Association of Immunization Managers

Combined AIM-AAP Partnership Meeting
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Limited Hotel, Charleston, South Carolina

Breakout Group B Notes
Strategies for routine and COVID-19 immunization catch-up

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Please Read to the Group Prior to Starting
Background:

- As of 1/18, 11.3% of children ages 6mo-4 years have received an initial dose of COVID-19 vaccine
    - Administration rates have been stagnant since October 2021 (~22K doses/week)
    - Jurisdiction rates range from MS (2%) to DC (41%)
- 8 of the top 10 jurisdictions for vaccination rates among 5-11 year-olds are also in the top 10 states for <5yo (DC, VT, MA, ME, MD, RI, CT, VA)
- Routine childhood immunizations fell another 1% for kindergarteners (2021-22 school year)

How do you think we can best integrate COVID-19 vaccination into routine well child care? What are the barriers to success?

• Low rates are not based on a lack of opportunity to get the vaccine but instead a VERY low demand
• Parents do not see COVID as a threat to their children
• Perception of doing something vs. doing nothing
• First two years of pandemic we told parents the kids were not at high risk
  ○ How do we change that perception on a dime?
• Utilizing key techniques like motivational interviewing with parents and giving them the strength to ask questions and make decisions
  ○ Talking about disparities and being culturally competent when talking to parent's is very important in getting them comfortable with vaccinating their children
• Universal purchase states – generally a culture of "protect everyone" and remove barriers
• Would be interesting to see the demographic and race/ethnicity of those vaccinated in the top 10 states
• More challenging to get information about children coverage rates than it is for adults
• A barrier is not knowing the data of where there are vaccine deserts in the state
• School-age children and the COVID providers in Philly are not in the same zip codes

- Large health systems have “centralized” COVID vaccine so the parents have to go get their kids vaccinated somewhere else which causes even the motivated individuals with the resources to access the vaccine to not go get the vaccine
- Rates of vaccines mandated for school entry versus those not required is different
    - Because of the differences, it creates a “those aren’t as important”
- Fear of long-term effects of vaccine scares parents (and adults)
- How you frame conversations is important; some families saw the pediatricians as not being honest – the parents want the good and the bad before making the decisions
- Publishing data on two years of outcomes and safety of the vaccine – where is the data that shows
- When you talk about “the practice” and the patients that have been vaccinated with little to know side effects makes it sound more real because it isn’t a blanket statement about ALL kids
- Need more data about observations of side effects of the vaccine (or lack thereof) to show the safety
- Counseling of the parent, discussion, etc. takes a lot of time because there is more hesitancy; starting to be like flu in that “I’ll take all the other vaccines but not flu”
- Barriers for COVID are very different than those of the other vaccines, the vaccine presentations, brands, etc.
- Sandwich in COVID with other vaccines due at the time of the visit so that it is not an after thought
- Parents ask “what is required for school” which then leads to some parents to say they only want the ones required for school
- Disinformation is prominent
- Need to “normalize” it to the point of being no different than Hib or other vaccine
- Most parent’s do not feel that the COVID vaccine is necessary for their child
- Long term effects scare parent’s, but they need to also understand the long-term effects of the COVID disease is even worse
- Single doses need to happen before it is going to be “normal” because it is so different
- Misinformation and dis information is so prominent and parent’s think they have the information already and don’t want to hear more about it
- Similar to HPV being first marketed as an STD vaccine, a lot of work had to be done to change the message about a cancer preventative vaccine; COVID is way harder because there is so much mis and dis information out
- COVID became so politicized so it will be years before any public perception changes
- Consistent and frequent information helped with COVID to get us where we are
- When not everyone is saying the same thing, then it makes it easier for things to get confusing; anti-vaccine messages are all the same so it’s easier
- You can do a lot of amazing work but then when the Governor uses language like “jab” or other terms that are not consistent, it can really hinder that progress
- Public Health has restrictions on use of social media so its hard to curb the mis and dis information
- Even in the states doing a really good job, in the young ages, the rates are still bad “the best of the worst”
- A high number of VFC providers are not vaccinating with COVID
- COVID centers – one stop shop for masks, testing, vaccination, etc. One location that people know of so that there is no question of where they could or should take their kids to be vaccinated

- Bulk of the work has been done by COVID centers and pharmacies and not VFC providers
- Can't make it part of regular care until we know what the goal is for moving forward; still in the emergency mode but no one knows what next year looks like
- Until it is on the ACIP vaccine list it will be hard to integrate
- If ACIP meets and says no monovalent and everything is bivalent and once or twice per year (for some kids) will make a huge difference
- The current recommendations are too complicated and still associated with EUA which brings lack of confidence
- Even in practices that are routinely offering it, there is still a very low uptake
- Has also caused flu rates to decline; parents will accept all other vaccines but then will say no to flu and COVID
- Lack of confidence because of the EUA
- Politicization is a big barrier
- College towns where there are professors and other educated professionals has higher uptake
- Anecdotally, when COVID went off the front page, the demand went down; not rushing in to get kids vaccinated because there is not as much of a sense of urgency; no longer front page news
- Back tracks on mandates creates hesitancy and fears
- Original messaging was to not worry about kids but now we're needing to change that messaging

Question: Are there policy differences between the top 10 states and other states?

