

Note for the Record
Immunize Kansas Kids
Access to Care Working Group
Jan 31, 2007

Members Present

Laura Harrington, KHI; Laura Sanchez, KFMC; Marlou Wegener, BC & BS of KS;
Sandy Perkins, WIC of KDHE; Nancy Tausz Jo Co HD; Ida Nesmith, Jo Co HD;
Kim Murphy, Evaluation Insights, Dennis Cooley, KS AAP
Pam Shaw, KS AAP, KUMC; John Rule, KHI; Harry Hull, Facilitator

The session began with a review of actions that had already been taken to improve access to care during the last year and the information that had been provided during the morning session.

The first step discussed was that the Governor's budget now before the legislature includes funds to support expanded immunization efforts through WIC. This is a welcome step forward, particularly in light of the improvement seen in immunization rates in Wichita in recent years. WIC currently has approximately 70,000 enrollees, with about 40,000 of them being children. WIC currently does not have an effective means of tracking immunizations. In many instances, WIC staff members have been accepting a maternal report of the child being up-to-date, without necessarily reviewing the immunization card in detail. On Feb 19, 2007, a new version of the WIC computer program will be introduced, which should improve tracking of immunizations.

Additional discussion on WIC indicated that there is effective coordination between WIC and immunization programs is sometimes absent at the county level. For example, it is not unheard of in small counties for a public health nurse on WIC duty to request that an incompletely immunized child come back to the immunization clinic in the same building staffed by the same nurse on another day. In larger counties, immunization clinics may also be scheduled at different times from WIC clinics. There are also counties where the immunization clinic is located on a different floor in the same building or in a different building. In each of these instances, the parent may have to go through 2 long waits to get both the WIC vouchers and the child's immunizations.

With new recourses anticipated, members of the group felt that it would be worth focusing on ways that immunization could be facilitated in WIC clinics. KDHE could work with counties to allocate additional staff to review immunization records and provide needed immunizations to children during WIC clinics. Additional efforts should be made to help parents get their children immunized by removing physical, scheduling and bureaucratic obstacles to immunization thereby reducing the time and effort that parents must expend to get their children immunized. It may be helpful to have individual county WIC programs report at regular intervals on progress in reaching statewide immunization goals.

A second topic of discussion was access of VFC eligible children to immunization services. From data presented in the morning session, it was apparent that the lowest immunization rates, the largest numbers of young children and the lowest VFC participation rates were in the largest counties in the state. The core of the problem was identified as limited access to overall medical care for children enrolled in Medicaid - not just limited to access to immunizations. Until recently, Medicaid reimbursement rates in Kansas had not changed for nearly 30 years. Under these circumstances, physicians were unable to recoup even their overhead when seeing Medicaid patients and consequently experienced a net loss of income from seeing Medicaid patients. Despite good intentions, many physicians either did not accept or severely limited the number of Medicaid patients they would accept into their practice. The consensus was that increasing VFC participation rates is dependent on increasing Medicaid participation rates.

With the recent increase in Medicaid reimbursement rates, the Pediatric Clinic at University Medical Center in Kansas City reports that they are making a profit on Medicaid patients for the first time. Discussion indicated that overcoming the reluctance of physicians to participate in Medicaid would take time and would be best accomplished by physician to physician interchange. KDHE has recently signed a contract with the AAP to educate physicians about immunizations and VFC. This effort is directed to family and general practitioners who see children in addition to pediatricians. Success will require multiple contacts over an extended period, not just a single contact. AAP was quite optimistic that, over time, the effort would significantly increase physician participation in Medicaid and VFC. Concern was expressed that Medicaid participation rates are likely to decline if Medicaid reimbursement rates are cut due to future state fiscal issues.

