

Minutes for the Immunize Kansas Kids
Steering Committee Meeting
August 23, 2006
10:00 a.m. - 3:00 p.m.

The Immunization Steering Committee met on August 23, 2006, at the Capitol Plaza Hotel in Topeka. Gianfranco Pezzino called the meeting to order at 10:15 a.m. Attendance was not taken at the meeting.

Gianfranco Pezzino welcomed participants. Tom Kean reviewed the agenda for the day.

Gianfranco Pezzino provided an introduction to the research activities occurring since the previous meeting, including:

- Immunization Financing
- Physician-clinic linkage database to eventually determine which physicians give immunizations in their clinics

Gianfranco Pezzino additionally provided an introduction to the research activities planned for the future, including:

- An assessment of the factors related to providers in clinics that may affect immunization coverage
- An assessment of the factors related to parents that affect immunization coverage
- A comparison of immunization coverage rates in private practices that give immunizations vs. private practices where children are referred to local health departments

Discussion: A steering committee member questioned whether the planned projects would give us a picture of the public sector as well as the private sector. Gianfranco responded that the projects would cover both immunization arenas.

Sunee Mickle provided an overview of the physician-clinic linkage database project completed by Laura Harrington and Sunee Mickle at the Kansas Health Institute. Major points of her presentation included:

- KHI needed a comprehensive list of primary care physicians and the many clinics at which they work, so a database linking physicians to clinics was created.
- The process began with 7,162 physicians in a Board of Healing Arts database which was reduced to 1,716 primary care physicians (pediatricians, family practice, general practice and any doctor without a specialty).
- Utilizing sources such as the Blue Cross and Blue Shield provider directory, the Kansas Medical Society printed directory, county-specific Web sites, the American Medical Association Web site, the Kansas Hospital Association Web site, the KDHE Web site, reverse telephone number lookup, and Google, researchers linked physicians who could potentially be providing primary care to children aged 0-5 years old in their clinics.

- Researchers matched physicians to 646 clinics and now plan to send a short questionnaire to the 646 clinic office managers.

Sheldon Weisgrau discussed the financing system for immunizations, including the costs and reimbursement of immunizations, both at the levels of individual practice and state. Major points of his presentation included:

- KHI completed a survey of local health departments to determine whether they received local funding for immunizations. One-third of health departments surveyed did receive local funding for immunizations.
- Almost every child has at least partial coverage for immunizations. On the state and local side of funding, there are state general funds, state aid to local health departments, state share of Medicaid and SCHIP and county and local funds. On the private side, there are commercial insurance plans. Self-insured plans are not mandated to provide coverage for immunizations; however, the six large ERISA employers surveyed did cover immunizations.
- There are additional costs to immunizations, however, including out-of-pocket costs, indirect costs (traveling to the doctor's office or taking time off work), costs of vaccines, and administrative costs.
- Very few providers know what it costs them to administer immunizations. Medicare says it costs \$17 for the first vaccination and \$10 for subsequent vaccinations. Insurance does not cover that much.
- The total expenses for immunization of a child will range from \$412 to \$633 for the whole series of vaccination shots between 0 and 3 years of age depending on the source of the vaccine. Insurers pay \$631 to \$758 for the shots. This means that the physician's margin can run from 0 to 84 percent. Therefore, doctors are not losing money on kids covered by commercial insurance.
- Providers are likely losing money on vaccinating VFC-covered kids.
- The total cost of immunizing all kids born in Kansas this year ranges from \$16 million to \$24 million. In 2003, we spent in excess of \$16 million — federal, state, county, and local, Medicaid and SCHIP, commercial insurance, self-insured plans, and military.
- Assuming a five percent yearly inflation rate, the 2006 spending is \$18.9 million to immunize kids. The costs of vaccines are increasing, however, and varicella is expensive.
- Funding appears adequate. Funding may not be the problem. Out-of-pocket costs may be a barrier for some. Inefficiency and duplication are also issues. Provider perceptions, too, may play a role in the immunization rate.