Are there novel approaches you've seen work to improve childhood/COVID-19 vaccine uptake?

- When the question of myocarditis in children came up, it was incredibly important and influential when talking about the risks versus benefits – what happens when a kid gets COVID
- Are conversations about routine vaccines different than COVID?
    - No, but the difference in the parent's perspective of all vaccines have changed. The conversation stays the same, but now there is a lot more hesitation
- All of the changes that have gone with the pandemic and the "masks vs. no masks" etc. has really hindered the trust in the information about the vaccine
- Repeated conversations about the vaccine until they decide to get vaccinated; continue bringing it up and talk about how much you both care about the child
- Parent's appreciate when the provider will take the time to talk about the vaccine and address the concerns the parent has is incredibly powerful
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- $10 Amazon gift cards
- $25 fuel cards (meet a basic need)
- In MD, they send flu vaccine to ALL VFC providers and that has helped rates, plan to do the same with COVID when it becomes part of VFC; push model
- Need to message to providers that waste is expected and that there will not be penalty
- In NJ, children under 6 going to a daycare must get a flu shot
- Mandates worked for a while
- DC "no shots no school" had to postpone the mandate for schools because of the Mayor giving a one year grace which hindered demand
- Buy-in from educators and schools

What about school-located vaccine clinics?

- Parent's like when things are "convenient" so this is a good
- Need to repeatedly share the information and safety before the clinic to educate parents
- Funded community-based organizations allowed for trusted partners to bring vaccine to a trusted space; convenient and trusted; especially in rural areas
- FQHC school-based clinics are very beneficial
- The need to partner with pediatricians to answer the questions and curb the hesitancy is helpful – "trusted messenger" at mass clinics
- When you provide disparate care, you create further disparities the otherwise would not be present
- When offering only COVID, the clinics were not as successful as when all vaccines were available
- Parents want to have the discussion with their pediatricians/providers
- Not as successful as flu clinics
- Timing was hard and the coordination of getting vaccine out took time; things moved fast
- A lot of success in schools when working with athletic departments; get kids up to date who are out of compliance and focus it on sports
- Student champions was very good strategy

- The differences between what is FDA approved versus not varies based on different vaccine presentations and makes it difficult to manage consent and other forms
- Afraid of mandates for COVID vaccine; some schools just don't want to touch it
- Legal barriers with school boards and education centers
- Some schools under attack and don't want any additional controversy, regardless of who comes in and does the vaccination
- COVID Navigators in schools that did testing also assisted in vaccination (DC); will be going away when funding stops
- Trusted messengers
- Some schools want to provide COVID vaccines, others just don't want to deal with the fall out
- Electronic consent for parents to choose vaccinations ahead of time and not have to be on-site for vaccination
- Easier with COVID because there is no cost associated at all so no billing needs to be set up
- Trusted place for information; even if not doing a clinic, providing education to parents can be impactful
- A lot depends on school leadership and what their view of the vaccine is
- School setting allowed for staff and parent's to also get vaccinated

For those in practice, how do you approach conversations about COVID-19 and routine childhood immunization catch-up? Are the approaches different?

- Stop the differentiation of primary versus booster; need to decide on one, two, or three doses; monovalent vs. bivalent, etc.
- Hard to make a clear recommendation when things are so different based on COVID presentations, there is a lot of clinical decision factored in so it is difficult for even providers to talk about let alone be confident about the recommendation
- Lack of trust in a vaccine that does not prevent transmission; hard to mandate something that does not stop the spread of the disease
- Going from the individual protection versus herd immunity; herd immunity will not be possible
- Responding to a novel virus; the virus changes and we need to change the tactics too; public health and government was viewed as the ones changing their minds, but it was the vaccine
- You would think that the presence of a deadly disease and seeing people die would be impactful on vaccination rates
- The deaths were not a story; if you lived in NY, you couldn't miss the freezer trucks and the death rate where as in other parts of the country people just don't see it
- If a million American deaths don't change the minds of people, what will? Heading in the wrong direction; would 100 deaths from measles phase anyone?
- If a kid comes in and no other vaccines are needed, COVID will be talked about
- In some situations it is approached differently because the reasons for parent's being hesitant are absurd; it's a different conversation entirely
- Providers are feeling repeated moral injury when having these conversations and they are tired of fighting
- High population of medical providers who don't believe in the vaccine, even if they themselves have gotten the vaccine; does not create an environment of promoting vaccine

- NJ AAP surveyed providers about the vaccine and it was early on so everyone was pretty on-board with it

Any other thoughts on how to approach routine and COVID-19 vaccination catch-up?

