2013 National Adult Vaccination Program Summit
Developing Champions and Building a Roadmap to Action
Capital Hilton, 1001 16th St NW
Washington, DC 20036

FINAL AGENDA

The 2013 NAVP Summit is a 1-day, interactive working conference aimed toward advancement of adult vaccination rates in accord with Healthy People 2020 goals. Centered on action and champion development, the Summit will build on the work of the 2012 NAVP Summit as well as successful national and state efforts and will emphasize opportunities available through the Affordable Care Act, Meaningful Use, and other regulations. NAVP is developed by The Gerontological Society of America and supported by GlaxoSmithKline, Novartis Vaccines, Pfizer, and Sanofi Pasteur.

WEDNESDAY, August 21, 2013 • Evening

6:00 PM–8:00 PM  Registration and Networking Reception

THURSDAY, August 22, 2013

7:15 AM–8:15 AM  Registration and Breakfast

8:15 AM–8:45 AM  Welcome and Introductions
James Appleby, RPh, MPH
Executive Director and CEO, The Gerontological Society of America

8:45 AM–9:00 AM  Path to Today
R. Gordon Douglas, Jr., MD, NAVP Workgroup Chairperson
Weill Cornell Medical College

9:00 AM–9:45 AM  Keynote Addresses

Vaccines and the Affordable Care Act: Opportunities to Increase Access to Vaccines for Adults
Phyllis Arthur, MBA
Senior Director, Vaccines Policy
Biotechnology Industry Organization

What Works to Improve Adult Immunizations: Examples of Success
Carolyn Bridges, MD, FACP
Associate Director of Adult Immunizations
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention
9:45 AM–10:30 AM  Discussion Panel
Keynote speakers will be joined by the following panelists for an interactive discussion and Q&A.

Payer Perspective
Ross M. Miller, MD, MPH
Medical Executive, Cerner Corporation
Physician Advisor, California Department of Health Care Services

Social Work Perspective
Robyn L. Golden, MA, LCSW
Director of Health and Aging
Rush University Medical Center

Policy Innovations Perspective
Maggie J. Morgan, JD
Clinical Fellow
Harvard Law School Center for Health Law and Policy Innovation

10:30 AM–10:45 AM  Break

10:45 AM–11:15 AM  Overview of Working Roundtables
Patti Gasdek Manolakis, PharmD
Facilitator, NAVP Project Director

This brief orientation will inform participants regarding the day’s activities building on the 2012 NAVP Summit to define a detailed national strategy for key areas.

11:15 AM–12:00 PM  Mapping an Adult Immunization Plan for 2014—Working Groups
Part 1. Generating Ideas and Identifying Strategic Priorities
Participants will work in one of three groups—centered on providers, the public, and policy—to engage in discussions and activities addressing the following questions:
- What strategies will create provider champions of adult immunizations and mobilize providers to immunize adults?
- What strategies will create lay champions of adult immunizations and mobilize the public to be immunized across the aging continuum?
- What policy changes or improvements are necessary to create a culture supportive of adult immunizations?

12:00 PM–12:45 PM  Networking Luncheon

12:45 PM–3:00 PM  Mapping an Adult Immunization Plan for 2014—Working Groups Resume
Part 1. Generating Ideas and Identifying Strategic Priorities (continued)
Part 2. Building Roadmaps to Action
The groups will develop action plans for accomplishing key strategic priorities emerging from the first part of this session:
- Mobilize providers to immunize adults
- Mobilize the public to be immunized across the aging continuum
- Expand policies that promote adult immunizations

3:00 PM–3:15 PM  Break
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Details</th>
</tr>
</thead>
</table>
| 3:15 PM–3:45 PM | **Roundtable Reports and Discussion** | - Mobilize providers to immunize adults  
- Mobilize the public to be immunized across the aging continuum  
- Expand policies that promote adult immunizations |
| 3:45 PM–4:00 PM | **Next Steps and Closing Remarks**    | R. Gordon Douglas, Jr., MD  
James Appleby, RPh, MPH |
| 4:00 PM       | **Adjourn**                          |                                                                         |
Chairperson

R. Gordon Douglas, Jr., MD
Adjunct Professor of Medicine
Weill Cornell Medical College

Paul Etkind, DrPH, MPH
Senior Director of Infectious Diseases
Community Health Team
National Association of County and City Health Officials

Stefan Gravenstein, MD, MPH
NAVP Program Director and GSA Member
Professor of Medicine, Case Western Reserve University
Adjunct Professor of Medicine and Health Services Policy and Practice, The Warren Alpert Medical School of Brown University
Clinical Director, Healthcentric Advisors

Walter A. Orenstein, MD
Professor of Medicine
Associate Director, Emory Vaccine Center
Director, Emory Program for Vaccine Policy and Development
Program Director for Operations Management and Initiatives, Influenza Pathogenesis and Immunology Research Center
Emory University School of Medicine

