



Critical Steps to Achieving Racial Equity in Children's Vaccinations

Update to Recommendations to Protect Children Under Age 12, Their Families and Communities

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Overview

In 2021, in anticipation of the COVID-19 vaccination rollout for children ages 5 to 11 years old, the Vaccine Equity Cooperative Kids Vaccine Working Group created [a set of detailed recommendations](#) to ensure all children, especially those who are most often underserved by existing systems, communities, receive equitable access to the COVID-19 vaccine. These recommendations rallied a diverse Working Group of concerned individuals and organizations in support of equitable vaccine coverage with a “no wrong door” approach.



In the fall of 2021, the Working Group met one-on-one with and then convened various government leaders at different stages of the vaccine rollout to help implement these recommendations and build and strengthen collaborations and connections for future partnerships. The Working Group appreciated the spirit of collaboration and support with which the recommendations were met, and the actions taken on the recommendations (e.g., [reimbursement for vaccine counseling](#)). Since then, the Working Group has continued to meet while tracking vaccine rollout and supporting uptake through our organizations and foundations.

Omicron cases and its variants continue to tax our vastly under-resourced health, public health, education and child care systems and personnel, with [14,195,580 total child COVID-19 cases reported, with children representing 18.5% \(14,195,580/76,885,307\) of all cases](#). Now that our children are returning to school and [with only nascent research on the longer-term impacts of COVID-19](#) on children, we must take decisive action to protect them from COVID-19 and other diseases that can be addressed by routine immunizations.

Yet, [COVID-19 vaccination rates remain low amongst children — especially very young children — with high state-by-state variability](#). A coordinated “all hands on deck” approach across federal and state agencies is critical at this time, in response to this dangerous gap in child vaccinations and the persistent disinformation designed to cast doubt in parents and guardians’ choices to vaccinate their children. The [unprecedented silencing of experts who advocate for vaccines](#) makes the battle to end vaccine-preventable diseases and keep children healthy that much more difficult. The recent resurgence of [measles worldwide](#) and [polio in New York](#) is further proof that the impact of anti-vaccination and disinformation campaigns are dangerously far-reaching and contributing to new health risks for a number of diseases and populations.

Our national response to COVID-19 cannot regress. It must progress toward an equitable and comprehensive strategy to protect our children from any and all preventable infections, illnesses, hospitalizations and deaths. As funders and practitioners who are deeply committed to the health and well-being of children, we are grateful that there are safe and effective vaccines against COVID-19 for children from infancy through adolescence. We also recognize that uptake of this life-saving vaccine has been incomplete at best and inadequate at worst, to protect the nation, at every age group, from COVID-19 and its potential complications. This means that ideally vaccination efforts would focus on all age groups simultaneously.

However, in the face of foreshortened time, funds and public attention, we believe it is prudent to focus on vaccinating school-age children. This will help create safer learning environments for children who have already experienced significant learning disruption and loss over the past two years. This does not diminish the importance of vaccinating the 0 to 5 year old group, but rather presents an opportunity to gain traction among parents who have not yet vaccinated their school-age children. Focusing on families that include school-age children will ensure that, in the face of likely additional surges of COVID-19 in the fall and winter, these children can remain in school, safely. To build on the progress that has already been made with implementation of our first set of recommendations, the Working Group is providing additional recommendations that respond to the slow progress of COVID-19 vaccinations for children, the [decline in routine childhood immunizations](#), and the release of Omicron-specific boosters this fall.

Short-term recommendations actionable over the next ~eight weeks:

In the near term, the Working Group suggests the following actions re: **what** can be done in the short term, with the Administration considering **how** to advance these actions promptly to ensure long-term value. If the federal government does not have these authorities, this group would like to discuss a mitigation plan.



