CALL TO ACTION
REACHING THE
HEALTHY PEOPLE
2020 GOALS
FOR ADULT
VACCINATION

PROCEEDINGS OF THE NATIONAL ADULT VACCINATION PROGRAM
SCIENTIFIC SUMMIT / APRIL 2012

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ABSTRACT

Although health experts widely recognize vaccination as the safest and most cost-effective approach to primary prevention for a host of diseases, adequately immunizing the majority of adults has remained out of reach. Even after failing to achieve the goals of Healthy People 2010, penning more ambitious goals for Healthy People 2020 has not led to an encompassing national strategy, policy or means to universal adult vaccination. The National Adult Vaccination Program (NAVP), a multi-stakeholder industry-supported collaboration, was undertaken by The Gerontological Society of America to develop a cohesive strategic and policy approach to improve adult vaccination aligned with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. As first steps, the NAVP convened an organizing workgroup to lead a scientific summit in April 2012, where stakeholders and experts could formulate recommendations toward a national strategy. Summit participants identified the need for a culture supportive of adult immunization facilitated by national leadership, education, quality improvement, expanded policies and mandates that would promote adult immunizations, align incentives and increase accountability. This white paper is a summary of the findings of the scientific summit and identifies a broad approach to achieving the Healthy People 2020 immunization goals.
Vaccination provides an effective, simple approach to primary prevention of a growing number of diseases. Public health experts and advisory groups are in decisive agreement on both the benefit of vaccination and the need to improve vaccine uptake. Despite the broad consensus, improving vaccine uptake of virtually all indicated vaccines in adult populations has proved challenging, severely lagging the success in vaccinating children. None of the Healthy People 2010 adult vaccination goals were met in 2010, while newer, more ambitious goals have been set by the Healthy People 2020 campaign (Table 1). Although the need for improving vaccine uptake has gained recognition, a national strategy has yet to emerge to attain these goals.
**TABLE 1. HEALTHY PEOPLE 2020 BASELINE DATA AND GOALS**

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>BASELINE DATA</th>
<th>HEALTHY PEOPLE 2020 GOALS</th>
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<tbody>
<tr>
<td><strong>Increase the percentage of adults vaccinated annually against seasonal influenza</strong></td>
<td></td>
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</tr>
<tr>
<td>Noninstitutionalized adults aged 18 to 64 years</td>
<td>25% in 2008</td>
<td>80%</td>
</tr>
<tr>
<td>Noninstitutionalized high-risk adults aged 18 to 64 years</td>
<td>39% in 2008</td>
<td>90%</td>
</tr>
<tr>
<td>Noninstitutionalized adults aged 65 years and older</td>
<td>67% in 2008</td>
<td>90%</td>
</tr>
<tr>
<td>Institutionalized adults aged 18 years and older in long-term or nursing homes</td>
<td>62% in 2006</td>
<td>90%</td>
</tr>
<tr>
<td>Health care personnel</td>
<td>45% in 2008</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Increase the percentage of adults vaccinated against pneumococcal disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noninstitutionalized adults aged 65 years and older</td>
<td>60% in 2008</td>
<td>90%</td>
</tr>
<tr>
<td>Noninstitutionalized high-risk adults aged 18 to 64 years</td>
<td>17% in 2008</td>
<td>60%</td>
</tr>
<tr>
<td>Institutionalized adults aged 18 years and older in long-term or nursing homes</td>
<td><em>66% of persons in long-term care facilities and nursing homes certified by the Centers for Medicare &amp; Medicaid Services reported having up-to-date pneumococcal vaccinations in 2006</em></td>
<td>90%</td>
</tr>
<tr>
<td><strong>Increase the percentage of adults vaccinated against zoster</strong></td>
<td>7% of adults aged 60 years and older reported having ever received zoster (shingles) vaccine in 2008</td>
<td>30%</td>
</tr>
</tbody>
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Source: Reference 1.
An abundance of reasons contribute to the difficulty in getting our adult population vaccinated. Many initiatives at stakeholder organization, state, local and national levels have attempted to address the problem, but these have typically aimed at improving uptake of a single vaccine and have not embraced a strategy encompassing all vaccines. Recommendations by scientific societies and the Advisory Committee on Immunization Practices (ACIP) have produced guidelines, but these recommendations and their associated public health messages about getting vaccinated fail to speak to the public in a clear and unified voice. Counter campaigns have drama that produces greater press than the staid voice of the public health community. Furthermore, the public health community continues to rely on outdated methods to connect with adults, especially younger adults, to join the movement to get vaccinated. The messages also have not framed vaccination as a life-long approach to health (like exercise and diet) to shift the call for vaccination from professional health advocates to a demand that arises directly from consumers. We have far to go to obtain the general public and professional awareness that results in insistence on staying up to date with vaccinations for adults at a level comparable to the awareness for childhood vaccination. This aspect is significant because the societal infrastructure upon which childhood vaccination campaigns are built (school entrance and continued attendance) does not currently exist for adults.