Barbara Resnick, PhD, RN, CRNP, FAAN, FAANP
GSA Member
Professor of Nursing
University of Maryland School of Nursing
Adjunct Professor
Department of Epidemiology and Preventive Medicine
University of Maryland School of Medicine

William Schaffner, MD
Professor and Chair, Department of Preventive Medicine
Professor of Medicine (Infectious Diseases)
Vanderbilt University School of Medicine
2013 National Adult Vaccination Program Summit

Developing Champions and Building a Roadmap to Action

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Washington, DC  20036

KEYNOTE SPEAKERS

**Phyllis Arthur, MBA**, is Senior Director for Vaccines, Immunotherapeutics and Diagnostics Policy at the Biotechnology Industry Organization (BIO). In this role Ms. Arthur is responsible for working with member companies in vaccines, molecular diagnostics and bio-defense on policy, legislative and regulatory issues. Ms. Arthur joined BIO in July 2009 as the Director of Healthcare Regulatory Affairs. Prior to joining BIO, she worked in numerous marketing and sales positions for Merck & Co Inc. in their Vaccine Division. Over her 16 year career in vaccines Ms. Arthur launched several exciting new vaccines in the United States and internationally, including the first HPV vaccine GARDASIL. During her years in Marketing she worked closely with clinical and academic thought leaders in infectious diseases, oncology and public health. In addition, Ms. Arthur also led a large vaccine sales organization of over 75 representatives and managers covering 14 states. Before graduate school, Ms. Arthur worked as a research assistant for two economists at the Brookings Institution in Washington, DC. There she conducted economic analyses related to savings and investment policies for the OECD countries. Ms. Arthur received her B.A. in 1987 in Economics and International Politics from Goucher College and her M.B.A. in 1991 from the Wharton School of Business at the University of Pennsylvania.

**Carolyn Bridges, MD, FACP**, is the Associate Director of Adult Immunizations in the Immunization Services Division, National Center for Immunization and Respiratory Diseases at the Centers for Disease Control. A board-certified internal medicine physician, Dr. Bridges was in clinical practice before joining the CDC as an Epidemic Intelligence Service Officer in 1996 working primarily on influenza. She has held a number of positions at CDC working on influenza and other vaccine-preventable diseases and transitioned to her current position in 2011 as the Associate Director of Adult Immunizations. Her career in public health has included research and policy on influenza prevention and control, vaccine effectiveness and transmission, and improving coverage for recommended adult vaccines.
Robyn L. Golden, MA, LCSW, serves as the Director of Health and Aging at Rush University Medical Center in Chicago, where she also holds academic appointments in the Departments of Preventive Medicine and Health Systems Management. She is responsible for developing and overseeing health promotion and disease prevention, mental health, care coordination, and transitional care services for older adults, family caregivers, and people with chronic conditions. For over 25 years, Ms. Golden has been actively involved in service provision, program development, education, research, and public policy aimed at developing innovative initiatives and systems integration to improve the health and well-being of older adults and their families. In 2003–2004, she was the John Heinz Senate Fellow based in the office of Senator Hillary Rodham Clinton in Washington, DC. Ms. Golden is also a past chair of the American Society on Aging and currently co-chairs the National Coalition on Care Coordination housed at the New York Academy of Medicine. She is a fellow of the Gerontological Society of America. Ms. Golden holds a master’s degree from the School of Social Service Administration at the University of Chicago and bachelor’s degree from Miami University.

Maggie J. Morgan, JD, is a Clinical Fellow at the Center for Health Law and Policy Innovation at Harvard Law School, where she works on national and state-based health law and policy initiatives aimed at increasing access to care for vulnerable populations living with chronic conditions such as type 2 diabetes and HIV. Ms. Morgan’s work focuses on maximizing the positive impact that health care reform will have on these populations as it rolls out over the next several years. In addition to her independent work, Ms. Morgan supervises Harvard Law students working on these projects. Prior to her work with the Center, Ms. Morgan clerked for the Honorable Nanette K. Laughrey in the Western District of Missouri. She received her AB from Harvard College in 2004, her MA in International Relations from the University of Chicago in 2007, and her JD from Harvard Law School in 2011. She is licensed to practice law in the state of New York.
Ross M. Miller, MD, MPH, is a health care executive with extensive experience in the industry, including medical and pharmacy management, outcomes research, managed care, quality improvement, and employer health services. He is currently a Medical Executive with Cerner Corporation and a Physician Advisor for the California Department of Health Care Services. Dr. Miller functions as the national Medical Director for Cerner’s employer-sponsored on-site primary and urgent care and occupational health centers with oversight of all clinical services, wellness programs, chronic condition management, and benefit administration. He is the Immediate Past Chair of the California Medicaid (Medi-Cal) Pharmacy Policy Section Drug Use Review Board and a current voting member of their Drug Advisory Committee.

