnant people. ● Focus on enrolling pharmacies in VFC. ● Establishing a “borrow” option for pharmacies and other providers to avoid the burden on them to pre-purchase vaccine. ● Pilot to enroll pharmacies in VFC and VFA - reach out to Rutland pharmacy to assess interest and needs (enroll by site) ● Replacement model ● CORE ● Lauren - choose a pharmacy (reach out to Redland, COSTCO, and Lakeside) ● VFC Coordinator - get approval of replacement model from CDC. ● Meredith - get buy in from AAP.

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	● Blueprint for Health - to improve health of Vermonters - program that has facilitators who can help primary care practices meet medical home requirements IZ program partners with Blueprint. ● Reach out to Blueprint to see if they can help provide technical assistance to pharmacies to set this up. ● Payors - Meredith - they already pay in; we'd be saving them money. **Medium** ● Look into allowing providers to "borrow" from VFA program and establish a mechanism for them to pay it back if they are giving vaccine to someone over 65. ● Pharmacies could use claims data. ● VFA could potentially have a code and then providers code to that and then at the end of the year the state reconciles with those providers. **Long** ● Explore the AHEAD model (Heather) ○ CNMI - health equity component. putting this in practice in January 2026 Pat Jones - new Health Reform Director multistate collaboration and multistate payor models ● Extend VFA program to population over 65. **Massachusetts** **CHALLENGE:** ● Funding, no program for adults ● Adults the provider needs to buy the vaccine and may or may not get reimbursed. ○ Doctors' offices and pharmacies don't carry due to funding or economic challenges.

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	• The labor to support the vaccination facilities is not there, we don't have the primary care workers to operate the facilities for each flu season. • We don't have a very clear understanding of the vaccine policy for Medicaid and the communication with the community is not clear. • There's a small group working on these needs, but internally there is not always communication between the teams to work together to help educate the community. • We have 351 municipalities, which means there are different policies for each zone - we don't have consistent collaboration opportunities. • The adult primary care world has not taken on vaccines other than flu and now COVID. In terms of extending into the health departments, it needs to move to the community supporters who can lead the charge with adult vaccination. • The way we communicate the vaccination needs to our community when they're due for vaccines. • Commercialization makes the process harder, once people were being charged for the vaccinations it lowered the rates and the coverage. • How providers are reimbursed, there are health centers that will say there's an equity issue. Some health centers have decided not to provide these vaccines due to payment issues with certain patients' providers/coverage. • It's challenging to hire clinicians right now due to burnout and aging population. **SUCCESS:** • COVID, a lot of vaccines distributed and partnering with CBOS. • Passport to log the vaccination records for residents. • When COVID was free, people were more interested in the vaccination. • We had a good campaign, but it was very expensive and now we have leftover gift cards as incentives for people.

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	● Vaccine Equity evaluation for the pandemic to review the attitudes around immunization. ● Helped that there was a fear of a pandemic. ● There was a big push for the 20 communities, we had case data that showed what populations needed the vaccinations that didn't have access to it. ● Onsite vaccinations and mass health clinics have been successful. ● Universal purchase program for children, which could work for adults. **GOALS:** **Short** ● health equity and convincing the governor that we need more funding. ● Establish regular meetings between EOHHS, DPH, and MassHealth (state-only group) to review current resources and identify pilot opportunities to vaccinate pregnant people (people of birthing age 18-45, with a uterus). ● Establish meeting series with state agents, Health Centers, Pharmacies ● Gathering information from providers and the community to survey the barriers (will align with Advancing health equity of Massachusetts-AHEM) ● identifying the appropriate population for the pilot program ● Develop simple language/1-pager for vaccine options within the community. ● Launch campaign to increase COVID/flu doses for 18–45-year-olds female individuals (proxy for pregnant people) in AHEM communities, there are 10 communities, starting with 2-3, one from each region, but fall within the same federal health center. **Medium** ● Integrate the community feedback into immunization policies/MMR throughout MA

