Vaccine Access Cooperative Regional Meeting for Adults
Frontier Heartlands Regions
June 25-27, 2024

MEETING NOTES

PowerPoint Slides: https://www.immunizationmanagers.org/content/uploads/2024/07/Adult-VAC-Frontier-Heartland-2024.pdf

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

June 26, 2024

Agenda	NOTES
Setting the stage: Adult Vaccine Landscape in our Region	Level-setting for attendees and sharing back the information that jurisdictions shared with us. For anyone still wondering what VAC is and why we're doing it - came from funding from CDC to improve COVID rates among children. Bring together agency partners across jurisdictions to sit at the table and work through strategies to increase immunization rates. Last year we convened 63 teams in eight regions; pharmacists, pediatricians, public schools, Medicaid, and many other partners made up the teams. Six months later, more than 60% were still meeting. This year AIM used CDC funding from our cooperative agreement to fund the meetings to bring people together to discuss adult immunizations and increasing rates.

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	Adult Vaccination: The cost of adult vaccine-preventable disease on society (not including COVID) is approximately $26.5 billion (adults 50+) The UK looked at 14 developed countries including the US and found that they can offset the cost by 19x with a robust vaccine program. These are the kinds of numbers that speak to people (legislators, funders, etc.) Very complicated system in the US and a lot of trust issues around immunizations. Paying for vaccines is very confusing and not easy to navigate, especially Medicare Part B vs. D. When people are unable to get vaccinated at the point of care, they are less likely to go seek vaccination services after. Medicaid non-expansion states have approximately 2 times as many uninsured as expansion states. Approximately 21 million people have lost Medicaid coverage and less than 50% have been re-enrolled. Some will go through the marketplace for insurance, the others will most likely remain uninsured. Medical providers are burned out, storage and handling are complicated, vaccine confidence is super low, and providers tend to think “I don't need to do it, someone else is doing it” but they aren't. Vaccines for pregnant people are becoming more and more complicated and more vaccines are now recommended. Frontier Region data - doing great with adult immunization rates and are at or above the national average in most cases. Talk to each other and talk to those who are doing better than your jurisdiction to see what they are doing differently.

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	Heartland is also doing very well compared to the national average. We asked you what the top three challenges are: 1) funding (to purchase vaccine or operations), 2) access to vaccine, and 3) hesitancy. There was a study done that showed you can increase rates by addressing access way better than trying to debunk misinformation or trying to curb hesitancy - Shelley to provide the link to the study. During this meeting, you'll want to ask yourself "what can we do and where do you want to start?" Role of adult vaccination is HUGE - do you want to focus on a certain population (age group, pregnant people, etc.), do you need to do something around infrastructure at the provider level (changes to billing practices, working with Medicaid for funding, etc.).
Asian Community & Cultural Center: Serving Immigrants & Refugees of ALL Backgrounds and Celebrating Cultural Heritage	Speaker: Nilofar Saidi, Health Grant Coordinator – nilofar@lincolnasiancenter.org Lincoln Asian Community and Cultural Center • Has several programs. Worked in the community for over 30 years - the large influx of refugees after the Vietnam war coming to Lincoln, NE has a long history of being a welcoming state- many refugees 30k. In Lincoln (10% of pop in Lincoln). Asian Cultural Center really started in the 2000s. • Main 7 programs, family resources, youth program, senior, culture advocacy. Family resources - do many things, help find a job, have classes on immunization, career support. Youth program - mentoring in middle and high school. Goal setting,

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	scholarship assistance, college visits, cultural clubs. Storytelling program. Elders program - Vietnamese, Korean, Chinese, African groups. Health outreach and education, social and physical activity, exercise classes. • Health education advocacy program - chronic disease management, nutrition, health education, home visits, peer support, breastfeeding education, • Vaccine outreach and promotion work - provide translation and education. Working with health dept and care providers to reach immigrant and refugee communities. Do videos in non-English languages, an advocate is from the community itself, so each language of the community - shares info in that language. Case management, home visits. • Many were able to receive vaccine at a location they felt comfortable at. Vaccine clinic - public spaces and houses of worship and invite community workers to them and advertise vaccination. • Each community has their own connection (Facebook, social media) to connect with others. To reach out, work with the health department to reach out. • Org has grown a lot in ten years, now about 30 from 4 - over pandemic time. Had a partnership with Healthy Lincoln who received REACH funding, asked the Asian center to expand their programs. Trusted messenger for each community is different. • Helped communities sign up to get vaccines in a location that makes sense for them, created a partnership with an urban institute from 2021 to 2024 - and worked to change minds of those who were vaccine-hesitant. Using knowledge and relationships to learn why the community didn't trust vaccine. MHI - minority health initiative to do

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	community health work. Worked with health department to provide services to refugee and immigrant communities. • Immunization outreach - translation resources - advocates working hard - receive a lot of resources from CDC and need to pick what is culturally appropriate for each community. Peers share stories with each other. Information comes from those in the community. Focus group for each language - successful. Speak in their language and share concerns. Provide resources for groups such as videos. The key success of the center is the focus groups. • Challenges - funding from the pandemic is ending or has ended, which will impact immunization work. Health education advocacy programs will continue, and some targeted work might change. The challenge is to continue working with vaccine-hesitant communities. • Important to have community organizations at the table when making plans because they can provide a diverse approach as they know the community they serve. Trust community advocates as the experts to bring education and information to their community. Have social capital to do the work. Hard to find speakers or providers who speak the community language in Lincoln. Questions: Q: NE - Community-based organizations are the main way you reach out to communities - how many organizations are there in Lincoln? • Not sure exactly - there are some culturally specific centers, among others. We are a community-based org and usually people reach out to us At Asian center have over 43 partnerships in the community. New Americans task force - over 40 agencies meet

