

**Immunization Advisory Committee
Summary of Minutes
Michael A. Bilandic Building
160 N. LaSalle St. Room N505
Chicago, IL
October 8, 2008**

Members Present;

Rashmi Chugh, M.D
Robert Daum, M.D
Robyn Gabel, M.S.P.H, M.J
Nancy Khardori M.D
Stephen Laker, M.S
Julie Morita, M.D
Rita Rossi-Foulkes M.D,

Susanna Roberts, R.N, M.S.N
Penny Roth M.S, R.D
Margaret Saunders, M.S, RD
Kathy Swafford M.D
Dennis Vickers, M.D, MPH
Ellen Wolff, R.N

Others in attendance:

Ann Chikahisa, GSK
Jan Daniels, IDPH
Julia Dilday, Medill News Service
(Northwestern)
Brian Flynn, Med Immune
Lauren Gross, IDPH
Paula Jimenez, Sanofi Pasteur
Mike Kimak, Wyeth
Judy King

Janet L.Larson, IDPH
Karen McMahon, IDPH
Barbara A. Mullarkey, IVAC
Madhu Nappi, IDPH
David Nardone, Merck
Roy Pura, GSK
Salaeha Shariff, ICAAP
Kenneth Soyemi M.D, MPH, IDPH

1. Welcome and Introductions

Dr. Khardori called the meeting to order and asked for introductions of the committee.

2. Old Business and approval of Minutes

Margaret Saunders indicated that her name was left off the members present from the July 16 minutes. Janet Larson indicated that they would make sure and add her name to the list. Steve Laker made a motion to approve the minutes and Robin Gabel seconded the motion.

3. New Business

Legislative & Rule Update: Karen McMahon indicted that there were no changes and or new updates on the legislative or rule updates. She explained that in the minutes it did reference the emergency rule that went into place in regards to the physical exam. When the emergency rule was filed, the

permanent rule was also filed. There is still some outstanding rulemaking language referencing utilization of Tdap vaccine as well as Td vaccine. With the type of rulemaking that was being done for the emergency rule, JCAR did not feel it should all be put together. Robyn Gabel asked if anything was planned for next year and Karen indicated that getting the rules finalized for the Prevnar requirement.

Vaccine Financing in Public and Private Sector: presented by Dr. Julie Morita (please see attached power point presentation)

Influenza Update: Karen McMahon indicated that we are officially in influenza season. Influenza surveillance has started and she indicated that the code for the first week was categorized as “no activity”. We have 68 sentinel provider sites in Illinois. Of those 68 sites, 37 are emergency departments scattered throughout the state. In reference to the Vaccines for Children program (VFC) we’ve been relatively slow getting the vaccine distributed. By the end of October, we should have over 50% of the vaccine out in VFC provider’s offices. Vaccine distribution for VFC has been a little more staggered this year. All 64 federal projects are under third-party distribution. Steve Laker indicated that the demand for flu vaccine appears to be down a little bit this year. He indicated that normally they would have given at least 1,500 and they have given 800. Karen McMahon indicated that there is a lot of competition for flu vaccines in the community such as retail pharmacies. Dr. Khardori asked if Sangamon county uses exclusively inactivated vaccine for the community clinics. Karen McMahon indicated that they go out to bid for the vaccine and Flumist is still higher than the inactivated vaccine. Dr. Khardori asked if the counties do their own bidding and Karen McMahon indicated that they go through the Illinois Public Health Association (IPHA), Minnesota Multi-State contract or the Northern Illinois Public Health Consortium. Dr. Rossi-Foulkes asked if we had any data on Flumist insurance coverage. Dr. Swafford indicated that she thought most insurance companies were covering Flumist.

Hepatitis B Survey results: Presented by Salaeha Shariff of ICAAP (Please see attached power pt. presentation)

Dr. Khardori indicated that we need a motion through this committee for a legislative process on the issue of preventing Hepatitis B in newborns. Dr. Daum made a motion to appoint committee members to have a teleconference to consider the options that we can take to remedy this problem and have it as an agenda item for the next committee meeting. Susanna Roberts seconded the motion. Dr. Vickers agreed to serve on the work group as well as Robin Gabel, and Julie Morita.