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	• Advertise community listening sessions for • Hold a town hall to share the survey results. • Launch a pilot program by March (based on community feedback) **Long** • increasing the vaccination rates for pregnant people by 10% • Universal purchasing program for flu vaccine with adults • Work on MIIS/IIS bridge **Rhode Island** **CHALLENGE:** • The burden that respiratory season puts on pharmacies. • Not having an adequate supply vaccine • have dedicated time for pharmacists not being overwhelmed. • Independent pharmacies are overwhelmed because they are being asked for too much and the winter season is a lot of work. • Reimbursements are too low to get additional staff to lower the burden on pharmacists. • Pharmacists are hesitant to vaccinate lower age groups. • No local health departments • Pregnant People often defer to OBGYN for vaccines. • Vaccine hesitancy • LTCF do not report to IIS. • Direct data entry for LTCF requires a lot of staff time. • Identification of LTCFCs resident in IIS is difficult. • Pneumococcal vaccination rates in 65 plus are low.

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	● TDAP rates are low. ● Adult registry was not up and running until October 2020 ● PCP shortage **SUCCESS:** ● Pharmacy technicians can vaccinate in RI and RI is a universal purchase state. ● All birthing hospitals are enrolled in VFC. ● Independent pharmacy (public health hub) they do lead screening and vaccination, and they are now contracted with RIDOH. ● developed flyer for pregnant people describing what vaccines they need and why. ● They are translating material. ● Being a universal purchase state ● They provide data loggers to providers. ● Pharmacy technicians can vaccinate under supervision. **GOALS:** **Short** ● Flu rates for Pregnant people and pneumococcal rates LTCF. ● Distributing materials in English/ other languages that pharmacists and partners can give to pregnant people describing which vaccines they need. ● RIDOH will use adult framework funds to do QI project with OBGYNs (project should be up and running by flu season) ● RIDOH Diabetes program will be doing a QI with pharmacies and primary care providers to increase vaccination coverage. RIDOH developed flyers for pregnant people that will be distributed to partners and available online.

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	Medium ● Establish a Pharmacist Advisory Committee (mostly independent pharmacies). Since all independent pharmacies are enrolled in VFC and can administer vaccines to adults. The RIDOH can work with them to be stronger advocates for adult vaccines and determine what pharmacists need to be more comfortable and what does the community need to be more comfortable. **Long** • Increasing flu vaccine coverage in pregnant people to greater than 80% • Increase pneumococcal vaccination rates among 65+ in LTCF to greater than 80%. **Connecticut** **CHALLENGE:** ● Pharmacists are not considered providers and cannot charge admin fees. ● Funding from the program and community health ● Adults have to be very specific on which vaccines. The ones that are in high demand are not supported by the state (aka the flu). providers end up not offering vaccines which causes access issues. ● most adults utilize pharmacist - not recognized as healthcare providers and cannot bill for insurance - no admin fee and no consultation fee. ● Is there any uptake in awareness in going to pharmacy to vaccines for adults. ● Patient referral when they need to maintain the same product (men b and rabies)

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	• Vaccine Finder - data on where to get vaccinated. • Data is an issue - solid adult data to get funding for programs. • Lack of 317 funding for emergencies • provider standpoint - there is limited time (reactionary medicine and not preventive medicine) Preventative care gets pushed to the back burner - educational outreach will need to come from their community. • case managers for people 65 and older will be a resource for education. • basic education - people don't know what they are for or why you need them. • EMRs give props but it is a time issue. • other than flu there are not standing orders to provide a vaccine. • Scope of practice and standing order issues because they need a provider on site to write the standing order. • Pharmacists keep losing money on each patient. **SUCCESS:** • universal childhood program and would like to do that for adults. Leadership is buying into that concept. • recently passed leg to allow pharmacy techs to vaccinate • HE vaccination program to focus on how to talk about vaccine that are needed. • Lucky state and the data is looking good - blue state (buy in commissioner and governor) religious exemptions repealed, IIS required - strong legislative leadership - it 12 years to get back to universal for all kids. • Passionate partners • Pedi vaccines there are mandatory stops for schools - this makes sure that the bulk of pop get the vaccines. • Pharmacists fall under the board of pharmacy outside of the DPH - broaden the net even before the covid.