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	monthly and share updates on new arrivals, school enrollment, and work. Partnering with those who speak the language will extend the reach of work already being done. How are they funded? Through many different things - over 40 grants to fund the work we do. Some direct, some pass-through. (CDC, Urban Institute) Q: Claire - Federal funding through Urba - is that ending? • The partnership was for 3 years 2021- 2024 so just finished. There was some federal funding across the country which is ending - focused on COVID vax helped develop awareness and education around immunization (this comment was Claire not speakers). Q: Are you a part of a larger immunization coalition? Have connections to statewide coalition? How do you get the message on immunization along with other priorities? • A local connection, not at this time a part of state coalitions. Q: CO - funded so many organizations during pandemic - what would be helpful if not have money, what can states do to make sure partnerships are sustained during low funding? • Continuing to meet - can be easy for partnerships to dissipate when structure ends so continuing to reach out and talk about needs and resources. Also with staff turnover, institutional knowledge was lost, and we have lots of rebuilding.
Overview of the Success Framework for Adult Immunization Partner Networks	Recommended actions are needed for awardees to develop strong partner networks that can have the maximum impact on addressing adult immunization needs and advancing health equity. ● Strength: being action-oriented and purposeful ● Defining partner network ○ Working with the collaboration of groups at the community level ● Partners: can be informal or formal with internal or external entities ○ Examples: government agencies, tribes, and tribal entities, health-related entities, local entities

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	○ The partners will vary based on the needs of the community your immunization program is serving. ● Success framework for adult Immunization partner networks created in 2022. ○ Graph of the lifecycle of partnership management ○ Consider nontraditional partners when using this tool as well. ○ Four phases of the partnership management life cycle ■ Define goals and priorities. ■ Expand organizational capacity. ■ Advance activity implementation ■ Evaluate and learn. ● View PowerPoint for links to resources and examples for the different phases

Team report outs on discussions and developing strategies	Nevada: Challenges • Access, oversaturation of COVID-19 vaccine messaging, transition to focusing on flu vaccine messages. Goals • Short: increasing adult vaccine access and influenza vaccination uptake. • Medium: work with LTC facilities • Long: Pharmacies as the main access for adult vaccines Successes • Partnership with LTCF in healthcare. Compliance licensing and finding partners to vaccinate when the need arises. Can be tricky to navigate since it's not a one-size-fits-all all but has been great seeing partnerships flourish. Also, consistency by showing up at the

	same place regularly, people see the same face and know where to go. Early in the pandemic learned to not show up to Hispanic events in a white van due to linkage with immigration services. • We built a lot of partnerships during COVID-19 - the challenge is maintaining the relationship as we are not able to fund them anymore. Identified strong partners in rural counties. • The health district in Las Vegas included candy as a reward - for the homeless, helped to keep people involved and incentive made a difference. Utah Challenges • Funding for adults - there will be special projects funding so fall on state funding with no 317 funding there will be no projects. Though we never had access problems. Thinking of rural parts • Having insurance in some cases or not having insurance in many cases can provide access barriers • Red tape around funding related to vaccine fatigue • Utah- not required to report into the registry, no one place to look up adult vaccine info, no demographic data included, can't see who we are missing • NV- IIS does not collect pregnancy data, and does not have the most complete data • Big chain pharmacy relationships are a challenge • Nevada Coalition was defunded, the small waiting period before establishing a new one • In Utah- FQHCs don't offer adult vaccines • Bridge funding going away- gap for uninsured coming for all states soon • Access- Utah would like more data to understand the access issues Successes • Partnerships with LTC facilities, QIO and community partners is huge • Building trust within communities is key, example do not show up at a Hispanic event in a white van, can be associated with immigration enforcement

	• Capitalizing on relationships/ vaccine champions in rural counties • Immunization Coalition in Utah is good • Immunization Coalition in Nevada WAS good, new one needed • Pharmacy relationships in Utah are great, Associated Foods received their vaccines from the State and they still maintain those relationships (hundreds of pharmacy locations in Utah) • Financial incentives didn't work, but transportation vouchers did ○ Since COVID, registry in Utah connects with more providers Goals Short • one is access. like to know and have data on access. strengths and weaknesses, then work with the adult coalition and eliminate access issues. Will take that to heart on research access. Instead of focusing on COVID-19 - not going to get bigger - with flu is what brings a lot of our issues, so short-term access. Flu for sure. like an option for getting the flu, then suggesting COVID. unsure what to do with COVID-19. • assisted living -can get flu and pneumonia, cannot get COVID, must send them to pharm for that. • Look at the data to understand access issues, drill down to understand, is access or hesitancy. • Increase access for Flu & educate about other vaccines • Access is not just location • Pharmacies- support, educate on coadministration • CEUs for pharmacist education Medium-Long • need pharmacy workgroup - trying to start something -started working with Utah pharmacy association and they sent out to their partners. Work on Medicaid part D next. • Pharmacists get upset when hearing they have not had enough training. It's so fast-moving and can't just stop training.

