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Every Shot Counts: Improving Pediatric Vaccine Access

Announcer:

You're listening to *On the Frontlines of Pediatric Vaccines* on ReachMD. Here's your host, Dr. Shelina Ramnarine.

Dr. Ramnarine:

This is *On the Frontlines of Pediatric Vaccines* on ReachMD, and I'm Dr. Shelina Ramnarine. Today, I'm joined by Dr. Ravi Jhaveri to examine barriers to equitable pediatric vaccine access and strategies for overcoming them. Dr. Jhaveri is the Division Head of Pediatric Infectious Diseases at Northwestern University Feinberg School of Medicine in Chicago. Dr. Jhaveri, thanks for being here today.

Dr. Jhaveri:

Thanks for having me.

Dr. Ramnarine:

So let's jump right in, Dr. Jhaveri. From your perspective, what are the most significant structural barriers preventing children in under-resourced communities from receiving vaccinations on time?

Dr. Jhaveri:

So, first, I want to make sure that we start with the positive, which is that the majority of kids—no matter what obstacles we might put in the way, whether it's policy or access barriers—still get vaccines. The vast majority of them do. Parents vote with their feet every single year. So I think when we have conversations about vaccines, we often focus too much on the negative, and I want to make sure we reframe that. We still do well with the majority of kids getting their vaccines.

Now, that being said, we still have structural barriers. It still takes many visits over the course of the first 18 months for a child to be fully vaccinated. There are issues related to getting to the office and being able to have the appropriate caregiver consent for vaccines. My wife is in primary care practice, and so she would always share with me the challenges of one parent versus two parents, or having a grandparent there, and who's able to consent for vaccine. And so there are many things we have to think about.

Obviously, now with the growth of commercial pharmacies, those are becoming an important provider of vaccines not just for adults, but also for children. But from state to state, the rules about how young a child a pharmacist can vaccinate can vary significantly. And so it might be as young as three years old, but it might be as old as 12, and it depends on the state you're in. And so I think there's still many concerns.

The last, I would say, is that we still remain concerned about some of the changes in federal policy that might impact the children who qualify for Vaccines for Children. Many of your listeners are aware that Vaccines for Children is the single largest provider of children who qualify for Medicaid and who are financially disadvantaged, and so they are eligible for free vaccines. And this is one of the best federal programs out there. It started in the '90s, when it became clear that there were significant disadvantages for those children in terms of getting vaccines. Vaccines for Children is tethered to the current vaccine recommendations by the Advisory Committee for Immunization Practices. And as the ACIP recommendations are potentially being shifted, many of us are concerned that that's going to impact children who qualify for VFC vaccines.

Dr. Ramnarine:

So it sounds like there are policy barriers. Are there also barriers in terms of access to care or structural barriers within the healthcare system itself? And it also sounds like this could vary based on the age of the child—infant versus older kids or teens.

Dr. Jhaveri:

Yes, there are still physical and structural barriers for the youngest kids. You still have to get to appointments, and, depending on whether you live—in an urban or a rural environment—the availability of providers that are able to see and vaccinate children, with the looming cuts to Medicaid coverage, is going to impact many patients. And so if they're not able to qualify for care, they're not going to be able to get there to get vaccinated. So that's a big thing.

I think the other thing is, obviously, in the rural setting, with those cuts, the fairly remote nature of where people live impacts who is able to see those patients and, again, to qualify for vaccines. And there may not be a fallback when it comes to pharmacy access or other providers.

And that's really focused on the infants. If they're adults or older children who need catch-up vaccines or maybe didn't get vaccinated initially, our systems are even more challenged for providing them with vaccines. I think that providers are used to giving infants vaccines, and so we have processes that are in place. As kids get older, or for adults, our office-based systems are less well-equipped.

Dr. Ramnarine:

So it sounds like you see access barriers playing out differently depending on the population or the region. Is that accurate? And are there also nationwide problems as well?

Dr. Jhaveri:

Yes, that is accurate. And yes, these are, I think, nationwide problems too. There are very few settings where they're equipped to vaccinate all patients with all conditions of all ages. And so perhaps there are a few pharmacies who are able to do that in certain settings. But there are very few settings, with the exception, maybe, of the federally qualified health centers, which have a deliberately broad focus, because their interest is really providing care to whoever walks in their door. So I think they perhaps have the best systems to care for and to provide vaccines for all comers. But even with that being said, some FQHCs—just because of the resources and setup—tend to focus more on one group versus another. And so it may not be that every FQHC site is truly equipped. They still likely shuttle patients from site to site based on their age or demographic. And so, again, the burden then falls on the patient to go to the right place at the right time to get their vaccine.

Dr. Ramnarine:

So when these access barriers go unaddressed, what are the downstream clinical consequences you've observed in terms of outbreaks, individual patient outcomes, or community-level immunity?

Dr. Jhaveri:

The first thing we see is that kids are under-vaccinated, which means that they're missing booster doses. I think that parents are trying hard. They're doing their best, and providers are also doing their best, but there's a mismatch in terms of where people are at what time to get their vaccines.