Previously Dr. Miller was Chief Medical Officer and led the advisory group responsible for all Community Clinics’ clinical operations, disease management, and quality improvement within Los Angeles County and represented them on leadership and clinical committees of the California Primary Care Association. Prior to that, he was VP, Sr. Medical Director for CIGNA HealthCare holding several leadership positions in medical and pharmacy management. Dr. Miller’s career in health care administration was as a Physician Advisor of Quality and Utilization Management for the Children’s Hospital of Los Angeles as well as a member of its Board of Directors. His academic credentials include an appointment as an Assistant Professor of Pediatrics, USC School of Medicine, Director of the Introduction to Clinical Medicine program, and Physician Manager of the Pediatric Continuity Clinic.

Dr. Miller completed his certification from the California HealthCare Foundation-UCSF Center for Health Professional’s Health Care Leadership Fellowship and graduated from the UCLA School of Public Health Executive Master’s Degree Program for Health Professionals in Health Services Management. He has attained recognition as a Certified Physician Executive having completed the Graduate Program in Medical Management from the American College of Physician Executives. Dr. Miller received his MD from the University of Southern California and his BS from Stanford University. Over the years, he has facilitated, moderated and/or participated in over 300 health care advisory boards, developed educational materials for health care providers, and both published and presented extensively in managed care, quality improvement, disease management, and employer health services.
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**WORKING GROUPS**

**Policy Solutions**
*R Gordon Douglas, NAVP Chair*
Adjunct Professor of Medicine
Weill Cornell Medical College

*William Schaffner, NAVP Workgroup*
Professor and Chair, Department of Preventive Medicine
Vanderbilt University School of Medicine

*Patti Manolakis*
Facilitator and NAVP Project Director
PMM Consulting, LLC

*Phyllis Arthur*
Senior Director, B+Vaccines, Immunotherapeutics and Diagnostics Policy
Biotechnology Industry Organization (BIO)

*Anuradha Bhatt*
Policy Analyst
Association of Immunization Managers

*Allison Chi*
Program Coordinator
American Immunization Registry Association (AIRA)

*Rebecca Gehring*
Immunization, Program Analyst
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*Bruce Gellin*
Deputy Assistant Secretary for Health and Director, National Vaccine Program Office
US Department of Health and Human Services

*Robyn Golden*
Director of Health and Aging
Rush University Medical Center

*Scott Jauch*
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Pfizer Inc.

*Kathy Talkington*
Senior Director Infectious Disease and Immunization Policy
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*Margaret Worthy*
Adult Immunization Coordinator
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Adult Immunization Coordinator
DC/DOH/ Immunization Program
Providers/Provider Champions

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CDC Adult Immunization Projects

Suzy Harrington
Director, Department for Health, Safety, and Wellness
American Nurses Association (ANA)

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Sr. Medical Director, Team Leader
Pfizer Inc.

Marie-Michele Leger
Director, Clinical Education
American Academy of Physician Assistants

Thais McNeal
Director National Advocacy & Alliance Development
GlaxoSmithKline

Tracy Miller
Incoming President of Maryland GAPNA Chapter
Gerontological Advanced Practice Nurses Association (GAPNA)

Ross Miller
Medical Director
Cerner Corporation
**Public/Lay Champions**

**Paul Etkind, NAVP Workgroup**  
Senior Director of Infectious Diseases  
NACCHO

**Barbara Resnick, NAVP Workgroup**  
Professor  
University of Maryland

**Kelly Barland**  
Facilitator  
PMM Consulting, LLC

**Marie Boltz**  
Associate Director, Research, NICHE  
New York University College of Nursing

**Eddy Bresnitz**  
Executive Director, Adult Vaccines  
Merck Vaccines

**Carolyn Bridges**  
Associate Director of Adult Immunizations  
National Center for Immunization and Respiratory Services, Centers for Disease Control and Prevention

**Kelly Cappio**  
Manager, Vaccines and Biodefense Policy  
Biotechnology Industry Organization (BIO)

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National Foundation for Infectious Diseases (NFID)

**Debbie Digilio**  
Committee on Aging  
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Program Coordinator  
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DC Department of Health

**Peter Maramaldi**  
Hartford Geriatric Social Work Faculty  
Scholar & National Mentor  
Director of the PhD Program, Simmons  
School of Social Work

**Jody Sachs**  
Senior Scientist, National Vaccine Program Office  
US Department of Health and Human Services

**Tiffany Tate**  
Executive Director  
Maryland Partnership for Prevention

**Laurel Wood**  
Coordinator for Public Health  
Immunization Action Coalition
Vaccines and the Affordable Care Act
Opportunities to Increase Access to Vaccines for Adults

Phyllis A. Arthur, MBA
Senior Director, Vaccines Policy
Biotechnology Industry Organization (BIO)
August 22, 2013

