

Funding Woes Curb Childhood Vaccination Efforts

BY HEIDI SPLETE
Senior Writer

ATLANTA — The current vaccine financing system in the United States continues to derail vaccinations for underinsured children, based on new survey data from state immunization program managers.

"Limitations in 317 funding and state funding are clearly contributing to this gap," said Dr. Grace M. Lee of Harvard University, Cambridge, Mass.

"For example, we estimate that about 3.9 billion children are unable to receive Menactra in the private sector and 1.1 billion are also unable to receive Menactra in the public sector," said Dr. Lee, who presented results from a study of states' vaccine financing activities at a meeting of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

The explosion in the number and cost of vaccines for children and adolescents in recent years prompted the study. In 1985, there were 7 vaccines in the routine childhood and adolescent immunization schedule; in 1995, there were 10; and in 2006, there were 16, said Dr. Lee.

"In 1985, it cost \$45 to fully vaccinate a child. In 2006, the estimated cost to vaccinate a female child is approximately \$1,200," she said.

Many underinsured children must pay out of pocket for vaccines. Alternatively, private providers may refer them to the public sector to receive vaccines purchased by the state government with 317 funds or through the federally funded Vaccines for Children (VFC) program. But neither of these sources has kept up with the growth in recommended vaccinations.

The Section 317 program is a discretionary federal grant given to each state (plus all U.S. protectorates, territories, and six cities) to be used for vaccines for underinsured children and adolescents who do not meet the criteria for the VFC program or whose parents or guardians can't afford the out-of-pocket costs for full vaccination. Most of the Section 317 funds are used for routine childhood and adolescent vaccinations, although any remaining funds can be used to pay for vaccinations for underinsured adults.

"Historically, vaccines weren't so expensive, but now it is getting harder to vaccinate all children with everything due to a lack of increase in 317 funding," Dr. Lee commented.

Dr. Lee and her colleagues conducted a two-phase study that included qualitative interviews with 48 state immunization program managers followed by a national survey and interviews with the state managers plus two city immunization program managers.

The survey and interview questions asked how and whether the cities and states provided vaccines to underinsured children, Dr. Lee said.

Overall, about 50% of underinsured children could not be vaccinated in their medical homes unless they could pay out of pocket, according to the survey results. The meningococcal vaccine (Menactra) was the least-covered vaccine. Menactra was not covered by private providers in nearly 70% of states in the study and it was not covered in public clinics in approximately 40% of the states. Of note, the ACIP recently recommended expanding meningococcal vaccination to include all adolescents aged 11-18 years.

The survey respondents expressed discomfort at having to turn away children who could not afford to pay for new vaccines, Dr. Lee noted. The respondents cited insufficient state funding as a primary barrier to vaccination, and they reported using several strategies to address the lack of funds.

A total of 27 states' managers reported limiting provider vaccine choice, and 25 used annual state appropriations to address financing limitations. A total of 13 managers reported expanding their definitions of federally qualified health care centers (FQHCs) so more underinsured children would be eligible for the VFC program. In addition, 11 managers reported negotiating state contracts with vaccine manufacturers, 9 reported decreasing their purchases of adult vaccines, and 4 reported designating annual health plan appropriations.

Of the 13 states that reported expanding



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FQHC designations, 9 designated some public VFC providers in their states as FQHCs; 3 designated all public VFC providers as FQHCs; and 1 state manager designated all public and private VFC providers as FQHCs. Dr. Lee said in an interview that she was unable to disclose which states had expanded the FQHCs because the interviewees' names were kept confidential.

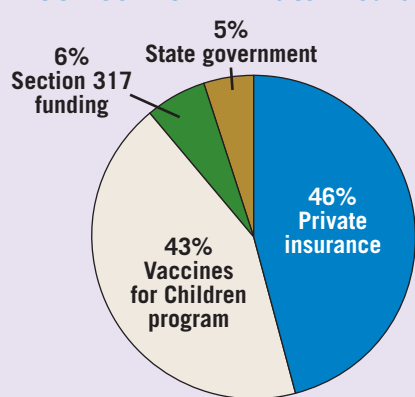
In particular, the strategy of expanding FQHC designations to improve access for VFC patients could help relieve the increased stress of paying for vaccines for children, Dr. Lee said.

But the study did not address the other side of vaccine financing—reimbursement—which remains a hot-button issue for physicians.

"All is not well in the realm of private providers," Dr. Jonathan Temte said during the discussion period following the presentation. "A bigger issue is reimbursement. Even if a vaccine is covered you won't necessarily get paid for all your expenses," said Dr. Temte, a family physician at the University of Wisconsin, Madison, and the American Academy of Family Physicians' liaison to ACIP. Some physicians are no longer willing to incur the costs of vaccination and are sending children to public clinics, he observed.

For the most current information about coverage, billing, and policies, visit the FQHC Web site at www.cms.hhs.gov/center/fqhc.asp.

Largest Funding for Children's Vaccines Comes From Private Insurance



Note: Data from the vaccine manufacturers' 2005 Biologics Surveillance. Source: Dr. Lee

ELSEVIER GLOBAL MEDICAL NEWS

Simple Questionnaire Identifies Pediatric Drug Reactions

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — A simple screening tool administered to parents helped identify a number of potentially serious drug reactions in their hospitalized children, Dr. Michael S. Leonard reported at meeting sponsored by the National Initiative for Children's Healthcare Quality.

The symptom-based questionnaire, requiring only yes/no answers, was offered 408 times and was completed 143 times. Of those, investigators judged 57 (40%) to be "suspected" adverse drug events.

On further examination by a clinical assessment team, seven (12%) of those suspicious events turned out to be actual adverse drug reactions, and six of them

required treatment. Describing these results as "surprising," Dr. Leonard of Women and Children's Hospital of Buffalo (N.Y.) said, "This is a far, far higher number than [in] many of the published studies out there."

There are other methods of determining the true number of adverse drug events, including incident reports, chart reviews, and "trigger tools" developed by the Institute for Healthcare Improvement (www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral). All of these methods have their problems



and might underestimate the number of such events.

Without an accurate estimate of the baseline level of adverse drug events, it's difficult to determine whether steps taken to reduce those levels are working. The survey developed at Women and Children's Hospital of Buffalo has versions in English and Spanish. It does not ask parents to draw conclusions about whether their child is having a reaction to a drug. Instead it asks them whether they've noticed any changes in breathing,

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DR. LEONARD

redness, swelling, rash, pain, or the child's level of activity during the prior 24 hours. A single affirmative answer to any of these questions defines a suspected adverse event to be investigated further.

The survey was administered on four medical-surgical floors during 5 consecutive days. Patients ranged from infants to adolescents who were being followed by general pediatricians or subspecialists.

Dr. Leonard suggested that this tool, or one like it, could be useful in satisfying the Joint Commission's national patient safety goal 13a, which was established in 2007. Goal 13a calls on health care providers to "define and communicate the means for patients and their families to report concerns about safety and encourage them to do so."

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