A third area of discussion was that local health departments could do a better job of supporting physicians improve their immunization practices. County health departments in Kansas possess considerable expertise in immunization, which could be mobilized to support their local physicians. One way this could be accomplished was for county health staff to conduct an immunization practices improvement program. This would be particularly useful because of the myriad changes in the immunization schedule over recent years. County staff would visit offices to discuss procedures and review immunization records of patients. Data generated would be used to document success and suggest ways that the practice could better achieve immunization goals for their patients. The word "audit" would likely conjure up unnecessary negative associations and should be avoided. Costs and sources of funding for this approach were not discussed in depth. Currently, both Medicaid and individual insurance providers conduct audits of immunization coverage for individual practices, but such audits do not provide specific suggestions for improving coverage. A significant frustration for these immunization audits, particularly in regard to Medicaid patients, was that they did not account for patients who were enrolled in or assigned to the practice, but had not been seen for care. The Kansas City area was particularly frustrating because families frequently moved back and forth across the state line. Documenting movement of these children out of state as well as immunizations provided out-of- state was particularly frustrating. Providing physicians with CME for attending courses on immunization as a

means of improving immunization services mentioned as unlikely to be successful because the Internet has decreased the need for and attendance at such courses. There was also a brief discussion on whether perceived contraindications to immunization were an obstacle in providing immunizations, with the conclusion that they played a minimal role.

A fourth area of discussion was generating a greater understanding of who the under-immunized children are and why they are not being reached. Since Kansas children have very high compliance rates with the school immunization requirements, nearly all children have access to some form of immunization services by age 5. The principal problem is ensuring that children under 2, particularly the 12-15 month olds, are reached. The Immunization Registry would be an ideal starting place for identifying children who are delayed in receiving their immunizations, but is not fully developed at this time. The Kansas Foundation for Medical Care conducts an annual survey of immunization coverage and can provide data at the state level, immunization coverage in the most recent survey was 74% for children under 2. Detail on the race, ethnicity and missed opportunities for immunization were not readily available from the survey. Further exploration of the use of the Medicaid coverage survey was vital to define specific populations where outreach might help improve rates. John Rule discussed the studies being undertaken by KHI both in the morning session and in the working group meeting. Additional discussion is needed to determine how the data collected in these planned studies could be used to better identify the children who would be the target of specific immunization improvement efforts and the best strategies for reaching them. It was mentioned that a study linking WIC and Medicaid with birth records was under consideration (by KDHE?). The new WIC computer system should be assessed as a potential data source. Studies of these children should specifically document missed opportunities for immunization including WIC visits and visits for episodic medical care where no immunizations were given.

At the end of the meeting, the following were agreed:

1. Efforts to improve immunization coverage in Kansas during the next year should focus on geographic areas most likely to yield significant results. Because coverage is lowest and populations are large, efforts should focus on urban and semi-urban counties.
2. Efforts should be guided by the understanding that nearly all parents want to do what is good for their children and nearly all physicians want to do the right things for their patients. Our efforts should focus on helping both parents and physicians to immunize young children by making it easier for them to do so.
3. Efforts to improve immunization in WIC clinics are likely to yield important improvements in immunization coverage in Kansas. In addition to the new staff that will hopefully be provided through the Governor's budget initiative, KDHE and county health departments should review how issues related to physical plant and scheduling can be addressed to facilitate children being immunized during WIC clinics. Bureaucratic procedures should also be reviewed and obstacles removed.

4. The combined efforts of KDHE and AAP to educate physicians about immunization and increase physician participation in Medicaid and VFC are commendable. Success of the program is likely to occur over a period of years and will require continuing commitment to the effort.
5. A more precise profile of the unimmunized population in Kansas is needed, specifying why they are unimmunized and identifying their missed opportunities for immunization. Having a fully populated, fully functional immunization registry would be an important step forward. Exchange of immunization information with registries in neighboring states and Native American tribal immunization services (especially in OK) is an important element of a successful registry. Recognizing that the Registry is unlikely to provide such data in the short term, KHI, KFMC, KDHE and the working group should explore methods for collecting such data so that a proposal could be presented and discussed at the next meeting on May 8.
6. The working group would meet by conference calls, with the next meeting being in approximately 1 month.

Topics not discussed:

1. Impact of proposed limitations on the use of Thimerosal-containing vaccines in Kansas.
2. Who should be participating in the working group, but was not present. Should they be invited to join/rejoin? Should they receive minutes of working group meetings?