New Entrants to the Marketplace
30 million newly insured by 2022

• According to the Congressional Budget Office:
  – 9 million individuals will enroll in Exchanges by 2014, increasing to 25 million by 2022
  – 7 million individuals (mainly adults) will enroll in Medicaid by 2014, increasing to 11 million by 2022

• According to a 2012 study by PwC:
  – More racially diverse, less educated, and more likely to speak English as a second language
  – More likely to be under / unemployed and to cycle between the Exchanges and Medicaid
ACA by Segment

- Private insurance
  - Large employer-sponsored self-insured health plans
  - Non-exchange individual and group markets
- Public programs
  - Qualified health plans (QHPs) sold in the Exchanges
- Medicaid
  - Traditional populations
  - Alternative Benefit Plans–eligible populations
- Medicare

Private Sector – Opportunity #1

Private insurance plans must cover most adult vaccines

- Immunization Coverage Standard (Section 1001)
  - No cost sharing (first dollar coverage) for all ACIP-recommended immunizations when administered by an in-network provider
- One of the first provisions to go into effect (September 2010)
- This coverage standard extends throughout the private sector health plan marketplace – individual, group, ERISA
- Over time health plans lose their “grandfathered” status and must implement the full changes
Private Sector – Opportunity #2

Encourage plans and governments to expand the definition of in-network providers

- Currently: Private health plan networks and the exchanges do not expressly include community immunizers such as pharmacists, school-based clinics, or public health clinics as in-network providers
- Opportunities to expand the definition:
  - CDC Third-Party Billing Project can help vaccinate more adults while adding to the defined network of immunization providers in private plans
  - CMS is building the federal exchange and could include a broader definition of network adequacy for immunizations for adults

Public/Private Sector: State Health Exchanges – Opportunity #3

New Exchanges also must apply the immunization coverage standard

- Three models for the state-based exchanges:
  - State fully administers the exchange (17)
  - State enters into a partnership with the federal government to jointly operate the exchange (7)
  - State cedes responsibility completely to the federal government (27)
Public/Private Sector: State Health Exchanges – Opportunity #3

New Exchanges also must apply the immunization coverage standard

- Essential Health Benefits (EHB)
- All individual and small group plans (inside and outside the exchange) will be required to cover services in 10 specific service categories, including preventive services
  - Serves as a reference for the benefits offered by all plans operating in that state
  - Will incorporate the immunization coverage standard (no cost sharing)
  - Extends to all health plans sold in the individual and small group (<100 persons) markets, in/out of the exchanges


Public Sector – Medicaid Expansion

To Date, 20 States & DC Plan to Expand Medicaid Eligibility, 14 Will Not Expand, and the Remainder Are Undecided

State Commitment to Expand Medicaid Eligibility

Public Sector – Opportunity # 4
Adopting no cost-sharing standard for adult Medicaid Traditional Population may have financial benefit

• Traditional adult Medicaid population
  – ~ 20 million non-elderly adults 18 years and over
  – Mainly consists of pregnant women, parents/caretakers of dependent children, low-income parents, and working age adults with disabilities

• Population is **not** covered by the ACA immunization coverage standard – most states impose a small co-pay

Public Sector – Opportunity # 4
Adopting no cost-sharing standard for adult Medicaid Traditional Population may have financial benefit

• **ACA includes a modest state incentive through the Federal Medical Assistance Percentages (FMAP)**
  – 1% increase in FMAP if state decides to cover preventive services at no cost sharing for all adults in Medicaid (traditional and expansion populations)
**Public Sector – Opportunity #5**

*Adult Medicaid Expansion Population will have access to adult vaccines at no cost sharing*

- ACA expansion primarily would add coverage for newly eligible adults
- ~15 million new “childless” adults could be eligible
- Actual numbers affected will be lower as a result of states deciding to opt out of expansion
- Population eligible for the “Alternative Benefits Plan”
  - Alternative Benefits Plan must be benchmarked to the EHB
  - Each state must create and implement an Alternative Benefits Plan for its Expansion Population
  - The ACA immunization coverage standard (no cost sharing) applies in full to Medicaid Expansion Population

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**Public Sector – Opportunity #6**

*There is a reimbursement bump for Medicaid primary care providers*

- ACA includes 2-year (2013–2014) increase in Medicaid reimbursement rates for family practice, pediatric, and internal medicine providers
  - The statute was very specific on the providers impacted
- Currently: Implementation of the Medicaid bump has been slow in the states, does not apply to Ob-Gynes, and needs to be measured
- All states have had their plans approved; payment is retroactive to January 1, 2013.
- ASTHO, NACCHO, AIM and other stakeholders are encouraging states to communicate on the Medicaid bump to providers
Public Sector – Opportunity #7