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	● Community health centers are a safety net - no uniform services are provided at local health dept. ● Pharmacist do not need a standing order for all ACIP vaccines. ● Minute clinics are involved in the VFC. **GOALS:** **Short** ● Set up a marketplace and find partners. ● getting leadership to buy in and establish universal program for adults and make pharmacies providers. **Medium** ● Pharmacy to become recognized providers - required for the universal **Long** ● Create a Universal Adult Program

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Adult Immunization Program Q&A What would you like to know from other programs?	VERMONT ● Q: Can providers bill for the cost of vaccines or administration fee? ● A: Vermont-if you have Medicaid, they can only get reimbursed if you are enrolled in the program, except for Flu/RSV due to the prep act. Some are not enrolled in the program due to the administrative burden on the provider. MAINE ● Q: 317 allocation plans? ● A: Most cost-effective vaccine to stretch the number of doses, but never actually spent all of our funding. So, we took our 317, and the number of sites enrolled, and asked the sites enrolled to pick what they wanted with the budgeted left allocated. It's been great for the providers for them to pick and choose what they need. We added RSV/COVID to their choices. ● Q:IS there an enrollment process for the 317 sites? ● A: yes, and we do site visits for all of them, some adult program sites require more handholding, ballpark around 100 sites that are enrolled, 50-60 that are actively stocking vaccines. ● Q:317 funding for education? ● A: If you have 317 funding, you can use it for emergency preparedness activity associated with a training or an educational institution and utilize that event to vaccinate at that event/activity. ● Q: What have you identified as a challenge with supporting LTCF? ● A: stakeholder engagement is lower than other community outreach efforts. Taking it back to the stakeholders to answer surveys on what can be done to support that group. Patient issues, outbreaks in the facility. Staff VS Resident issues, we are trying to protect the health of the

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	immunocompromised. The staff is burnt out and not prioritizing offering vaccinations to residents. QIO (https://www.cms.gov/medicare/quality/quality-improvement-organizations) that helps the nursing homes are trying to support the residents. ● Massachusetts Medicaid sees that it's more beneficial to focus on the residents on a LTCF than the staff. ● Recognition program, LTCF love banners, stickers, and publications, these are cheap ways to provide incentivization. This might also put pressure on other facilities that are not doing anything. ● One of the programs in Massachusetts, Vaccine Access Administration, virtual office hours to share problems and provide feedback to the public health department. This was for all community-based organizations that were involved with equity access and required support for providing vaccinations in their communities. There are also town halls that supported the same function to allow CBOs to connect and share their needs or challenges. ● Q: one of the bills from the pharmacy perspective, it will take place in November https://www.congress.gov/bill/118th-congress/house-bill/1770
Brief team report outs on	

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plans and next steps	**Maine** **GOALS:** **Short** ● Increase IZ rates at LT care facilities. Doing material review and seeing if they need to increase or change materials (e.g. translation). Are attending LT care conference - can engage facilities on what they'd like from core team. Connection with IIS. College exercise leveraging 317 (flu and COVID). ● Add ME PCA to existing IZ program calls with vaccinating providers. Caitlin will add Ben to the dissemination list and Ben will send to the membership. ● Ben will talk with colleagues about peer-to-peer between LTCFs about feasibility (Maureen). Already planned to recognize Ambassadors in November. Will chat with the team 7/26. Will also discuss possible q6mo training with DOH for IIS and other services awareness. Possibly add a poll to the webinar to help understand the needs. Plan to have the first one after the November conference. iPad w Doodle poll to understand needs. ● MEPCA fall conference– Ben will look into recognition of LTCFs with vaccination increases. Caitlin will register to exhibit at conference. Will bring tailored resources to distribute including IIS connectivity. ● MEPCA will provide IZ program with their info that is given to families about immunizations. ● Look at languages needed for LTCF staff and share with IZ program to provide translated materials. ● College EP plan: ○ Clear with PH leadership (Jessica will ask on call next week) ○ Jessica will contact her counterpart in PHEP. Will work to make sure the PHEP POD is also looped in.

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	○ IZ program will contact UMaine student health. ○ Expect PHEP will do the promoting and PHEP logistics except vaccines. ○ Caitlin will reach back out to CDC about additional 317 funding. ○ Jessica to tweet Stephen King about donating signed books as prizes. **Medium-Long** ● Focusing on universal adults - legislation this session. ○ Connect ME Medicaid with RI Medicaid regarding coverage for 65+ ● **MEETING DATE:** first weeks of Aug, Sept **New Hampshire** **GOALS:** **Short** ● Working with LT care facilities to increase vax rates for fall resp season. ● Outline the work and draft project charter. ● Get leadership buy in. hold educational sessions with LT facilities. ● Put out a survey for staff and residents. ● Continue current efforts to disseminate info (newsletters, meetings, etc.) **Medium** ● Use survey to understand barriers and opportunities → develop strategic plan **Long** ● implement strategic plan, what are quality measures in long-term care.