The time to act has come, and the tools to mount a successful adult vaccination campaign to achieve the Healthy People 2020 goals are in reach. The recent enactment of the Patient Protection and Affordable Care Act (ACA) and the upholding of its constitutionality add opportunity and leverage to initiatives intended to improve vaccine uptake. The ACA intent assures near-universal, affordable coverage through health insurance as a way to increase primary disease prevention by the health care community through improved access and cross-payer efficiency. Starting in January 2014, Americans will be required to have coverage or pay a fee of at least $695 per person or $2,085 per family, or 2.5% of household income, whichever is greater. Although not mandated to provide coverage, employers will be motivated to do so to avoid penalties. The ACA requires insurers, with exception of state-regulated grandfathered insurance plans, to cover ACIP recommendations within a year of adoption by the Centers for Disease Control and Prevention (CDC). Additionally, Medicare beneficiaries, participants of the largest insurance program in the United States, will receive a personalized prevention plan that incorporates the ACIP-recommended vaccines without cost sharing.
Other federal initiatives should help improve vaccine access, knowledge and education. Appropriations have been made for the Prevention and Public Health Fund, Community Preventive Services Task Force and school-based health centers as well as support for pilot demonstration projects at community health centers. The Center for Medicare and Medicaid Innovation has established four models to directly impact immunization, permitting: (1) providers to receive increased payment for immunization services; (2) providers to receive payment for immunization education; (3) community vaccination programs; and (4) new categories of professionals to assess patients’ vaccine needs and administer vaccines. Collectively, the many federal initiatives will catalyze interest, generate research and motivate adoption of strategies to improve vaccine uptake.

The National Adult Vaccination Program (NAVP) is a multi-stakeholder, industry-supported collaboration undertaken by The Gerontological Society of America (GSA) to identify strategic approaches and supportive policies to increase adult vaccine uptake. The GSA is the oldest and largest national interdisciplinary professional membership organization that touches all facets of aging and fosters the application of scientific research into the development of policy, making it a natural home for the NAVP. The NAVP convened a workgroup of notable experts to develop, lead and oversee the program to advance a cohesive national strategy toward reaching the Healthy People 2020 adult vaccination goals. The workgroup met through a series of teleconferences during the spring of 2012, and held an invitation-only scientific summit on April 26, 2012, to gather the evidence and make recommendations on how to achieve the NAVP initiative. The proceedings of the NAVP Summit and its call to action are discussed in this white paper. The NAVP Summit findings also provide the foundation for a 2013 invitational conference on improving vaccination rates for adults, which will showcase promising and best practices from across the nation.
SUMMIT PROCESS / OVERVIEW
To achieve its goals, the NAVP convened a workgroup of vaccine and policy experts (Table 2) to organize a scientific summit and draft an overall plan for the NAVP. The workgroup also developed and recommended the scientific program and invitation list for the NAVP Summit.