4. Open meeting speaker-Barbara Mullarkey, President, Illinois Vaccine Awareness Coalition. Barbara presented the following questions:

- Will you place public comment on the agenda right after approval of minutes to give parents with small children the opportunity to comment and read?
- Will you put the names, titles and organizations, addresses and contact information of the Immunization Advisory Committee members on the IDPH website?
- Will you give suggestions to IDPH Director for enforcement of the 2006 mercury free vaccine law and to eliminate the same exemption which subverts the legislature's intention?
- Will you publicize the names and statistics of HPV adverse reaction reports for the U.S particularly those in Illinois?
- What happened to the presentation of HPV statistics requested by Robyn Gabel at your July meeting?
- What number of members constitutes a quorum?
- Would it be possible for members to use microphones?
- When will I receive answers to the July 17 questions?

Dr.Chugh asked if there was a way to pursue filling the representative from the Illinois State Board of Education on the Immunization Advisory Committee. Karen McMahon indicated that we have to make a request through the Superintendent of Schools and that we would need to resubmit another letter.

Dr. Khardori asked about meeting dates for 2009 and four tentative dates were given March 18, 25, July 22, and Oct 14. Janet Larson was requested to check the legislative session schedule for the March dates. Janet Larson indicated that all committee members needed to complete their Ethics training by Oct 31, 2008 and that she had the training materials at the meeting for those who had not sent theirs in yet.

5. Adjourn

- Dr. Khardori declared the meeting adjourned.

Perinatal Hepatitis B Hospital Policy and Practices Survey

Salaeha Shariff, MS
Immunization Project Manager
Illinois Chapter, American Academy of
Pediatrics
October 8, 2008

Presentation Overview

- I. Survey Background
- II. Survey Methodology
- III. Survey Findings
- IV. Report Conclusions
- V. Recommendations & Next Steps

Background

● 2003

- ICAAP conducted a survey of Illinois birthing hospitals revealing that only 60% of these hospitals had policies and/or standing orders to routinely provide hepatitis B vaccine to infants prior to hospital discharge.

● 2007

- Follow-up survey conducted to assess IL hospitals Perinatal hepatitis B policies and practices.
- Survey examined policies regarding administration of hepatitis B birth dose prior to hospital discharge. For comparison purposes, survey also contained questions on policies and practices related to perinatal HIV.
- Survey developed by the Centers for Disease Control and Prevention and modified for ICAAP use
- Funding for this study was made possible by funds received from the Office of Health Protection, through the Illinois Department of Public Health.

2007 Survey Methodology

● 108 IL birthing hospitals

- Excluding the city of Chicago
- Survey sent to pre-identified individual deemed most appropriate to respond to the survey
- 3 rounds of survey mailings were conducted
- Survey Response Rate: 83%
 - 90 Hospitals Responding

● Data held in Access database

- Analyses conducted using SPSS, using simple frequencies and cross-tabulation procedures
- Chi-square was used to test the statistical significance of observed differences

Survey Findings

Characteristics of Respondents and Hospitals

- Professional Category of Respondent

- Nurse: 49.4%
- Pediatrician: 1.1%
- Clinical Nurse Manager: 32.6%
- Administrator: 3.3%
- Other: 13.3%

- Highest Level of Neonatal Care Provided

- Level 1: Basic: 16.7%
- Level 2: Specialty care: 70.0%
- Level 3: Neonatal intensive care: 13.3%

Characteristics of Respondents and Hospitals (cont'd)

● 2005: Respondent Hospitals Number of Live Births

- Mean: 1257
- Median: 1039
- Range: 96 - 4,000

Neonatal Policy Decision Makers (multiple response permitted)

● Involvement in Making Policy Regarding Neonatal Practice

- | | |
|----------------------------|-------|
| ■ Neonatal Nurse Committee | 27.8% |
| ■ Chief Pediatrician: | 42.2% |
| ■ Chief Obstetrician: | 8.9% |
| ■ Neonatologist: | 34.4% |
| ■ Nurse Manager: | 65.6% |
| ■ Clinical Nurse Educator: | 20.0% |
| ■ Pediatric Department: | 38.9% |
| ■ Other: | 17.8% |