	• have our dentist's recommending HPV but that's about it. Data is an issue - do not get demographic data. if not required to report, and if they do, then it's just the person and vaccine - don't know demographic info. Populations or zip codes we are missing. It would be nice to have that data. with associated foods, they are in some low-income areas, showed data about uninsured in the area, and said they could have people coming into the store if they carried covid. Kansas Challenges • Funding for actual doses, Funding for vaccine purchase, Lack of Medicaid expansion, Access to vaccines in a medical home setting, Dis/misinformation. • Some providers have stopped providing. • Provider fatigue • Still some residual problems from people feeling providers are "sneaking" COVID vaccine. • Providers are leery of all vaccines due to the backlash surrounding COVID. • Staff turnover/shortages of vaccine champions in the primary care setting • Transportation in rural areas • Health ministry care coordinators are acting as transportation for community members. Successes • We have a high demand for free adult vaccines, Clinics are asking for doses because patients are asking for it. • The positive is there is a high demand, however, the challenge is that there is a low supply. • Coalition building of like-minded people. • However, it is very hard to get providers to engage. • Increased engagement with pharmacists to improve vaccine access. • Policy & legislation: • Failure of anti-vaccine policy

	• Pharmacy techs able to administer vaccines.
	• "Poaching" – providers suggesting vaccines to the entire family when one family member may have an appointment.
	Goals
	• Short: discuss ideas for the interprofessional group to focus on
	• Medium: identify champions of different players in the environment to invite to the collaboration meeting.
	• Long: establish a professional collaboration with a big meeting with all partners to have a conversation on adult vaccines, collaborations between FQHCs and pharmacies e.g.
	
	Missouri
	
	Successes
	• Collaboration with pharmacy association- gap closure project (funding them to do a gap closure through MedSync, incorporating community health worker data collection for immunizations)
	• 27k interventions are a big success.
	• The COVID money helped, it got more adult providers thinking about COVID-19 vaccination, however, it's not sustainable. They need a VFC program for adults, with less red tape so we can increase access.
	• MO managed to enroll 1 pharmacy for the vaccination clinic and created a pilot program on getting adults vaccinated.
	  ○ 400+ providers submitting interventions, CHS, and pharmacists.
	  ○ They need to go through training and
	• 1 type of education for adults in clinics, providing education and addressing routine conversations 5–15-minute MedSync call. Over 25,000 interventions, with data on 18,000, have shown a 10% gap.
	  ○ Bringing awareness to the public during their routine visits.
	  ○ The next phase is education and vaccination clinics (homebound visits, after-hours pharmacy hours, vaccine desert area), health equity incentivizing the visit.

	- Next phase, support coordinating your vaccination at a local pharmacy close to you, it doesn't need to be COVID-specific, it can be for any vaccination or health check. - Created a data sheet for the patient plan, to review the proper documentation and QA. - Public health has always been a space where there are a lot of silos, and immunization is overlapped, but seems there's a lot of competition. - Educating VIA Zoom with webinars was a success in the past but not any longer, people are not paying attention. Challenges - Several - increasing provider education. Not adequately trained, A lot of reports on adverse effects, etc. That boils down to education. Reaching providers where they are is important. Vaccine confidence studies were conducted. Barriers are providers only seeing patients one or two times a year. - No handle in MO on how many people are giving immunizations. Don't have eyes on how many providers provide and carry vaccines. - MO believes that 50+ are vaccine-hesitant, and the millennial generation is more hesitant, not only because it's not being recommended or there's not enough data on the science and providers don't know how to explain this to patients. Misinformation or lack of correct information. - Various systems are in place that are not updated routinely, and they don't all speak to one another. It can feel like information overload. - Last year we had a handful of new recommendations and brands for vaccinations without direction. - As an example, Walgreen's protocol is not up to date, so they communicate an outdated protocol, to people who are looking to get vaccinated, but it can be incorrect information. - If it's coded correctly, for adults the pharmacist will not spend time explaining the vaccinations available to patients. - We have pharmacies that do LTC and COVID, but MO is not a mandated registry. There is a law that requires the pharmacy to ask the patient for consent to report their vaccine

	data. This is a small group. • A lot of pharmacies keep the registration of vaccinations. • Hearing from providers, that TDAP vaccination will go to the federal registry, which does not exist. • No Strong statewide registry that pulls in all the vaccination data to review. • Each EMR system is costly to run for each provider, they do not see it as valuable. • Technical support would be a standard requirement from the CDC for accountability on the EHR side. Meaningful use funding for providers. • Not just an email or toolkit but a meeting to discuss products and the standards. • Merit Incentive payment system, CMS program - they will get more money if they can get various qualitative activities to receive this incentive. • Support, what would be helpful is to work with their EHRs to meet all their IISs'. Goals • Short: Reestablishing the ACCI, (advisory committee of childhood immunizations) • Figure out the systems involved in connecting with community-based partners. • Medium: Building community partnerships that were either developed already or will come with the vaccine gap closure • Execute outreach to the partnerships. • Identify barriers with a bidirectional referral (Pharmacy to CHWs), a "closed looped process" from partners to prepare for the stakeholder. • Create a survey to send out. • Long: Develop ideas to plan a referral process around barriers, bringing stakeholders to the table to align on what would work for their county • List possible referral processes to have stakeholders(partners) develop. Oklahoma: Successes • Have 124 providers in the 317 programs, have a new IIS, and established a new mobile unit. • getting interest from providers that reach uninsured and underinsured, community health