So I think the first thing we see is that kids are under-vaccinated, where we review records and realize they're missing a booster dose or that they don't have the requisite doses for full immunity. We've been lucky that we have not seen major outbreaks. But, in the last couple years, we are seeing, obviously, the measles outbreaks make a lot of news. That's because, largely, people are refusing vaccination. I think that's a separate issue. It's not really the access issues here. We are seeing, too, increases in pertussis or whooping cough. And I think that's not just vaccine refusal. That's also fewer doses over time in many patients, both young and old. And so that is sort of a canary in the coal mine, in terms of the idea that our rates are not where they should be. And we need to work harder not just to address issues around vaccine hesitancy, but also around access, to make sure we're capturing as many patients as we can and making it as easy as possible.

Dr. Ramnarine:

For those just tuning in, you're listening to *On the Frontlines of Pediatric Vaccines* on ReachMD. I'm Dr. Shelina Ramnarine, and I'm speaking with Dr. Ravi Jhaveri about the disparities impacting childhood vaccine uptake.

Let's shift gears now and talk about how we can address these challenges. Which of these structural barriers are most addressable at the policy level, and what would an intervention look like in practice?

Dr. Jhaveri:

I love the fact that we're going to try to problem solve here. I think one of the things that I would love to see our medical system do is create a little more flexibility when it comes to providing universally recommended childhood vaccines.

So I'll give you an example. Right now, our system is very tethered to the medical home. So the idea is that the medical home is your primary care doctor or physician where a child gets all their vaccines and receives central care. In an ideal world, that works great. The reality is that, often, the convenience or scheduling may not fully serve a patient's needs. So let's say a patient is seen at an urgent care,

in the emergency department, or, unfortunately, let's say if they get admitted to the hospital for some other reason, like for an asthma exacerbation, or something like that. And a provider at that institution realizes this child is missing X, Y, and Z vaccines. I would love for us to have a system where we could easily provide those vaccines when the patient is there in front of us.

We have done better in recent years about doing this for, let's say, influenza. Our institution has an inpatient and specialty clinic and an emergency department system where we'll offer flu vaccine for anyone who's here, if they want it. We can't do that, or we don't do that, because the reimbursement system and the reconciliation for those is not there—because of the medical home. I would like for us to have some exceptions for kids who are behind on their vaccines to allow for much easier administration and recording of these vaccines. I think that would serve patients in any setting much better. So that's one proposed solution to try to address some of the structural and access barriers that exist.

Dr. Ramnarine:

Could you tell us about any specific programs or policy changes that have already improved vaccine access? And do you see potential for scaling or replicating these elsewhere?

Dr. Jhaveri:

So I know that one of the focuses that people have had is, let's say, school-based vaccine programs. And, obviously because of school entry and because of the number of kids who might need boosters, particularly around, let's say, kindergarten, this could be a really powerful way to provide vaccines to those kids who may be behind, or to do so that they don't fall behind.

School-based clinics are available in many settings, particularly resource-limited settings. Obviously there are resource demands that go into having school-based clinic and personnel, and you have to have a system for parents providing consent, so that vaccines can be given. But if you can work all that out, I think that's a terrific example. Certainly, many other countries rely on school-based vaccination to maintain very high levels of vaccination in their groups, and I think this is a model that we could do better here in the US.

Dr. Ramnarine:

Now, beyond policy change, what can individual clinicians or clinical staff do differently to reduce these barriers at the point of care?

Dr. Jhaveri:

I think there's a couple of things we could do. I think working out in advance, let's say, the consent issue I mentioned. If you know that the grandparent is going to be the one taking the child to their vaccine visit or their doctor's appointment, think ahead about providing the permission or calling the office to say, "Hey, grandparent is coming. I am letting you know." Or, it'd be great if there's some way to do a DocuSign electronic consent that's sent to your email, in MyChart, or whatever patient portal you have, so that can be addressed. I'm sure there are practices and sites that are doing that well, but I think that's something that we probably, on a systems level, could do much better, as one example.

I think about family-friendly hours for many settings. We know that nine-to-five hours work well for many people, but not for everyone. And if you have very little time and flexibility, you may not be able to take the time off to take your child to the doctor for their vaccines. That is also something that I think we as a system could do much better. And so thinking about how we could do some creative schedule and access type things.

There are certain institutions, too, that have mobile clinics or mobile vaccine units, where we bring care to the patient where they are. Our institution has a mobile clinic, and we have certain areas of the city of Chicago that do have access challenges, and so we're trying to address those barriers with a mobile clinic that's fully equipped to give vaccines. We do flu clinics over the course of the season, and, again, could potentially also do routine childhood vaccination, in the appropriate time and setting.

Dr. Ramnarine:

As we come to the end of our program, Dr. Jhaveri, what is the most important thing clinicians should bring back to their practice to help mitigate the challenges we discussed today?

Dr. Jhaveri:

I think that clinicians know and see these barriers. I think, often, they have difficulty getting the attention of many administrators when it comes to family hour changes and the access and consent-type issues. But if there's a way that we could collectively, as providers, bring up the concerns and challenges that our patients experience on an everyday basis when it comes to getting to the doctor, receiving their care, following up on things, receiving their vaccines, and doing this reconciliation, and try to figure out a way to problem solve, I think we would all be better for it. Again, I think our patients recognize vaccines are a powerful and positive force in their life. And so we should really think about flexible systems to allow us to err on the side of vaccinating rather than not vaccinating.

Dr. Ramnarine:

With those final comments in mind, I'd like to thank my guest, Dr. Ravi Jhaveri, for joining me to share strategies for addressing barriers and improving pediatric vaccine access. Dr. Jhaveri, it was great having you on the program.

Dr. Jhaveri:

Thanks so much. It was great to be here.

Announcer:

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