● Who Decides Neonatal Practice Policy

- | | |
|--|-------|
| ■ Single decider, not a nurse or pediatrician: | 3.3% |
| ■ Nurses only: | 14.4% |
| ■ Pediatricians only: | 16.7% |
| ■ Mixed professional group: | 65.6% |

Written Policy and Standing Orders for Perinatal Hepatitis vs. HIV Policy

	Both written policy and standing orders	Written policy only	Standing orders only	Neither
<i>HBsAg testing of pregnant women</i> % (n)		% (n)	% (n)	% (n)
Review prenatal HBsAg test results at time of admission to L&D unit for all pregnant women	43.3% (39)	31.1% (28)	10.0% (9)	15.6% (14)
For women without a documented HBsAg test result, test as soon as possible after admission	48.9% (44)	20.0% (18)	13.3% (12)	17.8% (16)
Written policy for repeat testing of pregnant, HBsAg-negative women at risk for HBV infection during pregnancy? ¹¹	n/a	2.2% (2)	n/a	n/a
<i>HIV testing of pregnant women</i>				
Review prenatal HIV test results at time of admission to L&D unit for all pregnant women	74.4% (67)	20.0% (18)	4.4% (4)	1.1% (1)
For women without a documented HIV test result, test as soon as possible after admission	80.0% (72)	14.4% (13)	4.4% (4)	1.1% (1)

Written Policy and Standing Orders for Perinatal Hepatitis vs. HIV Policy (cont'd)

	Both written policy and standing orders	Written policy only	Standing orders only	Neither
<i>Infant prophylaxis - HBsAg</i>				
Administration of HBIG within 12 hours of birth for infants born to HBsAg-positive mothers	62.5% (55)	13.6% (12)	10.2% (9)	13.6% (12)
Administration of hepatitis B vaccine within 12 hours of birth for infants born to HBsAg-positive mothers	59.8% (52)	11.5% (10)	14.9% (13)	13.8% (12)
Administration of hepatitis B vaccine within 12 hours of birth for infants born to mothers with unknown HBsAg status	53.3% (48)	13.3% (12)	12.2% (11)	21.1% (19)
Administration of hepatitis B vaccine to all newborns before hospital discharge	42.7% (38)	1.1% (1)	18.0% (16)	38.2% (34)
Written policy for documentation of maternal HBsAg test results in the infant medical record? ³	n/a	67.4% (60)	n/a	n/a

Presence of Both Written Policies & Standing Orders by Highest Level of Neonatal Care Provided

	Basic	Specialty Care	Neonatal Intensive Care
Facility has both written policy and standing orders for:			
<i>HBsAg testing of pregnant women</i>			
Review prenatal HBsAg test results at time of admission to L&D unit for all pregnant women	40.0% (6)	41.3% (26)	58.3% (7)
For women without a documented HBsAg test result, test as soon as possible after admission	60.0% (9)	44.4% (28)	58.3% (7)
<i>HIV testing of pregnant women</i>			
Review prenatal HIV test results at time of admission to L&D unit for all pregnant women	80.0% (12)	73.0% (46)	75.0% (9)
For women without a documented HIV test result, test as soon as possible after admission	80.0% (12)	79.4% (50)	83.3% (10)

Presence of both Written Policies & Standing Orders by Highest Level of Neonatal Care Provided (cont'd)

<i>Infant prophylaxis - HBsAg</i>	Basic	Specialty Care	Neonatal Intensive Care
Administration of HBIG within 12 hours of birth for infants born to HBsAg-positive mothers	46.7% (7)	62.9% (39)	81.8% (9)
Administration of hepatitis B vaccine within 12 hours of birth for infants born to HBsAg-positive mothers	40.0% (6)	62.3% (38)	72.7% (8)
Administration of hepatitis B vaccine within 12 hours of birth for infants born to mothers with unknown HBsAg status**	20.0% (3)	58.7% (37)	66.7% (8)
Administration of hepatitis B vaccine to all newborns before hospital discharge*	73.3% (11)	37.1% (23)	33.3% (4)
*p<.05 **p<.01			