Medicare beneficiaries will be encouraged to seek their immunizations

- ACA created the Personalized Prevention Plan (PPP) for all new and existing Medicare beneficiaries
- Annual requirement that providers discuss all applicable preventive services with the patient and either administer or refer
- Positive: Good opportunity to initiate discussion of appropriate immunizations
- Negative: the PPP is part of Part B services, thus providers may only discuss vaccines included in Part B and not Part D

Adult Immunization Opportunities of ACA – Summary

- Non-grandfathered health plans
  - New coverage standard for preventive services with zero cost sharing
- Medicaid expansion
  - Potential addition of millions of newly eligible persons (mainly adults)
  - New eligible population must be offered an Alternative Benefits Plan benchmarked to Essential Health Benefits
  - Medicaid primary care providers may receive Medicare reimbursement rates for preventive services for 2013 and 2014
  - Optional 1% FMAP increase for first dollar coverage of adults
- Medicare incentives
  - Personalized Prevention Plan for all new and existing enrollees
  - Continuing issues with Medicare Parts B and D and vaccines
Questions?
What Works to Improve Adult Immunizations

Examples of Success
August 22, 2013

Carolyn Bridges, MD, FACP

Immunization Services Division
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention
Atlanta, Georgia

Current Situation

• Coverage as of 2011 remains low for most vaccines recommended for adults
  — Continued racial and ethnic disparities
• Opportunities to use 317 funds for vaccination of adults
  — Fewer uninsured and underinsured children
  — 2012 vaccine purchases on federal contracts
    • Pediatric: ~$3.9 billion
    • Adult vaccine purchases: ~$45 million (317 only)
• Increased awareness of adult immunizations and increased partner involvement
  — National Adult and Influenza Immunization Summit
  — Identifying and acting on ways to reduce barriers for adult immunizations
• Available data on evidence-based interventions and examples of “What Works” to improve coverage
### Vaccination Coverage for Target Groups by Vaccine, Age, and High-Risk Status, NHIS 2010* and 2011

<table>
<thead>
<tr>
<th>Vaccine / Age / Status</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza, 18-64</td>
<td>30.8</td>
<td>20.7</td>
</tr>
<tr>
<td>HPV in women, 19-26</td>
<td>33.1</td>
<td>29.5</td>
</tr>
<tr>
<td>Tdap, 19-64</td>
<td>8.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Hepatitis B, 19-49, HR</td>
<td>42</td>
<td>18.5</td>
</tr>
<tr>
<td>Pneumococcal (ppv23), 19-64, HR</td>
<td>15.8</td>
<td>20.1</td>
</tr>
</tbody>
</table>


**Hepatitis B, 19-49 HR data not collected in 2011.
### Meta-Analysis of Interventions to Increase Use of Adult Immunization

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Odds Ratio*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational change (e.g., standing orders, separate clinics devoted to prevention)</td>
<td>16.0</td>
</tr>
<tr>
<td>Provider reminder</td>
<td>3.8</td>
</tr>
<tr>
<td>Patient financial incentive</td>
<td>3.4</td>
</tr>
<tr>
<td>Provider education</td>
<td>3.2</td>
</tr>
<tr>
<td>Patient reminder</td>
<td>2.5</td>
</tr>
<tr>
<td>Patient education</td>
<td>1.3</td>
</tr>
</tbody>
</table>

*Compared with usual care or control group, adjusted for all remaining interventions


### Potential Impact of Strategies to Increase Adult Vaccination Coverage

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Population</th>
<th>Median increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization information systems</td>
<td>Adults</td>
<td>*</td>
</tr>
<tr>
<td>Client reminder/recall systems</td>
<td>Adults</td>
<td>6.1-12 percentage pts.</td>
</tr>
<tr>
<td>Health care-based interventions in combination</td>
<td>Adults</td>
<td>8 percentage pts.</td>
</tr>
<tr>
<td>Client or family incentive rewards</td>
<td>Adults</td>
<td>8.5 percentage pts.</td>
</tr>
<tr>
<td>Provider assessment and feedback</td>
<td>Adults</td>
<td>9-16 percentage pts.</td>
</tr>
<tr>
<td>Home visits</td>
<td>Adults</td>
<td>10 percentage pts.</td>
</tr>
<tr>
<td>Provider reminder systems</td>
<td>Adults</td>
<td>10-16 percentage pts.</td>
</tr>
<tr>
<td>Community-based interventions in combination</td>
<td>Adults</td>
<td>15 percentage pts.</td>
</tr>
<tr>
<td>Reducing client out-of-pocket costs</td>
<td>Adults</td>
<td>15-22 percentage pts.</td>
</tr>
<tr>
<td>Worksite: on-site, reduced-cost, actively promoted influenza vaccine</td>
<td>Adults, HCP</td>
<td>21 percentage pts.</td>
</tr>
<tr>
<td>Standing orders when used alone</td>
<td>Adults</td>
<td>27-28 percentage pts.</td>
</tr>
</tbody>
</table>
Standing Orders