### TABLE 2  NAVP WORKGROUP MEMBERSHIP

<table>
<thead>
<tr>
<th>WORKGROUP MEMBER</th>
<th>AFFILIATION* &amp; ORGANIZATION† REPRESENTED</th>
</tr>
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<tbody>
<tr>
<td>R. Gordon Douglas, MD</td>
<td>Weill Cornell Medical College*</td>
</tr>
<tr>
<td><strong>NAVSP Workgroup Chairperson</strong></td>
<td></td>
</tr>
<tr>
<td>Paul Etkind, DrPH, MPH</td>
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</tr>
<tr>
<td>Stefan Gravenstein, MD, MPH</td>
<td>Warren Alpert Medical School of Brown University*</td>
</tr>
<tr>
<td><strong>NAVSP Project Director</strong></td>
<td>The Gerontological Society of America†</td>
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<tr>
<td></td>
<td>Healthcentric Advisors*</td>
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<tr>
<td>Walter A. Orenstein, MD</td>
<td>Emory University School of Medicine*</td>
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<td></td>
<td>Emory Vaccine Center*†</td>
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<tr>
<td>Barbara Resnick, PhD, RN, CRNP</td>
<td>University of Maryland School of Nursing and School of Medicine*</td>
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<td></td>
<td>American Geriatrics Society†</td>
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<td></td>
<td>The Gerontological Society of America†</td>
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<tr>
<td>William Schaffner, MD</td>
<td>Vanderbilt University School of Medicine*</td>
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<td></td>
<td>The Edward Jenner Society†</td>
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</tbody>
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The invitation list was composed with the intention of including wide-ranging representation across health professions and professional organizations with an interest in adult vaccination and preventive medicine (Table 3). Although some invitees could not attend, representation appropriately covered the anticipated interested parties with expertise in adult vaccination, vaccine policy and Healthy People 2020 goals (Appendix).

<table>
<thead>
<tr>
<th>ORGANIZATIONS REPRESENTED AT THE NAVP SUMMIT</th>
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<tbody>
<tr>
<td>American Academy of Physician Assistants</td>
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<tr>
<td>American Geriatrics Society</td>
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<tr>
<td>American Immunization Registry Association</td>
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<tr>
<td>American Medical Association</td>
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<tr>
<td>American Nurses Association</td>
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<tr>
<td>American Pharmacists Association</td>
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<tr>
<td>Association of Immunization Managers</td>
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<tr>
<td>Association of State and Territorial Health Officials</td>
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<tr>
<td>Baltimore City Health Department</td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>Cervical Cancer-Free America</td>
</tr>
<tr>
<td>The Edward Jenner Society</td>
</tr>
<tr>
<td>Emory University School of Medicine</td>
</tr>
<tr>
<td>Emory Vaccine Center</td>
</tr>
<tr>
<td>Gerontological Advanced Practice Nurses Association</td>
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<tr>
<td>The Gerontological Society of America</td>
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<tr>
<td>GlaxoSmithKline</td>
</tr>
<tr>
<td>Healthcentric Advisors</td>
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<tr>
<td>Immunization Action Coalition</td>
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<tr>
<td>Infectious Diseases Society of America</td>
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<tr>
<td>Maryland Partnership for Prevention</td>
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<tr>
<td>Mayo Clinic</td>
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<tr>
<td>Merck Vaccines</td>
</tr>
<tr>
<td>Michigan Primary Care Consortium</td>
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<tr>
<td>National Association of County and City Health Officials</td>
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<tr>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>National Council on Patient Information and Education</td>
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<tr>
<td>National Foundation for Infectious Diseases</td>
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<tr>
<td>National Gerontological Nursing Association</td>
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<tr>
<td>Omnicare Inc.</td>
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<tr>
<td>Pfizer Inc.</td>
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<tr>
<td>Sanofi Pasteur</td>
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<tr>
<td>University of Maryland School of Medicine and School of Nursing</td>
</tr>
<tr>
<td>U.S. Department of Health and Human Services-National Vaccine Program Office</td>
</tr>
<tr>
<td>Vanderbilt University School of Medicine</td>
</tr>
<tr>
<td>Warren Alpert Medical School of Brown University</td>
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<tr>
<td>Weill Cornell Medical College of Cornell University</td>
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Next, three working roundtables assembled to develop action plans for delivering sustainable change within the following themes: system/framework/process, payer/provider and patient/caregiver. Summit participants were divided into groups, with each group assigned to one of these three roundtable themes based on participant expertise and preference as well as representation of the summit’s stakeholder organizations. Both a trained facilitator and an NAVP workgroup member pair facilitated the activity to maintain efficiency, focus, and consistency. The roundtable participants engaged in a quiet brainstorming (or “brainwriting”) activity with each person identifying a policy-focused strategy to improve vaccination uptake within the appointed theme focus and then writing the strategy on a Post-it note to share with the other roundtable members (Figure 1a). Strategies were then categorized at a higher level of organization toward a goal of sustainable change in national adult vaccine uptake (Figure 1b). In a final preliminary step, participants determined directional dependency of all strategies to identify drivers across categories (Figure 1c). This activity allowed prioritization of the main strategies (i.e., the key drivers) that most others are dependent on for success of the NAVP strategic plan. Finally, each group developed a preliminary action plan to accomplish key drivers.

