National Adult and Influenza Immunization Summit
"Setting the Stage for 2024-2025 Respiratory Virus Season: Where Are We and Where Can We Go from Here"
Webinar Q&A: May 23, 2024

QUESTIONS AND ANSWERS

Q: Are recordings of the May 9th and 16th presentations available? Have the slides been posted yet on NAIIS?
Summit Leadership: The slide presentations and recordings for the May 16th webinar are located at https://www.izsummitpartners.org/2024-naiis-may-16-23/.

Q: What are PBMs?
Mitchel Rothholz (via Q&A comment): PBMs are pharmacy benefit managers who process claims, control payments, and impact access to care. In vaccinations, for several of the vaccines, payment for vaccine cost may be inadequate and the amount paid for vaccine administration below costs. In addition, their policies can restrict access. While out of pocket costs have been addressed by IRA, it does not address provider reimbursement. Low reimbursement, delayed payments, and out of pocket costs to providers all impact ability to sustain access.
John Beckner (NCPA): PBM stands for pharmacy benefit manager. PBMs came into being many years ago as claims processors, but their role has expanded way beyond that realm. And now about 90% of the market is controlled by the three big PBMs, CVS Caremark, Express Scripts, and Optum. They contract with insurers to control prescription drug cost. Lately, they've done that by, in effect, reimbursing pharmacies, in a lot of cases, below their cost to acquire these prescription drugs. Any type of administration fee or pharmacy dispensing fee aside, in a lot of cases pharmacies are being reimbursed under their cost, which is contributing to a lot of pharmacy closures, particularly in the independent pharmacy sector. It's affecting pharmacies because they're employing utilization management techniques where they may limit access to a certain vaccine as a cost cutting measure. By doing that, they may not cover, for instance, a Tdap or they may cover only one of the RSV vaccines. And that's really limiting access. So not every vaccine is going to be covered, and many pharmacies are electing not to stock a particular vaccine if they're being reimbursed underneath their cost to acquire that particular vaccine. Allison, I'll give you an opportunity to chime in, but it's a big issue today.

Allison Hill (APhA): It is. And it's not only affecting pharmacy closures but also pharmacies that are staying open, because they may have to make the difficult decision to cut staff because they aren't making the reimbursement figures that they had expected or have made in the past, and they're not allowed to keep that staff on. So, not only is this a pharmacy issue, it becomes a whole healthcare issue because of pharmacies and the access issues…if people aren't allowed to go to their pharmacy to get their vaccine or their pharmacy isn't open at the time that they need it, it becomes a greater issue when we think about uptake with respiratory vaccines or any of the other vaccines.

Q: I'd like to ask Dr. Lee and Dr. Shanks to weigh in, because what we're talking about, I think, is time with patients, because we do know we have hesitancy. And if you're really constrained with time because payments are lower, that really impacts your ability to address a lot of that hesitancy. So, Allison, as you were saying, this is really a system-wide issue. Susan or Denton, do you want to comment?

Susan Lee (ACP): Yeah, for a short time, we had COVID vaccines in my office and my immunization rate for patients that had never received the vaccine was, like, 100%. Because when I actually had the time and because I felt it was important, I was able to talk to my patients, who I knew, so I knew what their fears were, and they were able to accept the vaccine. So that, to me, is a big success. And I think that speaks to the importance of the relationship that we have with our patients and the fact that we need time. We're asking primary care physicians with boots on the ground to do so many administrative tasks that don't include the patient, and it's [time] being whittled away. And so, from an advocacy standpoint, and I think this also is true for the pharmacist… Thank you to the pharmacist, I got my COVID vaccine at a time that was convenient for me, but I remember standing in line and it was just one pharmacist and a long line of people waiting. And I just remember, when I got the vaccine, I looked at him and said, "Thank you so much. I can't believe how busy you are. You know, I wish I could help you." And I saw in his face like a moment of 'thank you, so much for acknowledging me.' But I think that speaks true for the pharmacists who are helping us to get patients vaccinated. So I think we all need to advocate for more time that patients have with their physicians in the office.