	providers, etc. • can't have that large of a network that funds all the types of vaccines available, need to pick top 5. • looks like TDAP, hep b, MMR, varicella, and polio for the 317 funding. • community events- meet with different nonprofits who want the IP to provide resources. • groups who want to provide partnerships (getting face out there)- provide resources on diseases, where to find their records, etc. • moving OSIIS has been a great success- good reporting through the system. • has all big pharmacies (opportunity to work with health access networks) • underserved populations: been trying to serve but they don't have the right qualifications for having Medicaid. • have increased work with managed care organizations (contracted entities) • LTC facilities store and administer vaccines- organize "shot" days, about 270 LTC facilities in OK. Challenges • access and funding, challenge reaching rural areas with limited participation from providers, education across the board. • Funding- access to vaccines, large population on Medicaid, do the providers do not know they can bill to Medicaid, the providers aren't purchasing (where OK wants help) • provider recommendation is the best route, people might not trust pharmacists. • rural only have mom-and-pop pharmacies. • higher uptake in FQHCs • more access points in metro areas • tribal communities: purchase their own all on the VFC program. • curious about if the AI/AL data is complete. • current EHR • IIS is great- moved into new system in 2020 (envision • have 1300 providers feeding into IIS. • registry isn't mandated- only thing mandated is federal vaccines. • have been working with the state HIE.

	• providers have to pay to be a part of it. • data has big gaps. • big population of people who have submitted exemptions for kids. • legislative landscape: a few things that didn't go anywhere (wanted to take away state health department to manage exemptions) • want to do a communications campaign to educate providers on how to buy. • no coalition in OK (only one in Tulsa) • Is there a way for providers to share their purchasing? • in the VA system, they had to set up their own special fridge with digital datalogger etc. • rural clinics concerned with costs of monitoring (staffing costs, supplies costs) • IP staff can help FQHCs figure out emergency protections for vaccine storage. • 500 providers on VFC • education about the immunization program for healthcare providers— there is potential for major savings if they work with the immunization program. • only just started having an adult program coordinator during covid • gaps in patients knowing where to get their vaccines. Goals • Strategies: educate about the immunization program • Work with LTC to develop stronger partnerships and the economic value of increasing vaccinations for their patients. • Provider education: increasing the buy-in for purchasing by making sure they understand how they won't lose money. • Contracted entities education: look at Managed Care and how they can support provider participation. • Set up a meeting with all the partners. • establish the core group to build buy-in for the education campaign. • create a short PPT with the Oklahoma data to show the need for the project. • develop or find a persuasive "champion" who can speak with potential partners. • create a mission statement/summary with the core group once it is established that helps

	describe the group. • iron out any data-sharing agreement needs. Colorado: Challenges • CO doesn't have a convening org around adult vaccines currently, limited 317 funding, this year has had multiple outbreaks (saved by state funding), maternal vaccination partnership has been hard with ACOG, doesn't have a maternal vaccination coordinator, haven't taken steps to enforce reporting requirement for IIS, gaps in data, FQHCs are hampered by bundled payment model, LTC was very active in partnering during COVID but that has diminished Successes • state-wide IIS-based reminder/recall campaigns which has helped with the 65+ population around flu, robust reporting in the IIS, building and implementation of a mobile public health clinic program (community partners can request services), have some state funds to support immunization programming, working through the adult immunization framework pilot. Strategies • partnership building, try to do a Colorado "VAC," build a champion in the ACOG space for a better partnership, and convene partners about vaccine confidence (identify partners) to discuss a strategic plan. Goals: Short • Use CIIS to identify providers giving Abrysvo to identify champion(s) in OB-GYN network. • Identify providers giving adult vaccines to identify champion(s) for partnership. • Draft contractor position description for adult framework coordinator.

	• Hire adult framework coordinator.
	• Build partnership inventory spreadsheet with contact information.
	• Hold internal planning meetings with our core group: July 10th and July 23.
	
	Medium
	• Conduct survey with partners to identify barriers and successes with adult vaccination.
	• Plan and facilitate initial adult vaccine meeting with identified engagement partners - Colorado Adult Vaccine Collaborative (COVAC).
	• Gather data sources with Colorado-specific adult vaccination data.
	• Identify top priorities to tackle as a work group with partners.
	• Schedule recurring calls with partners.
	
	Long
	• Develop implementation plan and activities based on input and identified priorities from partners.
	• Not directly in plan:
	• Greater transparency from vaccine manufacturers, distributors and wholesalers on distribution of commercial adult vaccines
	• State Immunization Conference for immunizing providers.
	  ○ Vaccine confidence
	  ○ MMR
	  ○ COVID-19
	  ○ Vaccine research
	  ○ School located events
	
	North Dakota:
	
	Successes
	• have an adult program, during covid develop relationships with pharmacies, FQHCs, LTC, etc.