The NAVP Summit was structured to provide “state of the state” keynotes of current adult vaccine uptake; national vaccination policy and Healthy People 2020 goals; barriers to policies and approaches; and high-level strategies, both proven and theoretical, to improve vaccination rates. These underpinnings set the stage for workgroups to rapidly develop the NAVP longer term plan to improve vaccine uptake.
FIGURE 1 PROCESS STEPS USED IN ROUNDTABLE SESSIONS TO GENERATE STRATEGIES FOR IMPROVING VACCINE UPTAKE

1a Experts at the roundtable wrote policy-focused strategies on Post-it notes and placed them on worksheets that were passed around the table.

1b The Post-it notes were rearranged into categories representing an overarching strategy.

1c Dependent or driving relationships across categories were established.
In a concluding plenary session of the NAVP Summit, a representative from each of the three working roundtables presented the results of the day’s strategic activities, summarizing the top priorities and supporting activities for their lead priority. These results provide the foundation for the NAVP priority focus going forward.
SUMMIT OUTCOMES
The keynote speakers highlighted the differences between the medical community and other nonmedical disciplines to effect behavior change. The speakers provided examples of effective strategies to improve vaccine uptake by grassroots or other independent activities and collaborative activities between professional and consumer organizations. Existing initiatives supported by the ACA, ACIP, CDC and the Department of Health and Human Services, were presented as opportunities, which the national plan could leverage to further its results. A summary of the roundtable reports by the three themes follows.
In the category assessing the system, framework and process governing vaccinations, the key driver that emerged was to **create a culture supportive of adult immunizations**. The main activities to drive the development of a supportive culture included engaging stakeholders, creating demand, broadening the definitions of immunizers and developing messaging to create a positive value proposition regarding adult immunizations. The group recommended the need for clinicians to partner with other experts to identify intergenerational strategies to engage consumers, professionals and organizations. This conceded that clinicians and public health officials can benefit from new and innovative strategies that better capture the public’s imagination such as those that work well with sales and other kinds of campaigns. Information from social scientists, anthropologists and consumers show the use of social media (e.g., Twitter or Facebook) and new technologies (e.g., smartphones and tablet devices) could help revitalize engagement with the populations that administer and receive vaccines.

Better engagement would help instill a desire in and demand by consumers for adult immunizations. Furthermore, understanding and then directly addressing consumer beliefs, perceptions and attitudes through the new engagement strategies could help accelerate popular acceptance of vaccines. The educational approach could tap into identified trusted sources’ ability to capture the imagination and conviction of the target audiences. Mandating immunization also would foster demand, although this approach may be situational rather than overarching.

One barrier to vaccine access has been the limited use of nontraditional providers to deliver vaccines. Culturally, health care practitioners beyond pharmacists—such as dentists, podiatrists, emergency medical services personnel, mental health workers and others—could be educated, then licensed with a broadened scope of practice permitting them to vaccinate. Such an approach requires policy changes, which are most likely to occur if supported by those whose scope of practice already includes vaccine administration. Development of interconnected electronic health records, would facilitate accessibility of patients’ immunization history and vaccine needs among relevant health care providers. Accordingly, providers will need to serve as advocates for broadened policies and moreover as personal champions of improving vaccine uptake for their patients.
Promotion and advocacy may respond to both positive and negative incentives to vaccinate. Positive incentives can result from recognizing educational milestones related to vaccination, vaccine administration or educator certification or licensure. Specifically addressing health care workers’ adverse perceptions regarding vaccines in such education programs and rewarding successes in improved vaccine uptake can improve performance. Similarly, public reporting on vaccination performance by providers (including health care institutions) can serve as a positive or negative incentive, depending on the providers’ success. In any case, the roundtable members recommended that vaccine education be added into all health professions’ education as a required area of proficiency.