Denton Shanks (AAFP): [From the family physician perspective] I tell a story of many patients that have come in and say, 'Oh, I've been contemplating getting a vaccine for months [or maybe for years]. And I have finally decided today is the day and I am here to get the vaccine.' And then it turns out that they're here for Tdap or they're here for shingles, and they have Medicare, and we can't give that vaccine in our clinic, and we have to send them away to another pharmacy. And then they say, 'Oh, that pharmacy is always giving me problems.' And we just went from someone who has been unvaccinated for a long time, has taken lots of time to decide that they are now ready, and then as soon as they get in – and maybe even taken up majority of their visit today just trying to discuss the vaccine, they came in ready – and then we have to turn them away and send them to a pharmacy. It is great to send them to a pharmacy; I have no problem with that. But just the confusion of being here, ready to be vaccinated, and then, because of the complexities in this system (the billing, the access, things like that), we end up sending someone away that had their arm up, ready to be vaccinated.

John Beckner (NCPA): If you think back to the beginning of COVID, when vaccines were supplied to pharmacies, and pharmacies or other providers were paid an administration fee, the rates were off the charts. And now, when the reimbursement is back to normal reimbursement and pharmacies or other providers are reimbursed for just really the cost of the vaccine and nothing else, vaccine rates drop. So if we could fix the reimbursement and access issues, I think the rates would rise dramatically.

Q: You've all touched on all of this: time and convenience. Amy, you brought up a lot about that convenience at the workplace and noted this big drop in flu vaccinations being administered at the workplace. And I don't think we have other data for other vaccines. But I'm wondering if Amy, and then also our pharmacy colleagues or others, could talk

about what they're seeing in terms of requests for vaccination at workplaces. Have those dropped? And what do you think that we could possibly do as people are starting to go back to the office in person to improve that convenience and maybe work with our business partners to increase vaccination again in the workplace.

Amy Behrman (UPENN, ACOEM): It is a tough one, and I think a lot of the issue is cost, actually. Clearly things are contracting now; I don't have numbers on that. But the general sense is that the clients that used to hire health services or turbo medicine services to come in and do a workplace flu campaign or, hopefully, a COVID campaign or a respiratory virus vaccine campaign are wanting less; the number of people who actually come in to be vaccinated when you get there is shrinking as well. And it feels like the momentum has just gone. I know that there are a few big national research projects looking at that explicitly: how to improve the experience; how to improve the uptake; and how to improve this for, what we would call, outside clients, meaning non-healthcare workplaces, in addition to healthcare. I don't know that I have great answers. I do think flexibility and giving both the people paying for it, which in my case is going to be the employers, and the employees who are on a spectrum – of planning to vaccinate, wanting to vaccinate, might vaccinate, movable middle, probably won't vaccinate – giving them options (for products, for time location, for time off if they have the side effects that they're often very concerned about), I think that has to be rolled into the plan in the program. People need to know how they're going to handle this from an HR point of view. Will there be a workers compensation claim if somebody has a rash after a workplace vaccination that's required? Will there be paid time off if they're a part-time employee and they got their COVID shot in the cafeteria of their non-healthcare workplace, and they feel shaky and viral for a couple of days? I think planning this ahead of time and communicating it as normally as possible are important.

John Beckner (NCPA): I think lately, because of all the focus on COVID and, most recently, on RSV, there's a tendency, or may have been a tendency, on the part of not only providers, pharmacists, nurses, and employers to, maybe for lack of a better word, go to sleep on the flu. It's almost become an afterthought. And I think we really need to be thoughtful about our messaging and reach out to these employer groups to share information on the ROI of having a vaccination program through a local pharmacy. You know, what's the impact on productivity, on absenteeism? I think we need to revisit that. A lot of pharmacies, that's a big part of their business plan. They will go out and do employer work sites. They routinely do it now with technicians being able to vaccinate; it's more economical for them to go out and administer a large off-site clinic. It's probably easier now than it used to be, if there was enough interest on the part of the employer group. So, I think it's incumbent upon healthcare providers to be thoughtful about their messaging to these groups.

