



# KEY CONSIDERATIONS FOR PHARMACIES AND THE VACCINES FOR CHILDREN (VFC) PROGRAM: SUMMARY OF INTERVIEW AND SURVEY FINDINGS

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# EXECUTIVE SUMMARY

## Background and Context

Starting in the mid-1990s and accelerating after the 2009 H1N1 influenza pandemic, pharmacists and pharmacies have been increasingly active in offering influenza immunizations to adults. All 50 states now allow pharmacists to administer vaccines to adults. However, state laws vary in age and other restrictions regarding administration of vaccines to children and adolescents. As pharmacies become more familiar, convenient, and accessible immunization venues for adults, both pharmacies and public health agencies have seen the potential for expanding immunization access to children and adolescents—especially for minors who may not otherwise receive vaccines on schedule, or perhaps at all.

Extending immunization coverage to low-income children by removing cost barriers was an explicit goal of the Vaccines for Children (VFC) program. The program was launched in 1994, partly in response to a deadly measles epidemic in 1989-1991 that led to more than 55,000 cases of measles and 166 suspected measles-related deaths among unimmunized children.<sup>1,2</sup> Through VFC, CDC purchases vaccines for 16 diseases at a discount and distributes them free of charge to providers. As of 2014, 44,000 providers had enrolled in the program nationwide, meeting CDC requirements for eligibility screening, reporting, ordering, and vaccine storage and handling. The number of enrolled pharmacies has been much smaller—closer to 100 had enrolled in the program as of 2013.

## Project Purpose and Methods

To find out more about the key considerations affecting pharmacy participation in the VFC program, ASTHO contracted Cole Communications, Inc. to interview staff from CDC's National Center for Immunization and Respiratory Diseases (NCIRD) Immunization Services Division, state Immunization Program VFC staff, and pharmacy representatives. The interviews with state VFC program staff (n=29) and pharmacists (n=7) focused on 10 states (Arizona, California, Maryland, Minnesota, Nevada, Oregon, Tennessee, Texas, Washington, and Wisconsin) with laws allowing pharmacists to vaccinate children and adolescents, as well as recent efforts to consider, pilot, or implement enrollment of pharmacists in state VFC programs. In addition, all state Immunization Program Managers participating in the VFC program (regardless of whether or not they had pharmacists enrolled in their states and territories) and 111 enrolled pharmacists in the program, who had received a compliance or storage and handling visit from the state program in 2014, were sent an online survey about their participation. Survey response rates were 90 percent for the Immunization Program Managers and 21 percent for the pharmacists.

## Perceived Benefits of Pharmacy Participation in the VFC Program

In interviews, both VFC program staff and pharmacists saw pharmacy participation in the VFC program as an opportunity to increase coverage by expanding immunization access, especially in underserved areas or for populations

that might not otherwise seek care or come in contact with other healthcare providers (such as adolescents). In survey responses, Immunization Program Managers and pharmacists shared the view that increased convenience and access were compelling benefits, although the Immunization Program Managers perceived greater potential benefits for supporting emergency preparedness than pharmacists did.<sup>3</sup>

### Perceived Barriers or Downsides of Pharmacy Participation in the VFC Program

State Immunization Program respondents were candid in both interviews and surveys about the resource constraints they faced if pharmacy enrollment were to increase significantly. As one said, “Between enrollment, and initial visits, and site visits, and the paperwork, and the checking of the data periodically in the system, the sheer volume of that would bring us to our knees.” Pharmacists also felt that some of the requirements (such as segregating VFC vaccine supplies from others, purchasing thermometers and refrigerators, and completing required paperwork) were too onerous, given the volume of eligible customers.