The final area substantiating the driver of a culture supportive of adult immunizations dealt with the development of affirmative messaging that creates a positive value proposition for those who vaccinate as well as those getting vaccinated. This strategy can be supported through the use of champions in the health care office setting and in the community setting. In concert, a national advocate could help the local champions propagate affirmative messaging. The story line could be conveyed through the use of social media and approaches learned from colleagues in the social sciences and anthropology.

### KEY DRIVERS FOR IMPROVING UPTAKE OF ADULT VACCINES

**System / Framework / Process**
Create a culture supportive of adult immunizations

**Payer / Provider**
Provide national leadership for adult education, quality improvement and wellness visits in an environment of increased accountability and supported by resources

**Patient / Caregiver**
Expand policies and mandates to promote adult immunizations

Incentivize providers to immunize
The key driver identified to make improved adult vaccination a payer and provider priority was to provide national leadership for adult education, quality improvement and wellness visits in an environment of increased accountability and supported by resources for providers to reduce their financial risk.

Steps to achieving accountability by both payers and providers would include public reporting of vaccination success, initially by process steps toward a system that promotes education, vaccine offering and payment, and later by measuring vaccine uptake. Accountability should be identified and empowered by a coordinating entity to support a sustainable national effort.

Stakeholders need to work jointly to develop statements and messages for leadership to help build the business case and cost assessment of vaccine delivery along with associated cost avoidance by disease prevention. This information will help to convince payers, employers and health departments to reduce or remove costs of vaccine and unused vaccine at the provider level. A collaborative example comes from Rhode Island, where payers capitalize on a state- or larger-level bulk vaccine purchase, distribution and unused vaccine re-collection program of doses. The net result reduced financial risk at the provider level for ordering and administering vaccine.

To further support providers' ability to implement adult immunization, tools and resources need to be developed. These should be made available and widely disseminated to providers and vaccine administrators.
Upon consideration of patients and their advocates, the group identified two key drivers of equal importance to improve vaccine uptake and demand. One driver addresses expanding policies and mandates to promote adult immunizations and the other discusses incentivizing providers to immunize. Some components echo or complement those of the system/framework/process and payer/provider components previously noted.

Expanding policies and mandates would address structural approaches to increasing vaccination. For example, Medicare Part D coverage could rebate manufacturers of adult vaccines to subsidize adults to be immunized through direct payments or tax credits. Leaders would need to build and mobilize a coalition to lobby the Centers for Medicare & Medicaid Services (CMS) to reach this outcome. The coalition would create and implement a grassroots campaign and engage one on one with key legislators to educate and invite them to join in advocacy by making phone calls to CMS. Mandates recommended would require that any person who receives federal or state services must agree to receive all vaccinations to stay up to date in accordance with guidelines. Similarly, employers with more than 50 employees would be required to have a vaccination policy and incorporate immunizations into new employee training. The health care employer also would be required to immunize all employees working at a facility providing health care services. To improve adherence, the subjects of mandates would be required to submit data on their vaccination success; these data would form the basis for a report card system for employers regarding adherence to and success with achieving universal vaccination for their employees.
Similar requirements could be levied on providers by obligating them to submit data to the Healthcare Effectiveness Data and Information Set for all adult immunizations. Providers would be required to report all adult vaccination to their state registry. Outside audits of immunization records should support the integrity of submitted data and allow comparison of performance of different practices, departments and facilities.

Reporting could be incentivized through rebates for evaluating patient registry and vaccination and for reporting performance on time. To further incentivize reporting, a reimbursement code to ask patients about vaccination as required by their (state) registry should be developed. An immunization query and associated documentation should be part of standard care practice and health recommendations.

Similar to grade school entry requirements, the development of a vaccination requirement as a national standard for college entry would improve meeting Healthy People 2020 goals. The full adult schedule as a requirement for entry could be more easily enforced at that time than any time later in life. The Council of State and Territorial Epidemiologists, American College Health Association, and the major medical societies should participate in the development of such a national standard.