Ensure the roles within the United States government are clearly defined and resourced for kids vaccines, COVID-19 response and school preparedness

While there has been proactive and well-intentioned activity, it is unclear how vaccine operations, coordination and communication operate within and across agencies including the CDC, HHS, and the White House — as well as the USDA and Department of Education. *Creating a position for a singular lead across COVID-19 response and a singular point person for both routine childhood immunizations and COVID-19 vaccination will aid in resolving interagency, intra-agency, and external confusion about leadership, enhance coordination and communication across government agencies by establishing regular convenings, bolster public-private / nonprofit partnerships and support the empowered inclusion of trusted messengers on the ground (e.g., pediatricians, community health workers/Promotoras, educators and others). In addition, it will be critical to integrate the administration and resourcing of COVID-19 vaccination along with routine immunizations. [The recent GAO](#) report similarly calls for this kind of role and message clarity from HHS. Moreover, given the ongoing need, naming a singular lead should be implemented such that net capacity is added to the response team.*



In addition, we recommend the childhood vaccination lead work in partnership with the American Academy of Pediatrics and others, including the National Association of School Nurses and National Association of Community Health Clinics, on all related kids vaccine communications and logistics for pediatricians to inform the policies, practices, and processes that will impact their patients and communities. This includes supporting and encouraging routine childhood vaccination within the primary care medical home — which will create opportunities to administer COVID-19 alongside holistic primary care services including access to other recommended vaccines, counsel on immunization, and provision of well child and mental health care.



Reassess assets and reopen the National Vaccine Program Office (NVPO) to centralize assets and coordinate with the forthcoming HHS Children's Coordinating Council in the Office of the Secretary

With the urgent needs driven by COVID-19, the current assets within the government should be better centralized so that agencies that have subject matter experts and/or vaccine “leads” can coordinate their efforts within and across agencies. For example, the former National Vaccine Program Office within HHS, which the previous administration combined with the HIV/AIDS effort to create the Office of Infectious Disease and HIV/AIDS Policy (OIDP), could be reinstated and focused on developing guidance and technical support on vaccine communications. Even with limited resources within that group, an existing interagency vaccine task force is [developing the nation's immunization strategy](#) for 2021-2025.



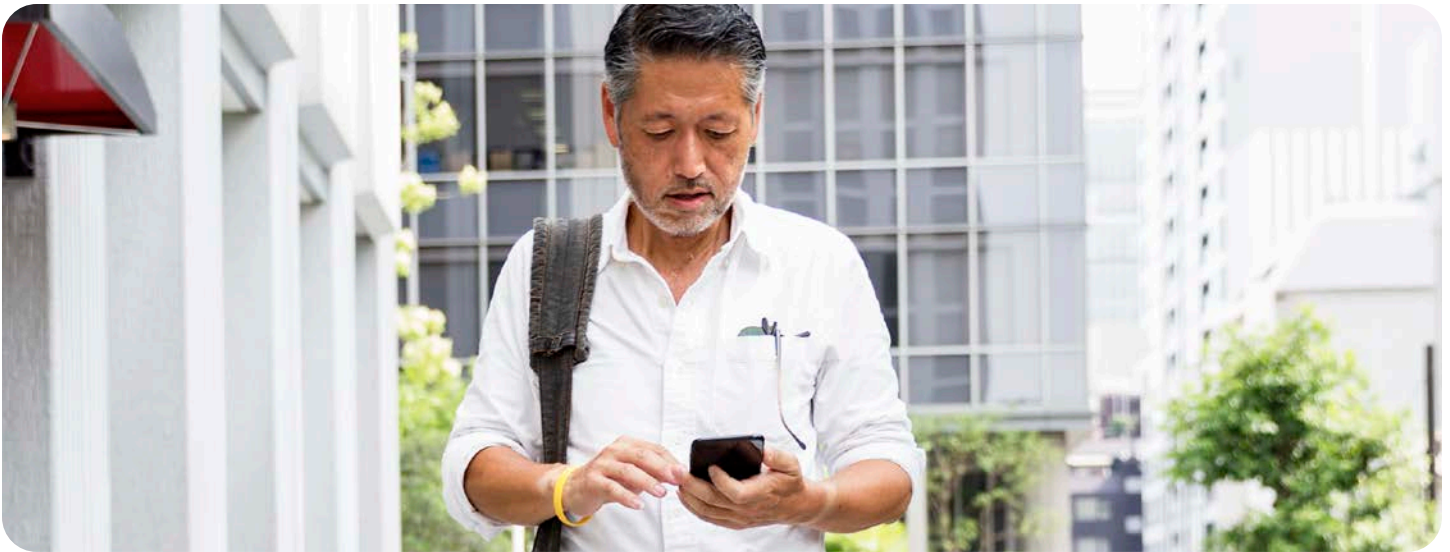
Create, disseminate, and amplify unified messages on all matters related to COVID-19 response