• Use of standing orders and patient/provider education at a public hospital resulted in 72% of women receiving postpartum Tdap (96% of those without contraindications or recent vaccination)\(^1\)
  – Population served is primarily Hispanic and medically underserved/underinsured
• Use of nurse standing orders to support an opt-out vaccination policy at a low-income urban family medicine center significantly increased influenza vaccination (to 49% from 36% the prior season)\(^2\)
  – Worked across gender, race/ethnicity, age, high-risk status


Standardized Offering

• In a network of 7 primary care practices, standardized offer and assessment of vaccination status by medical assistants resulted in similar uptake of influenza vaccination by white and African-American patients 65 years and older
  – 69% of white and 62% of African-American patients accepted vaccination (difference n.s. after adjustment for prior season vaccination receipt, age, gender, education)
  – No difference by race in proportion already vaccinated that season or citing vaccination as reason for office visit
  – Half of practices located in/near medically underserved areas

Provider Reminders

- In an RCT of older adults served by urban primary care centers, eligible seniors seen in practices using provider chart reminders and patient recall/outreach were more likely to receive influenza vaccination (64% vs. 22%)¹
- Effective in patients of all races but did not eliminate disparities
- In one clinic, including a prompt to discuss influenza vaccination in the electronic medical records of pregnant women increased coverage²
  - 61% of women vaccinated vs. 42% the previous season
  - 90% of patients discussed influenza vaccine with provider


Examples of Successful Implementation of Adult Immunizations Programs

- National Adult and Influenza Summit Provider Working Group collected examples over past year
- Multiple examples also provided by NAIIS Awards
- Both found at www.preventinfluenza.org
- Examples
  - American Congress of Obstetricians and Gynecologists (ACOG)
  - Indian Health Service (IHS)
  - Pharmacists
  - State health departments (SHD)
ACOG

A combination of synergistic strategies were implemented:

- A strong organizational statement and new immunization department
- A dedicated website (www.immunizationforwomen.org)
  - CDC vaccine schedule
  - Office start-up instructions
  - Patient communication advice
  - Coding, finances, ordering, liability, links to other sites
  - Specific vaccine topics with focus such as the pregnant/breastfeeding patient and female adolescents
- A focused practice-driven intervention targeting individual practices in ACOG District V (MI, OH, IN, KY) and District XI (TX)
  - Project Objective: To increase the types and doses of immunizations given in ob-gyn practices AND build sustainable partnerships with each respective SHD
- Working the Evidence Base
  - Tracking rates, deaths, hospitalizations, member uptake
- Other Interventions
  - Campaign involved 3 direct mailings of evidence-based immunization Toolkits to 35,000 ob-gyns in practice on seasonal influenza in 2011-12 and in 2012-13 as well as on Tdap in 2012 after release of the new ACIP Tdap recommendations

ACOG Results

- **District V Project**
  - 1/3 of sites added at least one vaccine
    - 19% giving more vaccine doses
    - 86% identified “vaccine coordinator”
    - 48% participate in state registry
    - 83% have SHD contact person
    - 41% actively working on office vaccine program
  - Resource utilization
    - 35% ACOG website
    - 49% CDC website
    - 44% vaccine schedule
  - Other practice changes
    - 39% integrate vaccine discussion during visits
    - 19% added vaccine info to chart
    - 14% added recall system for multi-dose call backs
- **National Data**
  - Influenza immunization rates for pregnant women increased from 15% to 47% in 2009-10 during H1N1
  - 50% rate continued in 2010-11 and 2011-12 influenza seasons
  - 63% of pregnant women received a provider recommendation for influenza vaccination in 2011-12 influenza season
Indian Health Service

- Federal agency charged with providing health care to eligible American Indian/Alaska Native people
- Eligibility: For members of one of the 566 federally recognized tribes and residence in the IHS catchment area
- Population Served: Approximately 2 million patients each year through a network of IHS, Tribal, and Urban Indian health care facilities in 35 states
- Additional provider reminders for medical risk based vaccine recommendations in development
  - Hepatitis B vaccine for diabetic patients
  - Hepatitis A and B vaccines for chronic liver disease and hepatitis C-positive patients
  - PCV13 for immune-compromised patients

Indian Health Service: Leveraging Technology

- Use of EHR and provider reminder prompts focusing on the following adult vaccinations:
  - Influenza for all ages
  - PPSV23 for 65 years+
  - PPSV23 for adults with high-risk conditions
  - Tdap for everyone 19 years+
  - Td every 10 years
  - HPV
    - Females 19–26 years
    - Males 19–21 years
  - Zoster for 60 years +
  - Hepatitis A and B for patients who receive first dose
Indian Health Service: Leveraging Technology