Carolyn Bridges (Immunize): I think that speaks to that community issue: having those groups who can do community vaccination clinics reach out to employers and others in their community and see how they can help.

Allison Hill (APhA): I think all of that is beneficial, that we have community healthcare workers going out to immunize at non-healthcare groups. But another issue is work-from-home. A lot of time employers aren't as enthusiastic about doing a vaccine campaign if everyone is working from home and then trying to get people in the office. So just coming up with a solution for that, instead of just having a common place for everyone to go to their local provider for that.

Q: Last year was a big year: new RSV vaccines for adults 16 and older and pregnant women, nirsevimab for infants, plus an updated COVID-19 vaccine, plus influenza. Can you reflect on trying to implement those three vaccines last year? Do you have any suggestions or thoughts about how complex, or not, that was? And any suggestions for other providers or for the summit about how to help providers implement those three vaccines? A few years ago we had one seasonal vaccine, now we've got three. How can we help providers implement three this fall, based on your experiences from last year?

Amy Behrman (UPENN, ACOEM): I think it's going to be a challenge; I think that's clear from the data that was presented on May 16 and just from lived experience over the last two years. There certainly is a population of people who will do anything for convenience and just want to get their vaccines and walk out and are delighted to go out with two sore arms and never have to think about it until the next year, but there's a larger population of people who really don't want to get two vaccines at once, much less three. And we're going to have to find a way to accommodate them, which might be as simple as offering your programs, as making it easier. It's hard enough for people to come in once, but somehow we would have to make it easy for them to come in twice or three times.

Susan Lee (ACP): One of the things that we've done in our office is promoted standing orders for vaccines. And this has allowed patients to come in without the need for an office visit. And it's really allowed us to increase our immunization rates. But I think, like many have mentioned, the factor of having convenience for our patients and convenience for physicians [is important]. We don't need to put the order in. It's somebody who's qualified that can administer and order the vaccine and then we sign off on it. So I think promoting things like that definitely help. The other thing that's very interesting to me, is that there has really been very little push back about the RSV vaccine despite it being a fairly new vaccine. I know my patients who have grandkids, they were the first ones to run out and get the RSV vaccine. We did look into trying to get this in our office, but we had a lot of issues with billing. We didn't know which insurance companies would cover it. It was very expensive. So, unfortunately, we opted not to stock it in our office for the adult population. But having the ability to stock these vaccines, and an easy way of billing it, will be super helpful.

Denton Shanks (AAFP): I'd like to see very simplified patient education. I think so many of the handouts these days, you turn it over and one side has fine print that just has a million words that no one's going to read yet still looks extremely confusing to a patient. So, very simplified education…what I mean: This is a little vial of juice. What is in that little vial of juice? What ingredients are there? Why do I need it and what's it going to do for me? That, just in a very simplified way, that is not misleading, would be very helpful.

Q: Based on your innovation role, what do you do in your healthcare system, or what other innovations could you recommend, to help improve our implementation of all three of our respiratory vaccine recommendations?

Denton Shanks (AAFP): Simplified education, maybe a QR code on the wall or something that was very easily accessible to where a patient could walk in, scan it with their phone, and watch a quick YouTube video. I think lots of things like that would be wonderful. Maybe a whole section of YouTube videos that just simply, clearly, within a two-minute video explain why, when, how, and what's needed. I think a lot of that could be very good. Maybe even more on the innovation

side, I wonder, is there any way we can combine these three vaccines into one? Is there any way that we could make it into a patch? I absolutely have patients that come in and have a fear of needles and that is the main thing. I had one recently that came in and told me many religious reasons why they didn't want to get the vaccine. They said that there's scripture about why they didn't want to get the vaccine. They told me that Jesus talked to them and told them not to get the vaccine. And then after openly listening to them for about 25 minutes, over and over, about all of these reasons, I kind of confronted them and said, "I think you may just have a fear of needles." And that patient said, 'Well, yeah, you caught me. I do. It's actually my fear of needles, it wasn't really any of this religious stuff. It was the fear of needles.' And the fact that I confronted them and talked to them about it that day, they got three vaccines and they got their blood drawn, which we've been waiting [for] to get their A1C and metabolic panel for quite a while. So it ends up being so many micro reasons.