While the science on COVID-19 vaccines, testing, PPE, masking, treatment and coordination of care has been consistent and clear, information about that science has lacked the clarity and consistency required to make such science common knowledge. An *overarching public health communication strategy* must center on trusted messengers who present layered, affirming, and clear messages to normalize testing, masking, vaccination and treatment. This should be done alongside processes that democratize access to these pillars of the pandemic response. To be frank, the CDC has lost a concerning amount of public and professional confidence as this trusted messenger. Platforming and elevating new voices will require evaluating and amending current vaccine communications, ensuring messages are consistent for diverse audiences across agency websites, and leveraging various communication channels and messengers to spread the information. These messengers should include school-based champions of critical messages (administration, school-based clinics and nurses) community-based organizations, faith-based organizations and local community leaders and other trusted groups.

Another communication challenge that has emerged is that changes to clinical guidance have not been clear or well-disseminated. Specific attention should be paid to enhancing relationships and improving communications between federal agencies and state and local officials implementing the response, including more permissive guidance on how states and locals can use federal funding to resource community-based organizations to do outreach and education. This will be critical as COVID-19 is part of our day-to-day lives and in preparing for the next large-scale health crisis.



Clear, unified messaging has the power to undermine long-term efforts seeking to diminish the public credibility of government agencies and , under-resource, dismantle and remove the authority of these agencies. In the face of such anti-democratic efforts, public health systems must proactively move in tandem to shore up their legitimacy and proclaim their impact.



Establish a strategic roadmap to combat vaccine disinformation and build vaccine literacy

The COVID-19 vaccine roll out has served as an evolving opportunity [to disseminate misinformation about vaccines](#), coordinate disinformation attacks about COVID-19, and launch anti-democratic campaigns more generally. Anti-science has gained traction, at least in part, because of insufficient vaccine and health literacy that predates the pandemic. This challenge is likely to worsen as state and federal governments move beyond “warp speed.” In addition, the current checkerboard of mandates for masks and vaccines, along with the inherent complexity across available vaccines and therapeutics authorized and approved by the FDA, together foster confusion and hinder care uptake, particularly among communities already under-served by the existing health information landscape Indigenous, Black, AAPI, Latina/o/e, and other communities of color.

Given this context, and the history that precedes it, pandemic/endemic response leaders must put forth a comprehensive plan to combat disinformation and advance population health literacy. That response might begin with implementing the recommendations set forth in the [Surgeon General’s report on combating misinformation](#), creating policy that mandates [social media algorithms](#) boost credible science, funding research to understand how [misinformation spreads](#) and mitigate its consequences, and generating multiple strategies to discredit, combat, and dismantle sources of disinformation that harm consumers.

This response should also consider ways to enhance and amplify positive messages from trusted sources. Inspiration can be drawn from examples such as the [Youth Anti-Drug Campaign or tobacco control efforts](#). Substantial federal government resources will be required for this effort to have a meaningful impact on vaccination rates, particularly among critical demographics like school-aged children.

This response should be paired with ongoing work to advance broader vaccine and health literacy and emphasize the need for routine and seasonal childhood vaccinations and regular wellness checks. Boosting population health literacy also requires confronting the pay walls and administrative barriers that block lay persons from consuming science texts and journal articles. It requires new laws to ensure the results of all federally-funded research are [made available to the public](#), for free, in perpetuity, independent of the presidential administration. It requires the continual creation of proactive information campaigns to target emerging infectious threats before they become public health crises.