Hospital Policies & Standing Order at Admission to L&D: CDC National vs. Illinois Survey				
	Illinois N=90		CDC Sample N=196	
	%	N	%	N
Hospital currently has:				
Written policy to review prenatal HBsAg test results at the time of admission to L&D for all pregnant women?	74%	67	70%	130
Standing orders to review HBsAg test results at the time of admission for delivery for all pregnant women?	55%	48	50%	77
Written policy for HBsAg testing as soon as possible after admission for women admitted without a documented test result?	69%	62	62%	116
Standing orders for HBsAg testing as soon as possible after admission for women admitted without a documented test result?	64%	56	55%	77
Written policy for repeat testing of pregnant, HBsAg-negative women at risk for HBV infection during pregnancy?	2%	2	11%	20

Prophylaxis Management of Infants Born to Women Who Are HBsAg-Positive: National CDC vs. IL Survey				
	Illinois N=90		CDC Sample N=196	
	%	N	%	N
Hospital currently has:				
Written policy for administration of HBIG within 12 hours of birth for all infants born to HBsAg-positive mothers?	75%	67	n/a	n/a
Standing orders for administration of HBIG within 12 hours of birth for all infants born to HBsAg-positive mothers?	73%	64	n/a	n/a
Written policy for administration of hepatitis B vaccine within 12 hours of birth for all infants born to HBsAg-positive mothers?	71%	62	80%	148
Standing orders for administration of hepatitis B vaccine within 12 hours of birth for all infants born to HBsAg-positive mothers?	74%	65	69%	118

Universal Vaccination of Infants: IL vs. CDC National Survey

	Illinois N=90		CDC Sample N=196	
	%	N	%	N
Hospital currently has:				
Written policy to routinely administer the hepatitis B vaccine to all newborns before hospital discharge?	44%	39	65%	121
Standing orders to routinely administer the hepatitis B vaccine to all newborns before hospital discharge?	61%	54	81%	126
Written policy for documentation of maternal HBsAg test results in the infant medical record?	67%	60	n/a	n/a

Comparison between 2003 and 2007 Illinois birthing hospital survey results on universal vaccination of infants

	2003	2007
Number of birthing hospitals responding	96	90
Response rate	73% (96/131)	83% (90/108)
Hospital has a policy to administer hepatitis B vaccine to all newborns prior to discharge ^[1]	41%	44%
Hospital has standing orders to administer hepatitis B vaccine to all newborns prior to discharge ^[2]	61%	61%
<small> ^[1] 2007 survey specifies written policy. ^[2] 2003 survey specifies written/standing orders. </small>		

Major Findings

- ~ 43% of IL birthing hospitals have both written policy & standing orders for review of prenatal HBsAg test results upon admission to labor and delivery
- 49% of hospitals have both written policy & standing orders for testing of women without a documented test result.
 - Contrast to HIV review & testing policy, where the corresponding proportions were 74% for review and 80% for testing.
- 62% of IL hospitals reported both written policy & standing orders for administration of HBIG and 60% for hepatitis B vaccine for infants born to HBsAg-positive mothers
- 53% of hospitals reported both written policy & standing orders for administration of hepatitis B vaccine to infants born to mothers with unknown HBsAg status, but only 43% reported both for vaccination of all newborns before discharge.
- Neonatal care level hospitals significantly more likely to report having both written policy & standing orders for administration of hepatitis B vaccine for infants born to mothers with unknown HBsAg status
 - (20% vs. 59% vs. 67% for basic, specialty, and neonatal intensive care respectively, $p < .05$).
- Hospitals providing higher levels of neonatal care were significantly less likely to report having both a written policy and standing orders for administration of hepatitis B vaccine to all newborns before discharge
 - (73% vs. 37% vs. 33%, $p < .05$).