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	• MEETING DATE: 8/2 **Vermont** **GOALS:** **Short** • identify and find pharmacy to enroll in pilot. • Identify borrowing policies (what other states have this?). • Pull baseline Medicaid and IIS data on pharmacy administration. • GIS mapping data we already have to compare gaps and identify pilot pharmacy. • Blueprint for health • Heather will connect with them to see if TA for pharmacies is possible. **Medium-Long** • Remove barriers for pharmacies to participate in vaccination efforts. • **MEETING DATE:** Sept 24 **Massachusetts** **GOALS:** **Short** • look at data and figure out how to best track progress, bring core team. • Review immunization data that's available to understand which population or geography we should focus on (by September); we suspect that there are some hidden disparities based on PRAMS data. • For the IIS data, we'd have to use 18-45-year-old females as proxy for pregnancy.

Agenda	NOTES Take all meeting notes in this column
	• Increase flu/Tdap/COVID vaccination rates for pregnant people with Medicaid by 1) campaign 2) community engagement of vaccinator groups and communities 3) prioritizing AHEM locations for interventions (e.g., DPH Mobile clinics, etc.) **Medium** • Connect with different partner groups (focus on flu and tdap in pregnant ppl on Medicaid). • Promote vaccination in the ob-gyn space and work out measurement. • Utilize AHEM data work group for their support on getting MIIS/IIS to connect (for pregnant people) **Long** • VFA program - convincing people it will work. • The ultimate goal is for universal coverage for adults for all vaccines (i.e., crib to grave)., but realistically we would pilot a universal program for pregnant people for flu vaccines by FY26. • Enroll and engage OBGYNS ahead of the 2026 flu season, (could use DCE staff time, AHEM networks, etc.) • **MEETING DATE:** Wednesday, September 4th - 12p-1pm **Rhode Island** **GOALS:** **Short** • Complete development of outreach material for vaccines for pregnant people. • Send an email on Monday to follow up with comms about pregnancy flyer. • Once the flyer has been translated, then we can work with comms to get the flyers uploaded online. • Other translations can occur as requested.

Agenda	NOTES Take all meeting notes in this column
	● There is a meeting on Monday for the QI project. **Medium** ● Send an email on Monday to follow up with comms about pregnancy flyer. ● Once the flyer has been translated, then we can work with comms to get the flyers uploaded online. ● Other translations can occur as requested. ● There is a meeting on Monday for the QI project. **Long** ● Vaccine and pregnant people - get rates back up to 80%. ● Pregnant People ○ The QI project (meeting Monday) is a starting point. ○ Discussion with communication vendor is scheduled, we could discuss creating social media content promoting flu vaccines in pregnant people. ○ Ask ACOG and OBGYN offices to share social media content created by RIDOH. ○ Reach out to the OBGYN and ask them to share RIDOH created infographic with their patients. ○ Create a SoapBoxx for flu vaccination during pregnancy and send it to OBGYNs, partners, pregnant women to create promotional content. ● LTCF ○ Look at the healthcare worker survey to identify facilities with high and low vaccination rates. ○ High performers can be asked to promote on Soapboxx ○ Low performers can be reached out to and ask why they are not getting vaccinated. ○ Reach to family advisor groups for LTCFs and ask them to promote on Soapboxx ○ The family advisor groups can also encourage facilities to offer vaccines to the residents.

Agenda	NOTES Take all meeting notes in this column
	● **MEETING DATE:** July 30th at 10am (in-person) **Connecticut** **GOALS:** **Short** ● connect with partners. **Medium** ● create a marketplace that includes all vaccinators - list FQHCs, where people can set up clinics. ● Explore model with Walgreens (voucher program for flu). ● Speak with pharma companies re: reimbursement for vaccines - explore if these can be included in a clinic model. **Long** ● See if clinic model works and explore universal program. ● **MEETING DATE:** Aug 27, Sept 10 (with CMOs)