	Challenges • Since they had funding during COVID, the current support system is weakened with not enough funding, LTC reimbursements, pharmacies signing up for Medicaid provider status, don't work enough with groups to educate. Goals • Short: use current partnerships to educate specialty clinics, etc. Reach more provide through Medicare providers. • Provide blanket approval for all pharmacies. • Serah Lead* Idaho example • Communication more vaccine message using Medicare, 12 grade reading level when messaging for providers. • Medium: get providers excited to talk about vaccinations, • Long: connect LTC emrs with IIS. South Dakota: Successes • launched new IIS in 2023, mobile clinics program, good immunization rates for LTC, and good partnerships with pharmacies. • LTCF - they are doing so well because they think it is law that they have to vaccinate, and it is one of their QI measures. They must offer by law. • Giving shots in the facility helps with the high rates. Strong relationship with pharmacies. (how can this be repeated in other areas?) • for COVID they were number 1 for a long time they had an acceptance rate of 90%+ • Started a competition between ND and SD has helped. • H1 and COVID-19 there was a good partnership with the hospitals and public health. Challenges • lack of resources and capacity, need more infrastructure for adult vaccine programming.

	• No program at the state • do not do much with adults - there are no federal funds to do it, but it would take federal funding. • Never really concentrated on adults but have done some flu as part of the preparedness programs. • Medicaid expansion could help - it's always been a payment issue. • Lack of awareness - patients don't know about the vaccines (vaccines are for children) • Lack of access - no providers or the time it can take to get too long to get care. • Rural makes it hard to access. • Public health nurses are not considered preferred providers, so the mobile units are not covered by insurance. • DOH medical director is out of networker for many plans - may not be a preferred provider. • There are several areas with no public health nurses. • There are many hoops with payers - what are the benefits to the health dept.? - How do you become a preferred provider in the health plan? • Cost of vaccines - clinics don't have the money to purchase ahead and don't get reimbursement. • The Amish community is anti-vax. • College campus - this is the first time college kids are making decisions for themselves. • no Meng college requirement • there is no way to close the loop to see if the provider recommendation resulted in a pharmacy giving the vaccine. • There is no one coming to the table. Strategies • Mobile unit - Austin has a successful program. • CPESN - pair the pharmacist with payers. • easy vac app by GSK - can tell people where they can go for vaccines. • College campuses • Seniors

	• Launch EasyVax.
	• Money to CHW to do IZ work.
	• Find a grant for the CHOP adult vaccine group for public health nurses.
	• create partnerships - the mindset is challenging.
	• The coalition needs additional funding to help grow the coalition.
	• Reminder recall with Lewis Pharmacy (check on the sate do not call list)
	
	Goals
	
	Short
	• EasyVax
	• Dani to read emails from Demo.
	• Develop outreach plan.
	• write a newsletter (on lack of access and why it's important)
	• share on social media.
	• rural health equity summit is an opportunity to disseminate.
	• AAFP conference
	• recruit partners to help disseminate.
	• Develop a tracking plan.
	• add an evaluation plan.
	• Grants for CHOP Resources or printing
	  ○ This will be added to the carry forward plan.
	  ○ added as a bi-monthly agenda item.
	  ○ wait until after ACIP for the 2025 version.
	
	• Brainstorm/list ways to work with PHN.
	  ○ Mapping of the deserts - find the gaps and fill them in where needed.
	  ○ share the CHOP book for the PHN to hand out at visits for the mobile units.
	  ○ Work on having them become a preferred provider in small communities, they are the school nurses and find out how to help.
	  ○ have more resources available for them.

	○ have education on vaccines. - UH CHW vaccine course ○ train to become champions. ○ Develop a relationship to be able to get a foot in the door when needed. • Explore more partnerships. ○ tribal ○ Path person - Dee to send the name to Dani. ○ AAP ○ AAFP ○ IHS ○ GPTLHD ○ QIOQIN ○ CHAD • ISD Strategic Planning input ○ Dani to reach out to schedule with Dee and Tim Medium • Senior and other adult outreach - CBOs ○ Dee to provide the outreach list for senior centers and best contact. ○ Information on eligibility ▪ newsletter ▪ infographic ○ Reach out to identified possible partners. ▪ Continue from the short-term list for outreach and contact. ○ Meet with CHWSD to explore collaborating. ▪ make a meeting with Ben to set a date. ▪ develop what to talk about (use the list from the public health nurses) ○ How can they be paid (Medicaid reimbursement) ▪ Collaborate with Tribal Health ○ monthly calls ○ find out who the tribal health official is.

	Long
	  o College Campus Outreach
	  o SD Families for Vaccines
	  ▪ They are working with colleges.
	  ▪ continue outreach for orientation.
	• Curriculum Development
	  o Brittney Mayer at SDSU
	  o find Nursing Program coordinator for on-campus clinics.
	  o Pharmacy students may need help as well.
	  o Augustana University (Auggie)
	  o University of Sioux Falls
	  o West River AHEC - Jennifer/Lisa
	• Support expanding mobile units.
	  o more vaccines available
	  o more units
	  o This is dependent on community health nurses.
	  ▪ This will require building the relationship with the PHN and seeing how it goes over the year.
	  ▪ be available as a resource.
	  ▪ refer people to the units if you hear groups need vaccines.
	• Funding for CHW engagement
	  o Tim - to look for other funding opportunities.
	  o leverage other funding.
	  o see if CHIP is being written to add it in as an item.
	• Growing ISD to support DOH Immunization program capacity - diverse funding means less DOH oversight, more freedom.
	  o Find grant funding for growth.
	  o connect to other state coalitions for brainstorming funding.
	Nebraska:
	