Major Findings (Cont'd)

- Contrast:
 - 90% of respondents reported that their hospitals have written policies for administration of intrapartum antiretroviral prophylaxis to both women and infants to prevent HIV transmission.
- 42.7% of respondents reported either that their hospitals did not participate in the VFC program with 39.3% reporting that they did not know about their hospitals' participation.
- Compared to a national CDC survey, somewhat higher proportions of Illinois hospitals report written policies & standing orders for review and testing HBsAg at admission to labor and delivery.
 - Illinois hospitals were far ahead of hospitals nationally on HIV review, testing, and infant prophylaxis.
- Universal Hep B vaccinations of newborns: compared to the national sample, IL hospitals lag behind on both:
 - Written policy (44% vs. 65%)
 - Standing orders (61% and 81%)

Report Conclusions

- There has been little change in universal vaccination of infants by Illinois birthing hospitals since 2003 survey
- Data documented by survey administration demonstrates that HIV & HBV policies & preventive strategies are not universally in place for babies born in Illinois.
- Surveyed IL birthing hospitals more likely to have HIV policies compared to HBV, & do much better than a sampling of national institutions for HIV.
 - Findings are likely due, at least in large part, to the Illinois Perinatal HIV Prevention Act.

Recommendations & Next Steps

- New efforts to ensure universal availability and implementation strategies for preventive policies for HIV and HBV must be undertaken without delay.
- Public Health Imperative: IDPH & ICAAP work together to formulate educational policies aimed at noncompliant institutions
 - Focus on developing educational messages detailing availability of the hepatitis B vaccine through the VFC-Plus program & through IDPH (all other infants born in hospitals with a universal vaccination program)
 - Focus on messages providing recommendations for repeat screening of women at high risk for acquiring hep B infections & management of infants born to mothers with unknown hep B status.

Recommendations & Next Steps (cont'd)

- Consideration of measures to mandate perinatal preventive policies for HBV.
 - Discussions with legislators sympathetic to legislated public health initiatives should be considered, should response to intense educational programs be suboptimal.
- Goal: Make Illinois a national model of universal compliance with recommendations to prevent both HIV and HBV.
 - All birthing institutions should routinely implement these measures and do so without delay.
- Vertical transmission can and should be virtually eliminated.
 - Illinois children deserve nothing less than a start in life free of HIV and HBV.

Vaccine Financing

Julie Morita, M.D.

Medical Director

Immunization Program

Chicago Department of Public Health

Number of Vaccines in the Routine Childhood & Adolescent Schedule

1985

Measles
Rubella
Mumps
Diphtheria
Tetanus
Pertussis
Polio

7

1995

Measles
Rubella
Mumps
Diphtheria
Tetanus
Pertussis
Polio
Hib
HepB
Varicella

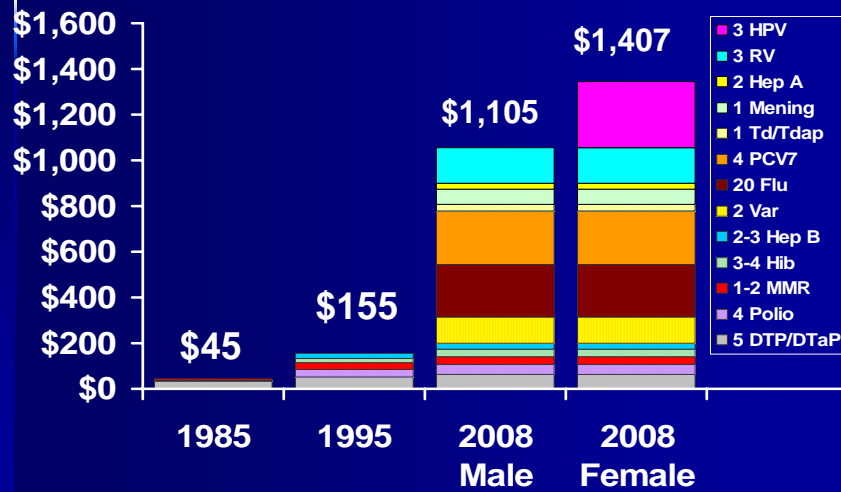
10

2008

Measles
Rubella
Mumps
Diphtheria
Tetanus
Pertussis
Polio
Hib
HepB
Varicella
Pneumococcal disease
Influenza
Meningococcal disease
HepA
Rotavirus
HPV