The roundtable members also recommended expansion of the scope of practice for additional types of practitioners with authority to order and administer vaccinations. This recommendation mirrored one from the systems/framework/process recommendation and supported a change in state regulations on practice to support this approach. The group recognized the need to lobby professional societies to get buy-in, and have practitioners lobby their boards to change licensure requirements to administer vaccines.

Policy input should be periodically sought from patients and their advocates in order to better understand their view of barriers to vaccination. This could be accomplished by convening community advisory boards and focus groups to discuss ways to improve
vaccination uptake. Search engines (e.g., Google) also could be used to find patients’ views and opinions. By obtaining comments from patients, more could be learned about what stops them from seeking vaccinations and these factors could be used to craft meaningful messaging.

As a second and equally important key driver at the patient and caregiver level, the group identified incentives to immunize, both financial and nonfinancial. Financial incentives would be implemented through health plans and insurers. These incentives could be constructed to operate as pay for performance, increased reimbursement per code or through new codes to reimburse for vaccination. As a separate and additional means, insurers and health plans could subsidize the immunization information system (IIS) component of electronic health records with CMS, the Office of the National Coordinator for Health Information Technology, foundations, CDC grants and the pharmaceutical industry.

Implementation of educational incentives should contribute to improved vaccine uptake. The creation of a quality improvement module for maintenance certification on professional boards relating to qualifications for immunization would be a good start. Free continuing education could be offered alongside peer-to-peer detailing through professional associations, foundations, pharmaceutical companies and educational institutions.

Intangible incentives by means of better efficiency and recognition also could be implemented. Patient medical records could have vaccination information highlighted, or electronic records could better use the IIS to more efficiently identify patients who may need additional vaccination to stay up to date. The development of recognition programs and awards from respected sources (including the media) to celebrate vaccination success for high performers may improve a culture of acceptance and provide intangible incentives to systematically offer vaccines to patients and health care workers. The overall approach could be supported through the availability of a free “best practices” toolkit from institutional and setting experts.
Several concrete recommendations were put forth by the NAVP Summit. Key drivers for reaching Healthy People 2020 goals include: creating a culture supportive of adult immunizations; providing national leadership for adult immunization through education, quality improvement and wellness visits; expanding policies and mandates to promote adult immunizations; and aligning incentives (educational, intangible and financial) to get providers to systematically immunize adults to the full ACIP-recommended schedule. These drivers need to encompass all aspects (patient, provider, insurer and system) and would involve education, cost and policy considerations. Despite the ambitious Healthy People 2020 goals, the pursuits identified by NAVP Summit participants are feasible if stakeholders work quickly to address them.

The NAVP Summit findings will be presented at the GSA Annual Scientific Meeting in November 2012 and will provide support for publication of an upcoming issue of GSA’s Public Policy & Aging Report that explores policy issues around preventive health services, particularly immunizations, and potential impact of the ACA. These findings were presented at the May 2012 National Adult Immunization Summit meeting and the NAVP plans to collaborate with other national projects and initiatives. Several publications documenting the work of the NAVP are already available and serve as a foundation for moving forward to maximize adult vaccination.

Resources at www.geron.org/navp

From Publication to Practice: A Look at Strategies to Improve Immunization Rates for Older Adults

What’s Hot in Immunizations Across the Aging Continuum

From Publication to Practice: An Interdisciplinary Look at New Developments in the Prevention and Treatment of Influenza in Older Adults

Public Policy & Aging Report: Exploring Policy Issues around Preventive Health Services, Particularly Immunizations, and Potential Impact of the 2010 Patient Protection and Affordable Care Act

What’s Hot in Immunosenescence: Implications for Patient Care
1 / HealthyPeople.gov website. Immunizations and Infectious Diseases
accessed June 22, 2012

2 / Tan LJ. Impact of the Affordable Care Act on Immunization
accessed August 13, 2012

3 / King B. Schlicksupp H. The Idea Edge: Transforming Creative Thought Into Organizational Excellence. Salem, NH: Goal/QPC; 1998
www.goalqpc.com/shop_products_detail.cfm?PID=162
accessed September 20, 2012

accessed August 28, 2012
APPENDIX

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Vice-Chair

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