	Challenges

	• Long-term care participating in data tracking, pharmacies getting enrolled in Medicaid. • Hard to get medical directors/providers at LTCF (esp. rural) on board to vaccinate (6% staff, 33% residents) • Not active with medical dirs. Assn in NE currently • Pharmacies are very busy and understaffed, so screening doesn't always happen. • Payment for pharmacists, DIRs, insurance isn't paid. • People don't understand how vaccine coverage works. • Not sure if Bridge has had an impact in NE. • HRSA payments to pharmacists for administered vaccinations were delayed. • Pharmacies are not recognized as Medicaid providers. • All immunizations in pharmacies are pursuant to a physician's prescription. Successes • LTCF standing order to vaccinate. • Hospital employee health • Hospital employees are required to be vaccinated. • NESIIS patient portal via QR code (started June 10) Goals Short • education materials for adults on where to get their records (phone apps) • Coalition to lobby the legislature for funding to purchase vaccines for adults– medical association, pharmacist assn. Bill drafted by Dec 1. AIM– assist with finding language for state vaccine funding and the economic case for vaccinating adults. • Already connected IZ with hospital associations, medical associations, and health care associations. • AIM webinar (with ASTHO?) to include PMs and SHOs about the importance of funding VFA. • Public awareness of NESIIS– getting partners to publicize. FAQ page for NESISS– has

	monthly meetings with that team and will let them know that the FAQ needs to be developed. Also, need translations within 6 months. Medium • work with larger employers to increase vaccination rates. • Mpox initiatives (community education/awareness) and working with LPH. • Education for larger employers– The VFA coordinator at IZ program could reach out to major employers with the case for ensuring vaccination and making sure employees know where they can be vaccinated. Start with state employees? • Education for LTCF staff– talk to Jalene Carpenter about starting an initiative (Dr. Anthone) Long • work with Medicaid to increase pharmacy participation and focus on access and education.

June 27, 2024

Agenda	NOTES
Adult Immunization Program Q&A What would you like to know from other programs?	**Q: Have any states had success working with the Medicaid Program?** • CO: Before COVID, NASHP facilitated a community of practice for Medicaid programs and immunization programs to work together on certain things. CO was fortunate to be selected to participate and focus on children and pregnant women. The CoP helped bring agencies together. It was hard to do that before. Recurring meetings were set up and CO still meets monthly with our Medicaid partners. We built some infrastructure from that CoP just around data sharing and data visualization, so we used Medicaid data and regional accountable entity data and matched it to IIS and were able to

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	generate rates and maps and shared it back with them. Through COVID too, data partnership was enhanced. Also helped CO identify Medicaid providers who are billing for well-child visits but were not part of the VFC program. Helped us identify providers who would be a good fit for VFC. • **Nebraska:** Medicaid plans are being rewarded for immunization rates. That is one of their priorities in Nebraska and one of their quality measures in Nebraska. Great to partner with them. • **Kristy**: AIM has resources as well. Talking points for working with Medicaid. Currently, we are working with four states providing technical assistance to really help them work with Medicaid whether that is creating data-sharing agreements or even trying to streamline the actual data-sharing work. We are slowly starting to build more resources for you all to be able to move those to really build those partnerships. • **MO:** sharing a program in Missouri that is replicable in every state and it's also replicable with other chronic disease management or gap closures in quality measures. It is focused on vaccine gap closures using pharmacists and CHW in a phased model. They started looking at education and workforce development, infrastructure, and pharmacies and so the first phases are open right now. They are built around pharmacies that have a MedSync program. Pharmacies already have a process for touching base with patients every month and so they built in that MedSync program a longitudinal education process. You are going to your pharmacy already consistently and you have that touch point.MO built in a 5-to-15-minute vaccine education and hesitancy counseling discussion into that MedSync call. First, they do an eligibility check to see what they need to be vaccinated on and what the gaps are and then CHW follows up every month really looking at it from the social determinants of health and access lens and then motivational interviewing not necessarily from just looking at a clinical knowledge or misinformation lens. To date (June 27, 2024)-over 27,000 interventions as of January 2 submitted by pharmacies and CSWs in our state and at

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	the end of May we had 18,000 with a 10% gap closure rate. (more discussed as well on other phases). Replicating this in Virginia with long-term care patients. **Q: Who are the CHWs?** • **MO**: Pharmacy technicians are becoming CHWs. They are already connected with patients, understand the pharmacy workflow, and are already usually doing those MedSync calls so now we're just plugging in a lens of HealthEquity social determinants of health and the five-to-15-minute motivational interviewing. In Missouri pharmacy technicians basically need to have their fingers printed and submit an application to be registered technicians. There's no certification, there's no education requirements so becoming a CHW also provides a kind of a level of purpose and career path that isn't there right now in this space. **Q: How are you incentivizing these providers?** • **MO:** CPT code that's 5 to 15 minutes and the average payment for that if it's currently turned on for your state for people to bill CMS or Medicaid is about $25.00. MO is a $25 reimbursement for five to 15 minutes and then the third phase which is the care clinics which is the education- built off that CPT code with the same reimbursement and the vaccine clinic itself and the vaccine gap verification that's $100 and then the HealthEquity reimbursement for uninsured and underinsured patients it's $125 and we took the cost of vaccines and figured out like if they were going to give the most expensive vaccine to all uninsured and underinsured patients what would cover that cost. Pharmacies could not have billed this in any other space so through this we can. **Q: did you work with your quality improvement organization for this project**