John Beckner (NCPA): I think each person's different. I mean, it just depends upon the person what's going to resonate with them in terms of getting a particular vaccine.

Susan Lee (ACP): During the pandemic, ACP put out a whole series of YouTube videos that we created in partnership with YouTube. If you look on our YouTube channel, you can actually find these very patient-oriented videos about the importance of vaccines. I'll e-mail the links to the group, but they're short and quite useful when you have discussions with patients.

Kelly Moore (Immuize.org): Immunize.org has developed an entire resource on addressing anxiety in vaccines: https://www.immunize.org/clinical/topic/addressing-anxiety/.

Q: One thing that you all have talked about or touched on a little bit is students and trainees; I think all of you work with students and trainees in some capacity. Are you seeing things that would be helpful to address [regarding] vaccines, or trends that we need to try and reverse in terms of attitudes and concerns about vaccines, and trainees and students, in particular?

Amy Behrman (UPENN, ACOEM): I do not think we are adequately educating our nursing, our medical and, honestly, even our pharmacy trainees to overcome the hesitancy that is there in a small but very important group. It's just regrettable to have to try to address this when they're 10 years into their careers as opposed to when they're 10 days or 10 months…

Denton Shanks (AAFP): …and say that vaccines are easy; the medical students can say, 'Well, that's a nursing issue'; nurses can say, 'Well, that's a pharmacy issue'; and pharmacy can say, 'Well, have your doctor explain that.' And it's just very easy to push it off to one of the other disciplines. So, unified information that is interdisciplinary and easy to understand. And I think some of that can also be state- and clinic-dependent on who's talking to you about the vaccine, whether it's the doctor, the nurse, or the pharmacist or other healthcare provider.

Amy Behrman (UPENN, ACOEM): And I would say, bluntly, to your prior point, Denton, that having larger print; smaller, shorter video (as Dr. Lee was saying) – video-based education is important for healthcare personnel as well as for their patients.

John Beckner (NCPA): I just wanted to mention that most of the pharmacy schools have the immunization training certificate course in their first or second year of school. So they are trained early on in their professional careers and certainly are in a position to take advantage of that: if they go into a pharmacy, to be an intern or work as a student, they're in a great position

not only to be trained but to be of tremendous assistance to that particular pharmacy in their immunization program. So, additional training is always welcome, but I think things have changed now with pharmacy education to the point where that course is made available early on.

Amy Behrman (UPENN, ACOEM): It's like we should emulate that in other spheres.

Q: What are your best, positive marching orders for your colleagues, kudos to a colleague or group of colleagues, or how can we get better?

John Beckner (NCPA): I can think of no better area for physicians, nurses, and pharmacists to collaborate on than working together through consistent messaging and shared educational opportunities to positively impact immunization rates. I know everybody's gotten a little fatigued with COVID and the new vaccines that have come on the heels of COVID. And certainly, respiratory season is a challenging time, but it's such a great time of opportunity for healthcare providers to positively impact the health of their communities.

Denton Shanks (AAFP): It would be positive if we could understand the pricing of vaccines. Maybe my comment still sounds negative. I recently had a patient that came in and has diabetes, asthma, and seasonal allergies that make respiratory issues very prevalent. And, we gave them the appropriate pneumonia vaccine and they came back and said, 'Why didn't you tell me about the cost of that?' It cost them $900. And I said, "I think there's an issue there, I think you should talk to our billing department and your insurance company." They came back later and said, 'I talked to insurance, and they said they'd just apply it to my deductible, and I'm going to end up meeting the deductible this year. So I guess I'm fine paying it.' And I couldn't get them. I said, "There's got to be an error." And they paid the $900 for their pneumonia vaccine. And it's just difficult. They come to me and ask and I say, "I think all of these should be free and covered by your insurance, whether it's flu or this or that." And then, six months later, nine months later, a year later, they end up with a bill from their insurance for some reason or another. And it's just the aggregate. I'm trying to be positive here. It'd be nice if this was all solved. There is a need for simplified billing.