A frequently voiced concern or potential barrier was the effect of pharmacy participation on a child’s connection to the continuity of care that a medical home provides, especially for young children who are seen for periodic well-child visits. However, both program staff and pharmacists noted that while medical homes might be ideal, they are not available to all families despite the coverage expansions achieved by the Affordable Care Act. Pharmacists also noted that the “immunization neighborhood” framework is designed to avoid fragmentation of care by promoting coordination, collaboration, and communication across all providers in a particular locale.\* Other concerns and potential barriers included the lack of standardization in reporting to immunization registries, storage and handling issues (with public health staff concerned that

\* The term “immunization neighborhood”, coined by APhA, involves collaboration, coordination, and communication among immunization stakeholders, with the goal of meeting the immunization needs of patients and protecting the community from vaccine-preventable diseases.

this is not being done properly and pharmacists emphasizing that they have extensive training and experience in storing and handling a wide variety of supplies and medications), variations and flux in state laws (leading to confusion and different interpretations), issues unique to pharmacy settings, and concerns about pharmacists’ training and comfort administering vaccines to children and adolescents.

Despite these concerns, when asked “Would you like to include pharmacies in your VFC program?” more than two-thirds of Immunization Program Managers (69 percent) said yes.

### Key Considerations and Lessons Learned

Asked what advice they would offer to others considering pharmacy participation in the VFC program, interview respondents offered the following suggestions:

- Place the VFC program participation in a broader context of public health-pharmacy partnerships, especially with regard to advancing overall emergency preparedness goals. Pharmacy groups would appreciate stronger public health support of the “immunization neighborhood” approach as a way of reaching increased coverage goals and on state-specific issues such as age restrictions and Medicaid reimbursement policies. In places where pharmacy enrollment in the VFC program is strong, public health agencies also can help promote pharmacies as a VFC venue for eligible families.
- Consider ways to reduce resource burdens or constraints on state programs, such as offering training to groups (instead of working pharmacy by pharmacy).
- Explore pharmacy liaison options, especially for larger chains, in which a pharmacy representative could work with multiple individual pharmacies to ensure that paperwork, training, reporting, and other requirements are in place. In addition, recognize unique pharmacy strengths and roles—especially relating to the differences between chain and independent pharmacies.

- Help pharmacies gauge whether or not their participation is worthwhile—for example, by providing data on coverage rates and gaps or sharing geographic information system (GIS) mapping of access gaps.
- Start small with pharmacies that are more committed, rather than trying to engage larger numbers of pharmacies all at once.
- Engage provider champions, such as pediatricians and family providers, who support the idea that pharmacists can extend the medical home (e.g., by identifying patients who lack one and referring them to a physician’s practice).

endeavors, mandates to participate in the VFC program in all jurisdictions has a number of barriers that must be overcome. A more productive and targeted VFC-pharmacy collaboration determined by the states and locales best positioned to benefit from it may be a more beneficial approach than blanket pharmacy participation in the national program. Allowing pharmacies and state and local public health agencies to determine the parameters of their partnerships could yield models and best practices for, while advancing the public health goals of increased immunization coverage and stronger emergency preparedness in communities across the country.

### Summary of Key Considerations

State and territorial Immunization Programs see the benefits of pharmacy participation, but most of those interviewed do not feel they currently have the resources to enroll, oversee, and retain a significant volume of pharmacies (or, for that matter, other providers). Pharmacy representatives also see the value of participating, but many wonder whether the effort to meet additional and quite rigorous requirements is worthwhile.

To use scarce resources more effectively, efforts to involve pharmacies in state VFC programs may benefit from a more **systematic assessment and ranking** based on a rough return on investment (ROI). For example, priority might be given to Immunization Programs in states with low coverage rates, state laws and reimbursements that encourage pharmacy participation appropriate to expanding coverage (e.g., for the right age groups, such as adolescents and HPV), and pharmacy champions within chains, individual pharmacies, pharmacy associations, or state boards.

### Conclusion

Based on perspectives gathered from public health agencies, pharmacists, and other stakeholders, while there is value in partnering with pharmacies on the state and local levels for the VFC program and other public health