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	• **MO:** No, but we are in Virginia. HQ I came to us about this project in the nursing homes in Virginia, so we were able to do that. Missouri just changed over QI programs for the 4th time we are not familiar with the people there. • **MO to share documents on this process with AIM. It can then be disseminated as requested.** **Q: Claire**: How are you using your 317-vaccine funding for this coming fall without an increase and with adding COVID and RSV are you a. not purchasing COVID or RSV because you do not have any additional funds or b. purchasing less of something else such as flu to purchase some COVID and or RSV. • **MO:** We are purchasing COVID, but we did not put it in our CNET. the amount of COVID that we estimated that we ordered for the last year. Typically, when we figure out our numbers, we look at the actual order for the last year and then we add 10% to that. And that is how we typically have always put in our 317 numbers by vaccine. For example COVID we ordered 14,000 doses last year but for COVID in our spent plan this time we are only doing 2500 because when we put in using our actuals plus the 10% like we've done over the last several before adding COVID and RSV just for the routine vaccines we were over the budget by $200,000. When we added in our actuals for COVID and RSV we were $900,000 over budget. So to add RSV and COVID we had to make some serious cuts so just looking at FY24 to what we're entering for FY25 for example we are decreasing the number of doses of Hep A by 1400 from what we had in last year's, not purchasing Hep B, our HPV is being decreased by 200, MMR from 950 to 250. We are decreasing al lot of other vaccines. • We are out of 317 funding. We have been for about 3 months. **Q: Claire**: **What if you have an outbreak?** • **MO:** We could tap into the emergency vaccine funding like for example we're talking

Agenda	NOTES
	about flooding right now and we have providers already reaching out about Tdap vaccines and we can't provide it but we can put in a request for additional emergency vaccine funding but that could take some time. • **CDC(Nathan): I**t should not take weeks especially for vaccines to come in. Agree that funding has always been a challenge. **Q: How does the CDC plan around emergencies and Ops. funding** • **CDC**: We try to get funding from wherever we can. No special calculation. When funds run out, they run out. That is why limitations are placed on how much a jurisdiction can order.
• **Brief team report outs on plans and next steps**	Nebraska: Goals Short • start to coordinate more around their tracking system. • Get an FAQ resource set up. • Collaborate with community-based organizations on this. Medium • work with larger organizations to get vaccines out. • Bigger things: work with LTC to improve metrics, develop incentive programs, and gather tips from the top 10% of vaccine administrators to develop educational resources. • Build relationships with legislators to get more state funding for vaccinations. • Aug. 1 is the next meeting.

Agenda	NOTES

	Long
	• Pharmacists recognized as Medicaid providers for VFC/VFA
	
	South Dakota:
	
	Goals
	
	Short
	• EasyVax
	  ○ Dani to read emails from Demo.
	  ○ Develop an outreach plan.
	  ○ write a newsletter (on lack of access and why it's important)
	  ○ share on social media.
	  ○ The rural health equity summit is an opportunity to disseminate.
	  ○ AAFP conference
	  ○ recruit partners to help disseminate.
	  ○ Develop a tracking plan.
	  ○ add an evaluation plan.
	• Grants for CHOP Resources or printing
	  ○ This will be added to the carry-forward plan.
	  ○ added as a bi-monthly agenda item.
	  ○ wait until after ACIP for the 2025 version.
	• Brainstorm/list ways to work with PHN.
	  ○ Mapping of the deserts - find the gaps and fill them in where needed.
	  ○ share the CHOP book for the PHN to hand out at visits for the mobile units.
	  ○ Work on having them become a preferred provider.
	  ○ in small communities they are the school nurses and find out how to help
	  ○ have more resources available for them.

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	○ have education on vaccines. - UH CHW vaccine course ○ train to become champions. ○ Develop a relationship to be able to get a foot in the door when needed. • Explore more partnerships. ○ tribal ○ Path person - Dee to send the name to Dani. ○ AAP ○ AAFP ○ IHS ○ GPTLHD ○ QIOQIN ○ CHAD • ISD Strategic Planning Input ○ Dani to reach out to schedule with Dee and Tim ○ working toward the late summer goal of meeting Medium • Senior and other adult outreach - CBOs ○ Dee to provide the outreach list for senior centers and best contact. ○ Information on eligibility ○ newsletter ○ infographic • Reach out to identify possible partners. ○ Continue from the short-term list for outreach and contact. • Meet with CHWSD to explore collaborating. ○ make a meeting with Ben to set a date. ○ develop what to talk about (use the list from the public health nurses) ○ How can they be paid (Medicaid reimbursement) • Collaborate with Tribal Health

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	○ monthly calls ○ find out who the tribal health official is. Long • College Campus Outreach ○ SD Families for Vaccines ▪ They are working with colleagues. ▪ continue outreach for orientation. ○ Curriculum Development ▪ Brittney Mayer at SDSU ▪ find a Nursing Program coordinator for on-campus clinics. ▪ Pharmacy students may need help as well. ▪ Augustana University (Auggie) ▪ University of Sioux Falls ▪ West River AHEC - Jennifer/Lisa • Support expanding mobile units. ○ more vaccines available ○ more units ▪ This is dependent on community health nurses. ▪ This will require building a relationship with the PHN and seeing how it goes over the year. ▪ be available as a resource. ▪ refer people to the units if you hear groups need vaccines. • Funding for CHW engagement ○ Tim - to look for other funding opportunities. ○ leverage other funding. ○ see if CHIP is being written to add it in as an item. • Growing ISD to support DOH Immunization program capacity - diverse funding means less DOH oversight, and more freedom.