This collective work will require the Administration and government agencies, businesses, professional societies — including pediatric medical societies — and community-based organizations, schools and community health worker partners to work together.



Increase data surveillance and tracking

The CDC continues to mishandle tracking cases of COVID-19 infection. While the U.S. may approach one million cases/day of Omicron, CDC isn't tracking cases domestically with the precision that the Weather Service tracks storms. Much has been made about outdated technology and methods used for disease reporting prior to and in the early stages of the pandemic, but progress remains slow. Decisions about what data is being collected and reported on (e.g., breakthrough cases) have been poorly communicated and a source of frustration for health officials and the public. CDC's patchwork disease reporting system [is in the process of a major overhaul](#). Still, without good surveillance data that instills confidence in our ability to offer guidance, course correct, and communicate accurately, the Administration appears to be under-resourced and uncoordinated. Increasing data surveillance and tracking, including strengthening reporting requirements around state-level data and funding improvements in local and state public health data infrastructure, should be an immediate priority.



Foster workforce leadership and effective community-driven best practices



Critical to this next phase is *intentional coordination of efforts centered around the experiences of a diverse workforce with trusted providers of health information and services, coupled with trusted "health extenders" (e.g., trusted messengers in populations with lower vaccine uptake)*. By developing a regular "situation room" type convening that involves members of United States government (Executive Office of the President, Department of Education, HHS including CDC, HRSA, ACF), public health departments, school-based health, and community partners, the Administration can focus on diffusing accurate messages on what is working, what needs a course correction, fostering peer-to-peer learning and what can be speedily spread and scaled elsewhere.

Additionally, the Administration should leverage Medicaid redetermination grants funded by CMS and existing HRSA, OMH, and CDC COVID-related funding for state, local, tribal, and territorial health departments, CBOs, national nonprofits, and community health workforces to support unified messaging, goal-setting, training, and strategies focused on childhood vaccines tailored for these key partners. This will ensure we capitalize on opportunities at vaccination sites and ongoing community engagement to address concerns, advance family vaccine literacy and support referrals to primary care/pediatrics.



Protect vaccinations, including the COVID-19 vaccines from commercialization to ensure their equitable distribution

The federal government has indicated that, absent additional congressional funding, it may run out of funding to purchase COVID vaccines by the end of 2022. This is unacceptable. Yet, conversations have been initiated about the process for ending universal purchase of COVID vaccine by the federal government and commercializing the vaccines. This process would shift financial burdens to the insurance marketplace, including private payers, Medicaid, and the Children's Health Insurance Program, which will, with near certainty exacerbate existing inequities in vaccine access. Commercializing life-saving vaccines, particularly during an ongoing pandemic and in the face of emerging vaccine preventable diseases, also risks undermining the role of public health entities in effectively guaranteeing vaccine distribution and administration for the population.

In the absence of other exemplary programs to provide free vaccinations for adult populations, the Vaccines for Children Program (VFC) must become the national standard for all vaccine distribution and a central focus of the COVID vaccine strategy for children. But since COVID vaccines for some age groups are still being offered under an FDA emergency use authorization rather than full approval, these vaccines are not presently eligible for inclusion in the [Vaccines for Children](#) (VFC) program.

It is essential that the federal government extend the COVID-19 funding for vaccines so that children can access them as adults can, and appropriately shift all plans for commercialization to universal vaccine access for children and adults in the US.



Encourage and fund greater vaccine administration in primary care practices

As the country moves into a new stage of the COVID-19 pandemic, the federal government must intensify efforts to increase child vaccination rates for both COVID-19 and routine immunizations. Administering COVID-19 and routine vaccines has become increasingly complex, especially with the introduction of the bivalent COVID-19 booster at the same time as the flu vaccine roll out. Many pediatric practices are struggling to keep up with the increased need for counseling patients and families during a time when they are short staffed, to stay abreast of changing vaccine ordering logistics and labeling, to maintain cold



storage space, and to follow conflicting messages on wastage for COVID-19 and routine vaccines. The administration must continue to ensure appropriate provider payment for vaccine counseling for both COVID-19 vaccines and routine immunizations, whether a vaccine is administered or not.