Discussion: A steering committee member asked for the definition of "Kansas Immunization Spending." Sheldon replied that some of that money goes to shots, some to infrastructure, some to everybody who needs immunizations, not just to kids in the 0 to 3 group. There's no way to estimate the out-of-pocket expenditures. It will add to this total. This is a missing piece. A comment was made by a member that most health departments have administrative fees on a sliding scale. Sheldon stated that he agreed 100 percent. Someone commented that there was a sliding-fee scale for private immunizations and that such a scale was not represented. A comment was also made that

in Missouri, there was \$750,000 in vaccine lost because of bad storage and handling. They wanted to know if such a cost were included. Sheldon responded that it was not. There was a question of whether this were a volume-driven issue. Sheldon replied that he was not sure. Gianfranco Pezzino commented that he was interested in whether the size of the practice determines price, noting that there was an economy of scale. There were general comments about the proportion of kids getting vaccinations through VFC versus private insurance, the fear that a statement of there being enough money could be detrimental to the cause of raising rates. Sheldon commented that success in high rates is not always correlated to excess money. Gianfranco commented that there needed to be well-targeted interventions, not just purchasing vaccine or increasing reimbursements, to reach the 15 to 20 percent of the kids who are not being reached.

Sheldon Wiesgrau offered an additional summation of his main points:

- Medicaid is not the culprit in immunization funding, since it pays as well as the private insurers pay.
- Physicians lose money only on the VFC shots.
- The data we have is not designed to do what we need.

Discussion: Tom Kean commented that we needed to state that we should sustain our investment or increase it, or otherwise policymakers would think that immunizations were a black hole. Sheldon responded that the real question was, “Who *are* those 15 percent of kids who aren’t getting immunized? Such data is important to know, if we intend to reach them.

Gianfranco Pezzino introduced the idea that the steering committee should add one additional meeting, for January 31 to the steering committee agenda. They proposed to keep the October meeting. This would allow for more planning surrounding the future of the group. Gianfranco noted that he would like to see a role for the group after January. The need for an additional meeting stems from the fact that:

- There was a sense among some of the workgroups that there was still some work yet to be completed.
- The original idea was a state action plan that was put together in part with the aid of the research activities, and such research activities are taking longer than predicted.

Howard Rodenberg presented the plan from work group number one. The main points of his presentation included:

- There is a need for safety nets. Although the goal of work group 1 is to get everyone into a medical home, realistically, this will not happen.
- In immunizations, it’s all about the money. Rodenberg introduced the idea of Immunomics 101: everything trickles down to the dollars.
- Assets of the project include: strong involvement from KDHE, KAAP, KAHL, Web IZ, a strong support for children’s issues.
- Challenges within the project include: funding issues, knowledge deficits, and delivery system issues.

- Kansas falls behind with the fourth DTaP shot. If the fourth DTaP shot is the problem, then we may not need a system overhaul, but rather, a concentration on this shot.

Discussion: There were general comments about cultural barriers. Discussion continued about the focus on the fourth DTaP. Gianfranco Pezzino noted that children who start late finish late, so that's the highest risk factor for not having the fourth DTaP. A steering committee member stated that he hoped that the committee didn't just focus on the fourth DTaP and noted that the group had an opportunity to put forth a widespread plan for future immunizations that would be sustainable. Gianfranco Pezzino asked for more details in the recommendation. Tom Kean also noted that more detail would be useful. He suggested that work group 1 should tease some things out of Sheldon's report.

Bruce Miyahara and Judy Seltzer presented the plan of work group number two, whose purpose was to focus on accelerating implementation of the statewide immunization registry. The main points of their presentation included:

- The providers are broken into health departments and other providers. One issue is populating the registry, while the other is making it useful to providers.
- The main problem is fitting providers into the registry system. It is not known how many billing systems are out there, where they are. Many historical records need to be entered.
- Parents may put pressure on doctors to enter child's records into the immunization registry.
- Electronic Medical Records is another input into provider consideration. How well does the registry interface with various forms of recordkeeping?
- Some providers will cooperate and use the registry because there's a public good to it. Not all providers will, though, so making it easy and working behind the scenes are also important.
- We need to understand the provider issues, to understand the billing issues.
- We need to survey offices to identify the top ten medical billing systems, survey providers to determine EMR vendors, build and sustain relationships with the providers. And then build relationships with practice managers.
- There is a small staff at KDHE to build the relationships that are needed.
- All of the best practices are based on relationship, relationship, relationship.
- Where are the kids in the health care system and who is treating them?
Answering that question will help us prioritize our work plan and strategies.
We're losing ground everyday we're not picking up those kids.