IHS Adult Vaccination Coverage*
FY 2013 Q1 Reports

* Based on Active Clinical Users (2 visits in 3 years), N = 522,310

Pharmacists

- Multi-component approach among pharmacists and pharmacies
- The American Pharmacists Association example
  - Strong organizational commitment to immunization
  - Dedicated website
  - Multiple messages to providers: Listserv of 60,000 immunizing pharmacists, webinars, communications, close attention to ACIP recommendations, news alerts as needed
  - Student pharmacist programs
  - State incentive programs
  - Policy work: Laws, policies related to immunization registries, pharmacist vaccination
  - Training focused on building competencies of providers; mandatory in most states
  - Required immunization curriculum for all accredited schools of pharmacy
- Results:
  - Increase from administration 5%-7% of adult influenza vaccines pre-2009 H1N1 to 18%-20% since 2010
  - Expanded administration to include multiple other ACIP-recommended vaccines
Prevention and Public Health Fund Program Area 5: Plan and Implement Adult Immunization Programs

- **Two required activities**
  - Collaborate with employers to improve immunization rates among employees
  - Collaborate with pharmacies to improve immunization rates among adult customers

- **Two of five optional activities**
  - Expand adult immunization at community health centers
  - Improve health care worker immunization rates
  - Promote hepatitis B immunization at local HD and STD clinics
  - Ensure all adult ACIP-recommended immunizations are included as preventative benefits by state Medicaid offices
  - Improve influenza and pneumococcal vaccination at hospital discharge
Examples of Successes From PPHF-Funded Health Department Projects and Pharmacist Collaborations

- **Massachusetts**
  - June 2010 legislation passed requiring mandatory reporting to their registry
  - As of July 2, 2013:
    - 880,000 adults with records in MIIS
    - 2,425,000 vaccines administered to adults >18 years
    - 47% of all vaccines in MIIS administered to adults

- **Washington State**
  - 3.5 times increase in number of doses reported by pharmacies in IIS in 6 months compared with the prior 12 months after working to increase pharmacy reporting

- **Arkansas**
  - Work with Arkansas Pharmacists Association and IIS
  - Resulted in 80% increase in influenza, 114% increase in PPSV23 and 298% increase in zoster vaccines entered into their registries March 2011-February 2012 compared with March 2012-February 2013

- **Virginia**
  - 55% increase in adult vaccinations entered into registry from pharmacies
  - Doubled the number of pharmacies enrolled in the IIS from July 2012-July 2013

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**CDC Adult and Influenza Immunization-Related Activities**

- Affordable Care Act
  - IIS and Meaningful Use
  - Health IT
  - Medicaid bump-up

- Many different adult immunization providers

- 317 Pandemic Planning Grantees = 64
- 317 Grantee Adult Immunization-related objectives
- Hepatitis B CoAgs n=14
- School-located vaccination CoAgs n=8
- Adult PPHF CoAgs n=10
- Adult Provider/Organization CoAgs n=2

- HHS Interagency Task Force on Adult Immunizations
- National Adult and Influenza Immunization Summit
- Vaccine manufacturers and distributors
- Advocacy Groups, e.g. IAC, NAP, GDA, AZ, ACC
- State and local health department organizations, e.g. AIM, NCCHC, ASTHO, Adult Coordinators
- CDC ISD
- NCIRD Vaccine SMEs
- NCIRD/OD
- Influenza Coord Unit
- NCHP-HSTP
- NCCDPHP - Chronic
- OPHFR
- NCEZID
- CDC Adult Immunization Schedule
- Adult Provider Survey
- NCRD Adult Vaccine Communication Evaluation and Development Center
- NCRD-Adult Vaccine Coverage Assessment and Reporting
- Standing Orders Project - HSREB

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2013 National Adult Vaccination Program
Summit – Carolyn Bridges, MD, FACP
National Adult and Influenza Immunization Summit

• Formed 2012 to build upon the strategies and successes of the National Influenza Vaccine Summit
• Built upon the work and effort from the 2007 and 2010 National Immunization Congresses to focus on actions that have potential to increase adult immunization rates
• In 2013, combined with Influenza Summit to form the National Adult and Influenza Immunization Summit
  – Recognizes overlap in platforms for influenza vaccination and vaccination especially of adults with other vaccines

Patient Education Group: Activities for Coming Year

• Build out adult immunization calendar to
  – Incorporate expanded bank of real-life stories
  – Provide tools (matte articles, tweets, etc.) based on key messages
• Update and enlarge Adult Vaccination Resources Library
• Develop proposal for consolidated website for easier access to information
• Identify effective adult immunization messages

CDC/NCIRD Office of Communications working on adult immunization communications and will share information with Summit
Provider Outreach Working Group: Next Steps

• Develop tools to help providers understand ACA implications and improve their payment for vaccination services, e.g.:
  – Best practices for operational efficiency
  – Billing tools

• Work to develop and implement strategies to increase the provider recommendation