16

Federal Contract Prices for Vaccines Routinely Recommended for Children and Adolescents



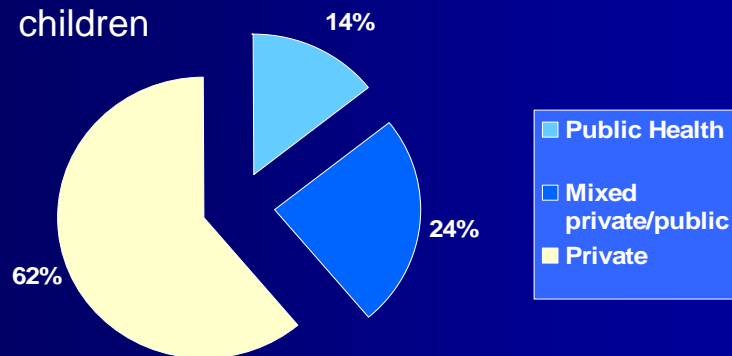
Burden of Vaccine Delivery on Providers

Recent surveys of family practitioners and pediatricians indicate significant financial concerns related to the purchase and delivery of vaccines, particularly newer and more expensive vaccines.

University of Michigan CHEAR unit (Freed et al, under review)

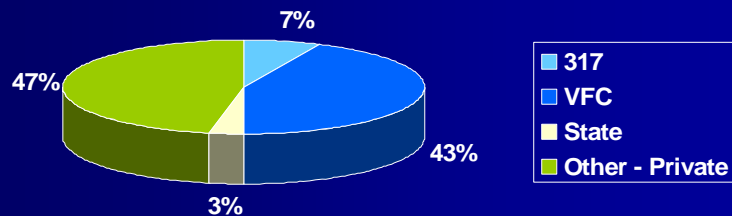
Pediatric Immunization Delivery System

Private providers vaccinate most US children



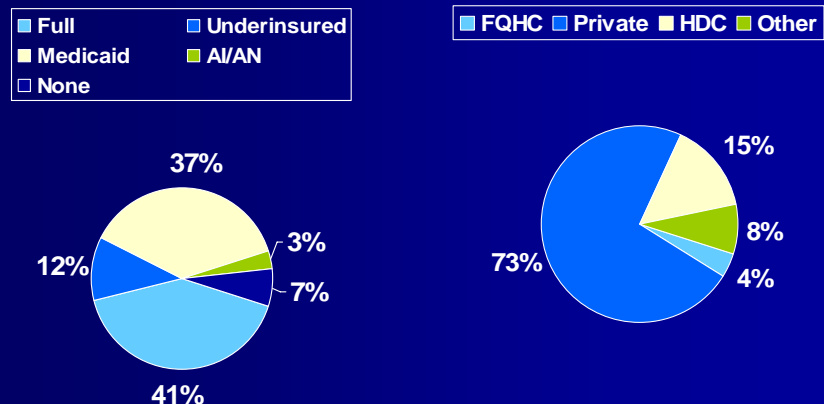
Source: National Immunization Survey, 2004
www.cdc.gov/vaccines/stats-surv/default

Vaccine Doses by Funding Source, 2007 (Children 0-6 years)



Source: Biologics Surveillance Data 2007.
Does not include influenza vaccine.