Discussion: A steering committee member noted that his nurse entered data at the end of the day and as she was answering the phone. That was the only way that they found they could populate the database. They found that the extra effort is worth it, because she no longer has to make phone calls to find out about immunization providers. Most providers do not have any kind of registry, so the main problem will be the back entry — how do you get the old data into the system? Another member noted that the registry could grow by concentrating on providers in areas with large populations of children and work to get that area on the system. It could also grow by getting larger providers involved.

Gianfranco Pezzino urged the group to gather more specifics.

Terri Roberts presented the ideas of work group number three, the work group focused on promoting policies, regulation, and environmental changes that increase access and utilization of immunization services. Terri noted that the group had a half day meeting in July after the June 14 meeting, and that this is where most of their ideas came from. The main points of her presentation include:

- The group considered issues related to payment, administration, and insurance.
- Kansas law should be changed so that ACIIP schedule determines requirements for school entry.
- The group wanted sustainable policies
- They wanted to consider policies from states with higher immunization rankings, and look at policies to help reach hard-to-reach children, and consider policies to expand the type of people permitted to give immunizations.
- The assets currently in place include the VFC program, financing, Kansas' mandatory coverage law for immunizations, and a state in which regulatory and legislative changes are not too difficult to implement.
- The current challenges are perceptions of VFC administration requirements, and ERISA.
- The Kansas Health Institute prepared information on laws as well as best practices in other states. From the information they gathered, they were able to make these recommendations:
 1. Seek additional funding to expedite immunization registry building
 2. Consider a mandatory immunization reporting law.
 3. Consider the adoption of ACIP recommended schedules.
 4. Create a continuing nursing education/medical education and online program to talk about how user-friendly VFC has become.
 5. Create an immunization advisory panel of parents, providers, and others.
 6. Create more educational programs for parents. An option is utilizing bilingual lay health workers to get education and training on how to go into communities.
 7. Standardize reimbursement rates for insurers.
- More information is needed on Iowa's mandatory reporting law, on what percent of VFC providers are family physicians and what percent are pediatricians, and on whether KSA 72-5209 is enforced.
- The group considered universal coverage but ruled it out.

Discussion: Gianfranco Pezzino was curious about the background and motivation for legislation related to immunization registries. Terri Roberts answered that there are states that have statutory authority for a registry. Sunee Mickle clarified that there are laws that state that we can collect info for databases, but what we want is something more like the cancer registry.

Nancy Tauze presented the ideas of work group number four, which is focused on creating parental and community demand for immunization services. The main points of her presentation included:

- Consumers need to know why immunizations are important, when to get immunizations, and how to work with the system to get what is needed.
- The system needs to be less disjointed and more unified.

- Assets currently in place: the topic is out in the open, Kansas already focuses on kids, there are many media options, and there is good connectivity in Kansas Health Institute.
- Current challenges: Don't see vaccine-preventable diseases, the system is disjoined, there are religious and cultural barriers, mixed messages and misinformation, the lack of a common language, missed opportunities.
- Things to do: multimedia, ad agencies, PSAs, advertisements on billboards, IKK website, groundwork for unified system, create demand, strengthen relationship of physicians and local health departments, recruit groups to distribute materials, prompt parents and physicians to ask about immunizations, strict exclusion possibilities.

Discussion: General comments were made about the problems with strict exclusion. Sheldon Wiesgrau pointed out that in that case, kids may wind up not getting immunized and not getting WIC either. Tom Kean suggested calling it an educational campaign rather than a media campaign.

Tom Kean provided an overview of the day's activities and included plans for the future. He hoped that all work groups would think in terms of the target audience as they make considerations and that the presentations would become more specific. He also urged groups to be able to say "if we do this – then these are the outcomes we'll get."

Gianfranco announced that there was a statewide immunization conference coming up and that he invited everyone to attend the conference. He announced that he would be presenting the background of the committee.

The meeting adjourned at 3:00.