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	○ Find grant funding for growth. ○ connect to other state coalitions for brainstorming funding. North Dakota: Goals • work on the LTC respiratory season toolkit for administering vaccines and payments. • set up an LTC respiratory season kickoff meeting to share best practices. • expand IIS access to managed care contractors. • send out CEU to Medicaid newsletters. • set up monthly/quarterly immunization partner meetings. • Meeting July 11 Colorado Goals • draft a coordinator position to lead through the framework pilot. • build a partnership inventory, and identify barriers and successes. • July 10 and 23 are internal planning meetings. Oklahoma Goals • Establish the core group to build buy-in for the education campaign (Immunization program, LTC at OSDH, Contracted Entities branch (OK HCA), Medicaid, OKPCA, LTC association) • Create a short PPT with the Oklahoma data to show the need for the project. • Develop or find a persuasive “champion” who can speak with potential partners. • Create a mission statement/summary with the core group once it is established that

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	helps describe the group.
	• Iron out any data-sharing agreement needs.
	• July 2 meeting
	
	Missouri:
	
	Goals
	• Develop a letter to send to the ACCI (these members could be part of the stakeholder's group, or more focused on children)
	• Figure out the systems involved in connecting with community-based partners.
	  ○ How do they communicate outside of your system?
	• Develop a list of COB partners and a map.
	  ○ Identify 1 stakeholder from each organization.
	  ○ Confirm 1 contact from each:
	  ▪ MPCA, MPA, MRHA, MIC, AAA, MHA, & Ambulance Association
	  ▪ Identify a data analyst lead contact.
	  ○ Create a letter to invite stakeholders to the conversation.
	  ▪ Personalize each letter, **"MOVAC" - Missouri Vaccine Access Cooperative**
	  ▪ Develop a survey to collect data on the barriers and landscape analysis to a bidirectional closed-loop referral process.
	  ▪ "Name 5 CBO in your area"
	  ▪ We need to communicate on what we are asking.
	  ▪ Define funding needs and sources, i.e. sponsors.
	• Analysis of survey responses and follow-up
	• Confirm Funding
	• Schedule an in-person stakeholder strategy meeting to develop an action plan and review the survey of system barriers.

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	• Strategic Goal: Part 1- developing a bidirectional closed-loop referral process for the state of Missouri to provide access to immunizations a social/community resources. ○ This would be a pilot to see if this works. Defining standards and capacity building. Kansas: • Focus on adults 19-64 respiratory. • Implement an adult IQUIP. • Meeting July 3- work with IIS coordinator • July 9 is a core group meeting, then meet monthly. • Work towards launching the patient portal. Utah: Goals Short • Set a Pharmacy Workgroup meeting • Hold workgroup meeting • Develop questions for Pharmacists for 8/28 meeting • At Coalition on 8/28 meeting add pharmacy questions to agenda Medium • Create action items from questions answered during the workgroup meeting • Possibly pilot a CHW project with champion pharmacy • Collect data from pilot Long • Use data from pilot to work with other pharmacies

Agenda	NOTES

	• Reimbursement= extra revenue
	• Improved patient relationships
	
	Nevada:
	
	Goals
	
	Short
	• Coalition - RFP process - gathering documents from successful states, formulating one that is best for Nevada.
	• Educational component for pharmacies to feel more empowered to offer the vaccine counseling.
	  ○ need to see what they feel their barriers are; make it a discussion and not assume what those barriers are.
	  ○ short term - start the discussions to assess where they are, board of pharmacy, pharmacy association, and individual pharmacies.
	  ○ School of pharmacy could be a source - historically was through the coalition.
	• Determine whether or not the CPT codes are “turned on” in Nevada for this to work.
	  ○ need to ask MO which codes specifically they are using to be able to go to Medicaid and ask the questions.
	• The first call is from the Board of Pharmacy to get the support and backing of the initiative.
	• Pharmacy Association
	• Retail Pharmacy Association
	• School of Pharmacy
	• firming up the plan/proposal
	• funded partners (LHAs, etc.) will be kept in the loop and can provide support and ideas and help to educate and promote the local pharmacists.

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	Medium
	• Selection process RFP - stand up by July 2025 - across the lifespan focus.
	• Curriculum development: tailor to the needs identified as well as those that the IZ Program is already aware of.
	  ○ previously had an IIS component with the school of pharmacy. Need to see if that is still in place or if it fell apart when the coalition dissolved or during COVID.
	  ○ Need to involve Pharmacy Techs to ensure it doesn't all fall on the Pharmacists - look at the certification of these individuals (where, how long, etc.) to see if there is an opportunity to provide immunization training during the certification process.
	• Focus on Adult Standards/Best Practices
	  ○ co-administration of vaccines and how to discuss that (currently some pharmacies are saying that vaccines shouldn't co administer vaccine)
	• CEUs as an incentive for Pharmacists to participate.
	• Summit or some sort of working meeting with the pharmacy groups to really create the buy in for the plan/proposal developed.
	
	Long
	• Need to start the coalition of another fiduciary group and then have them become their own stand-alone 501c3 long term.
	• Look into what MO is doing with pharmacy techs and having them be CHWs - capitalize on the fact that in Nevada, CHWs are able to bill Medicaid.
	• Help pharmacy techs to be able to become CHWs.
	• Regular meetings with the groups (maybe during the statewide meeting) to show the impacts, gather input, etc.