Insurance / VFC Status and Vaccination Venue, 19-35 Months of Age: 2006 NIS



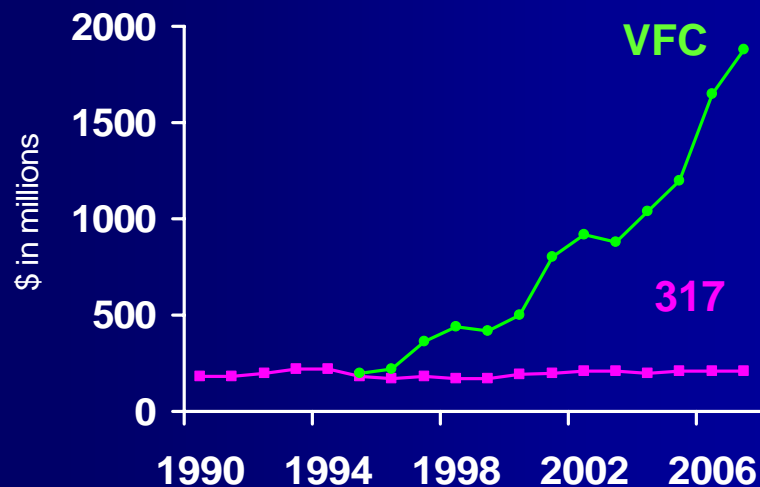
Vaccines For Children (VFC) Program

- Federal entitlement program to purchase and provide vaccines to enrolled healthcare providers
- Covers children 0 through 18 years: Medicaid, American Indian/Alaska Native, uninsured, or underinsured (only at federally qualified/rural health centers)
- Federal purchase of vaccines at federal contract price
- The ACIP votes to include vaccines in VFC, which are automatically financed after conclusion of a federal contract

Section 317 Grant Program

- Federal discretionary grants to support activities of state immunization programs
- Approximately 87% of funds go to childhood immunization
- States can use to purchase vaccines at federal contract price
- Significant source of safety-net vaccine for underinsured
- Annual appropriations have not been keeping pace with the costs of recommended vaccines

VFC and Section 317 Vaccine Funding to Immunization Programs



Private Sector Vaccine Provision

- Medical providers purchase and store vaccines for administration to patients
- Seek reimbursement from health insurance plans or other payers, or directly from patients (self-pay)
 - Vaccine purchase
 - Administration fee

The Problem Is Not Readily Visible

- Current vaccination coverage is high and disease incidence is low, however:
 - Data on coverage levels are not necessarily timely
 - There is limited measurement of coverage with newer (more expensive) vaccines, which appear to be the source of the problem
 - Morbidity not yet prevented by newer vaccines may not be recognized as a significant problem
- Future vaccines will further increase immunization schedule cost and size
 - Critical to address problem before a crisis occurs

Solutions Require Increased Funds

- Potential sources of increased funds
 - Government (i.e., taxpayers)
 - Distributes burden of funding across society for a societal benefit
 - Could be federal, state, and/or local governments
 - Purchasers (i.e., employers)
 - Consumers (i.e., out of pocket)
- Actual required increase in funds depends on:
 - Manufacturer and distributor charges
 - Non-vaccine costs of vaccination

National Activities

Immunization Congress, 2007

- Co-sponsored by AAP, CDC and AMA
- Identified major challenges
- Identified areas where additional information was needed
- Identified specific activities for CDC, National Vaccine Advisory Committee (NVAC), and professional organizations

National Vaccine Advisory Committee (NVAC) Vaccine Finance Workgroup Focus

- Public Sector:
 - Vaccines for the underinsured
 - Administration fees:
 - Medicaid admin fee not adequate in many state
 - No admin fee for other VFC-eligible children
- Private Sector:
 - Easing the burden of vaccine purchase and administration for providers
 - Insurance issues: adequacy of coverage for vaccines and administration fees

Public Sector Recommendations

Provide Vaccines for the Underinsured

- Extend VFC access to underinsured children and adolescents in public health clinics

OR

- Expand Section 317 program funding to support vaccine purchase for all children and adolescents who traditionally have relied on 317 for vaccines

Cover Costs of Vaccine Administration for All VFC Eligible Children

- Expand VFC to cover vaccine administration reimbursement for all VFC-eligible children and adolescents, (single system including Medicaid)

Improve Medicaid Reimbursement for Vaccine Administration

- Update, publish, and disseminate actual Medicaid vaccine administration reimbursement rates by state (CDC, CMS)
- Update maximum allowable Medicaid administration reimbursement amounts for each state (CMS)
- Increase federal match for Medicaid vaccine administration reimbursement to levels for other services of public health importance