- Mobile vans and other pop-up clinics are going away so trying to message the need to go to providers for vaccines
- HER tools that show care gaps; need to leverage those tools that exist that can help when a kid is in for something else to be able to educate and provide opportunity for vaccination (i.e. sprained ankle)
- What is the kid due for at the time of a non-traditional visit and how can we capitalize on the time
- Screen patients for vaccinations; if you don't ask you don't; IIS is not always updated so asking those questions every time is important
- Query vaccine registries to fill in gaps and see what is needed; offering the vaccine too at every visit regardless of what the visit is for
- Specialty care providers are seen as "medical home" in some situations; if those providers are not also talking about vaccine then there are gaps in the information and opportunity
- Framing the conversation and being confident can really help not "do you have questions or concerns" but instead "you child is due today, can we get them caught up while you're here today"
- Dentists and other alternative vaccinators that can still deliver education and vaccinate
- Who are the providers who have previously been non-traditional but then changed the rules with COVID; how do we leverage them?
- HPV and dentists work well because of the oral cancer
- FQHCs have dental and medical under one roof
- It's very much an "all about me" and no longer do people care about others
- There is almost too much messaging and it just hardens people; not sure that psychologically we can change the perception of COVID
- There is so much "bad" information online that makes people more hardened to deaths from COVID
- Constant messaging of how things are better now because of vaccines that have been around forever
- If we begin to look at it as those who've been vaccinated at all versus "primary series" etc., the numbers begin to look better; better than flu rates
- HI is in the top 10 states; what is culturally or operationally different?
    - Opened up the hospital for mass vaccination which created access for kids whose pediatrician did not provide the vaccine
    - Providers made their own connections and then referred kids where the vaccine was; the providers were then invested in it because they were self-motivated
- Messaged that there was a high vaccination rate to promote it but internally knew that it was minimal; harder on ourselves
- Mandates work: even with the decrease in kindergarten rates, we know that mandates work; enforcement varies though so it is only as good as it is enforced
- Too political to mandate COVID and now that momentum is creeping into routine vaccines

- Fractured trust that will be very hard to get back to "normal" – the politicization is doing a lot of harm
- Mandates can also be a "crutch" and therefore maybe we need to stop relying on the crutch so much and build a stronger foundation
- Lessons learned from HPV; trying to mandate too early can hinder progress for a long time
- The majority is afraid of the minority
- Mandates are there to push the hesitance people over the edge; there will still always be the few that won't
- Needs to be ACIP recommended (on the schedule) and not under EUA
- Until it becomes "routine" COVID uptake won't budge
- It's easier when it's part of routine (your child is due for four recommended vaccines today) don't single it out
- Single dose vials are key; the economic impact is catastrophic
- Private payors will need to pay for it or providers won't stock it because of the financial impact
- Would it be better to have a combo vaccine? Flu-COVID combined vaccine? Flu-COVID-RSV vaccine (seasonal respiratory vaccine)

Major themes and takeaways

- Motivational interviewing
- Have to walk a fine line on strategies with vaccination clinics, in some instances offering COVID with other vaccines is good, in other cases including COVID with a flu clinic could reduce demand because of the inclusion of COVID
- Demand is down across the board
- Persistent and confident conversations about vaccines is helpful
- Trying to change the perception from "it's a mild disease in children" to "kids need this vaccine" is very challenging
- Previously, there was no talk about "brand" or manufacturer but now COVID has started a new conversation
- Have to go to multiple locations when pediatricians don't offer COVID; even as someone who is motivated, it is incredibly difficult to get kids vaccinated
- Are the multiple doses as important – what is the goal post? Is it to get them vaccinated with the primary or all boosters too? Need to define the goal and all work towards it
- Is the primary series meeting the goal without the need for additional doses? Yes
- The original message was about preventing the disease, now its to prevent the hospitalizations and death; there is no getting rid of it at this point
- 3-dose versus 2-dose series; as a practice the decision was made to get the 2-dose instead of trying to get a kid in for 3 shots when 2 of the 3 don't provide good protection
- States were able to activate pop-up clinics and had vaccine available everywhere and now the shift is going back to the 9-5 M-F; how do we make sure that there is still access after-hours for everyone?
- ERs offering vaccinations to everyone, parents, kids, etc. is incredibly beneficial because parents bring kids in the ER
- What makes the top 10 states different: policy?

- We need to celebrate the successes; high rate of vaccination with at least one dose – the “majority” of the population is not scared of the vaccine and shows it is a social norm for adults
- Even testing has been significantly reduced; parents don’t even want to know because then they have to stay home from school, etc. It’s a bad social norm of having COVID; if you don’t test for it you don’t have to stay home, etc.
- Fear of judgement if a parent vaccinates their kid