Policy and Decision Makers WG: Next Steps

• Incorporate key relevant recommendations and suggestions obtained from discussions at the Summit into the WG plan
• Meet with remaining NAIIS WGs to align on key goals and objectives that require policy/decision-maker action
• Recruit 1-2 employer advocacy groups to join Decision Makers WG and the Summit
• Prioritize data needs and key messages for decision-maker categories
• Some action items suggested by the Summit
  – Recognizing community immunizers as in-network providers
  – Including all vaccines in Medicare Part B
  – Expanding in-state Medicaid programs to new enrollees
• Considering development of document on “state of the states” in terms of adult immunization environment
  – E.g., registry for adults, scope of practice for pharmacists, etc.
Quality and Measures WG: Next Steps

• Advocate for adult immunization measurements being added to chronic disease measurements
• Work with NQF to standardize adult immunization measures and build on their previous work standardizing influenza and pneumococcal immunizations
• Combine preventive services, including adult vaccinations into either a set of measures or a composite performance measure

Access and Collaboration WG: Next Steps

• Connectivity/documentation of adult vaccinations (support measurement goals) and increase adult vaccine integration into IISs (registries)
• Tools for providers (business and practice models; i.e., billing)
• Remove in-network provider barriers
• Finalize and implement the Updated Adult Immunization Standards
Summit National Award Winners

“Overall Influenza Season Activities” Award
• Recipient: National Council on Aging

“Healthcare Personnel Campaign” Award
• Recipient: Rhode Island Flu Task Force

“Immunization Coalitions / Public Health / Community Campaign” Award
• Recipient: Chicago Department of Public Health

“Corporate Campaign” Award
• Recipient: Walgreens

“Overall Adult Immunization Activities – Beyond Flu” Award
• Recipient: Minnesota Department of Health

Honorable Mention Award

“Healthcare Personnel Campaign” Award
• Recipient: University of Oklahoma College of Pharmacy

“Immunization Coalitions / Public Health / Community Campaign” Award
• Recipient: Assembly of Petworth
• Recipient: IAC of Washington – “Within Reach”
• Recipient: Alachua County’s SLI Vaccination Program

“Overall Influenza Season Activities” Award
• Recipient: Greene Area Medical Extenders

“Overall Adult Immunization Activities – Beyond Flu” Award
• Recipient: Arkansas Pharmacists Association
Outreach to Cardiologists

• Smart multi-messaging to cardiologists
  – Epocrates messaging reaching 40,000 cardiologists
  – Medscape training
  – Outreach from the American College of Cardiology, American Heart Association

• Targeted patient education materials

• Working the evidence base
  – Cardiac disease increased the risk of flu-related hospitalization by almost three-fold; four randomized trials demonstrate reduced risk of cardiac events among vaccinated patients who have existing cardiac disease
Influenza Vaccination Coverage Among Adults 18–64 Years Who Reported Selected Chronic Conditions, BRFSS 2007-2012

22% increase for patients with CVD
13% increase for patients with diabetes
2010-11 through 2011-12
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Affordable Care Act—Select Terms and Elements

Affordable Care Act (ACA). In March 2010, the U.S. Congress passed the consolidated Affordable Care Act (ACA) which included both the Patient Protection Affordable Care Act (PL 11-148), known as PPACA and the Health Care and Education Reconciliation Act of 2010 (PI 111-152). The ACA provides an emphasis on prevention, wellness and coordination of care.

Essential Health Benefits (EHB). EHBs require all individual and small-group plans to cover services in 10 specific services categories, including preventive services. This serves as a reference for the benefits offered by all plans operating in that state and will incorporate the immunization coverage standard. EHBs extend to all health plans sold in the individual and small group markets both in and out of the exchanges.

Health Insurance Exchange. Health insurance exchanges are essentially marketplaces where individuals and small businesses can choose insurance from a selection of health plans. Three models for administering the state-based exchanges outlined in the ACA are:

- State fully administers the exchange
- State enters into a partnership with the federal government to jointly operate the exchange
- State cedes responsibility for administration completely to the federal government

Individual Mandate. The individual mandate of the ACA will require most Americans to have health insurance coverage or pay a fee. Some exceptions to this mandate include people with financial hardships, religious objections, or persons for whom the lowest cost health plan exceeds 8% of their income. Advance refundable tax credits and cost sharing assistance are available to assist those whose income is up to 400% of the federal poverty level.

The Prevention and Public Health Fund (PPHF), which includes funds for immunization infrastructure, was created by the ACA and requires mandatory funding to public health programs to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs. It is aimed to enhance efforts in preventing disease and improving public health.

Qualified Health Plans (QHP). QHPs are insurance plans certified by an exchange as meeting all requirements (e.g., provides essential health benefits, follows established limits on cost-sharing). An insurance plan may operate on a state insurance exchange only if a plan meets the requirements to be deemed a QHP.