Activities of Federal Agencies and Offices

- Congress request annual 317 report from CDC and ensure funding at specified levels
- CDC and CMS continue to collect and publish information on costs associated with public and private vaccine administration
- NVPO calculate marginal increase to insurance premiums when all ACIP recommended vaccines are covered
- NVAC convene expert stakeholder panels to determine if acceptable policy options could be developed for tax credits for insurance coverage of vaccination benefits

Activities of Federal Agencies and Offices

- Decrease the time from creation to official publication of ACIP recommendations
- Expand 317 funding to support additional national, state and local public health infrastructure needed for adolescent immunizations
- Continue federal funding for cost-benefit studies of vaccinations targeted for adolescents

Activities of State and Local Agencies and Offices

- State, local, federal governments and professional organizations outreach to providers currently serving VFC-eligible children to encourage them to participate in VFC
- States and localities develop mechanisms for billing insured children and adolescents served in the public sector with technical support and possibly funding from CDC

Other Recommendations of the NVAC Adolescent Workgroup

- Ensure adequate funding to cover all costs (including to schools) associated with child and adolescent school immunization mandates
- Promote shared public and private sector approaches to funding school-based and other complementary-venue child and adolescent immunization efforts

Private Sector Recommendations

Improving Business Practices in Provider Offices

- AMA's RUC should review Relative Value Unit coding to ensure it accurately reflects non-vaccine costs of vaccination (including combination vaccines)
- Vaccine manufacturers and distributors work with individual providers to reduce financial burden for initial and ongoing vaccine inventories
- Professional organizations provide technical assistance on efficient business practices associated with immunization such as contracting and billing
- Medical providers, particularly in smaller practices, should participate in pools of vaccine purchasers to obtain volume ordering discounts

Reducing Underinsurance and Financial Barriers: Voluntary Standards

- CDC and other relevant stakeholders develop and support additional employer health education efforts
- Insurers and health care purchasers adopt contract benefit language flexible enough to permit coverage and reimbursement for new or altered ACIP recommendations and vaccine price changes that occur mid-contract period
- All public and private health insurance plans should voluntarily offer first-dollar coverage of all costs associated with the acquisition, handling, storage and administration of routine and catch-up childhood and adolescent vaccines
- Insurers and health care purchasers assure vaccination reimbursement is based on methodologically sound cost studies of efficient practices

Key Themes of Finance Workgroup Discussion

- Strong support for national-level solutions vs. state-by-state approaches
- Strong opposition from multiple stakeholders on use of universal purchase systems or insurance mandates to address financing problems
- Broad support for long-term solutions, i.e. modifying VFC program to include underinsured children served at public health clinics

Illinois Activities

- Illinois Immunization Summit, 4/14/2008
 - Funded by Illinois Department of Public Health
 - Coordinated by Illinois Chapter of the American Academy of Pediatrics
 - Attendees and presenters: AAP, NVAC, manufacturers, insurance companies, private providers, state and local public health

Key Findings

- Illinois has a two-tiered immunization program
 - VFC-eligible and insured children have access to all recommended vaccines in their medical homes
 - Underinsured children (~10% of the population) have access to 6/13 routinely recommended vaccines in their medical homes
 - Underinsured children can receive all vaccines at FQHCs/RHCs and in some public health clinics

Key Findings

- Illinois Medicaid reimbursement for vaccine administration appears to be low
 - \$6.40 per dose
- Measurement of the costs involved in providing services need to be ascertained
 - physician income and benefits
 - practice expenses
 - professional liability insurance premiums
 - frequency of services provided

Follow Up Activities - ICAAP

- Vaccine Financing Committee established
- Conducting a study to determine true costs of providing vaccines in physician offices
- Identifying best practices for physician offices
 - Group purchasing organizations

Follow Up Activities - CDPH

- Support federal legislative efforts
 - Extend VFC access to underinsured children in public health clinics
 - Increase 317 funding to cover children have traditionally relied on 317 funding
 - Expand VFC to cover vaccine administration reimbursement for all VFC-eligible children
- Continue to enroll providers in VFC program
- Develop a mechanism for billing insured children