Carolyn Bridges (Immunize): I just want to shout out to the Adult Vaccine Access Coalition (AVAC) for all the work that they've done with so many partners to help get legislation in place that says you shouldn't be charged an out-of-pocket cost for your vaccines. I may have to call that patient myself and do a little digging, but that shouldn't be the case for people who have health insurance. And that is super frustrating and it's no way to build trust for people who we want to get back soon. So thanks for reminding us about these continued complexities.

Allison Hill (APhA): I want to give a kudos for everyone who has contributed to making sure that we're talking about this issue early, months before, and we're getting a head start and just going out and being positive where we know that we can make a change this year. We've seen last year's numbers, and we know what we can do to cause some differences to increase uptake for this coming respiratory season.

Susan Lee (ACP): I will give a big plug: I'm a director of a patient-centered medical home, and I'm a big believer in team-based care. And the way that we do pre-visit planning and talk to patients about vaccines in our office is really a team effort. So, I'm going to give a big plug for team-based primary care, including all of our partners in getting our community immunized. I really think it takes a whole village to do that.

Amy Behrman (UPENN, ACOEM): I am going to say something I think is positive or at least opportunity-based. It is incredibly heartening and positive to think of the multidisciplinary collaborations that this meeting represents and that, day-to-day in our communities and hospitals, we also see happening, specifically between the nursing (shout out to nursing), pharmacy, and medical practice groups. I wonder if we could do a more powerful job of leveraging the electronic medical record (EMR) availability and the educational materials that have already been developed, such as those that Susan described that I'm embarrassed I didn't know about, and combining them and pushing them out in age-based ACIP recommendations that I see happening with flu, but I don't really see happening with other vaccines. And I wonder, thinking big, could that even be linked to interactive maps: you click that you'd like your RSV vaccine, and then click here for all of the local pharmacies or medical practices that are offering it? Just a thought. Can we use what we've already got and just use it better?

Q: Can communities or organizations adapt the Wild to Mild materials to have additional content (like adding COVID-10 vaccine)?

Erin Burns (CDC via Q&A): Not a straightforward answer -- it depends. If you reach out to me we can discuss specific circumstances. One group wanted to adapt it to COVID vaccine and we did not take them up on that. In other cases, we've been able to share assets.

Comments Captured from the Q&A Transcript

Comment from Q&A, JoAnn Parris (DOH WA): Systemic proper reimbursement WILL create and restore provider time with their patients to recommend and deliver vaccines for MDs and Pharmacists.

Comment from Q&A, Scarlett Swanson (DOH NM): Yes, the RSV vaccine has been well received by adults, kind of mild for the pregnant folks, and in HIGH DEMAND for nirsevimab!

Comment from Q&A, JoAnn Parris (DOH WA): I think many people would take two vaccines in one visit, but not 3. I know that's true for me, it represents a personal limit. RSV vaccine had early advertisement, and LOTS of it! That has supported good initial uptake!

Comment from Q&A, Sri Parajuli (DOH PA): QR code is such a great idea and fits today's digital world. Not only it provides quick info, but also lets people know which sites are credible and where to look for correct info. Impact of influencers can't be discounted as well. It will be nice to see more awareness about vaccines in the digital world.

Comment from Q&A, Mitchel Rothholz (Three-C Consulting Group): Embrace the principles of the immunization neighborhood and the NVAC Adult Immunization Standards.

Comment from Q&A, Irma Murauskas (OHA OR): Universal Healthcare and coverage?!

Comment from Q&A, Katheryne Murray (CSL Seqirus): Just a reminder that the manufacturer can be a great resource when dealing with billing/coding/inappropriate patient out-of-pocket costs, i.e. $900 for pneumonia vax.

Comment from Q&A, Thomas Acciani (GSK): In response to Amy mentioning a map of places to get vaccinated, GSK has supported the creation of a place where all vaccines listed can be linked to participating pharmacies, does not cover offices. https://www.easyvax.com/0