To help relieve some of the administrative burden currently associated with administering COVID-19 vaccines and participating in the Vaccines for Children (VFC) program, the federal government should ease requirements for practices, including the process and coding complexity for documentation of storage, and should promote best practices for state vaccine distribution such as distributing smaller quantities of vaccine. The Administration should also facilitate the availability and use of single-dose vials, as this will help increase provider adoption, reduce the amount of wasted COVID-19 vaccine, and ensure the feasibility of successful commercialization. Efforts to streamline and encourage the delivery of COVID vaccines in pediatric practices must occur hand-in-hand with federal government efforts to promote the need for COVID-19 and routine immunizations at the national level, as well as at a more targeted community level that can reduce disparities by reaching populations with lower vaccination rates.

These immediate action steps have the potential to change the course of the national COVID-19 response and also lay the groundwork for a stronger, more equitable pandemic response and public health infrastructure. Our Working Group welcomes questions and feedback related to these recommendations, as well as opportunities to facilitate or support their implementation. While some recommendations are more challenging than others, we must — and can — act now and work collaboratively in new ways to protect our children and families.

For reference, [Part I Top Level Recommendations](#)



Vaccine Distribution

Most children across racial and ethnic populations, income levels, and payer types receive their routine vaccinations at one of three sites: Medical homes (pediatricians, family med or med peds clinics, FQHCs), schools and school-based clinics, or public health departments. As a result, the community-based vaccination sites that were critical to advancing racial equity among the adult population, may not be as integral to equitably vaccinate 5-11 and 12-17 year olds.



Critical Role for Schools and School Based Clinics

The robustness of the national school health infrastructure (school-based health clinics, school nurses etc.) varies by district and state. But given the core role schools play in the lives of families and communities, they are a crucial site to partner with in the vaccination effort – for disseminating information about vaccines and delivering vaccines. Schools are also important to bridge access gaps for underserved communities who lack a medical home.



Increased Support for Public Health Departments at All Levels

Public health departments, at the local and state level, are the backbone of targeted public health responses and in many jurisdictions the main site of vaccination for children and families who lack medical homes, are recent immigrants, or lack insurance coverage. Ensuring health departments are equipped and resourced to: support linkages between schools and medical homes, coordinate local efforts to proactively provide patients with information about vaccination, and offer vaccination, will be a necessary complement to the broader effort to vaccinate families.



Maximizing the Use of VFC

The backbone of the national effort to provide routine immunizations to the pediatric population is the Vaccines for Children program (VFC), which since its inception has helped narrow and sometimes even close gaps in routine vaccination by racial and ethnic group and across income levels. Maximizing and optimizing use of the VFC program will be critical to equitably and effectively vaccinating 5-11 and 12-17 year olds.



Reimburse and Incentivize Vaccine Counseling

Families will likely have questions for their pediatrician/primary care provider regarding vaccines even when they are not a vaccination site. There is no current mechanism to pay for this counseling in current billing and coding systems. In addition, some families will require several rounds of counseling before they are ready to receive a vaccine even from their primary care provider, but the primary care provider can only receive payment when the actual administration happens. Payment systems must encourage appropriate vaccine counseling. This is an urgent problem for CMS, state Medicaid programs, and private insurance to address. A couple of places have added reimbursement for counseling, including North Carolina Medicaid and New York City.



Enable a “No Wrong Door” Approach to Ensure Whole Families Are Vaccinated

The 5-11 year old roll out is an important opportunity to vaccinate families and communities and bolster community-level protection. This is an especially important approach for communities with low vaccination rates among adult caregivers, who then may be less likely to vaccinate their children. Family vaccination strategies capture the essence of the “no wrong door approach” and ensure caregivers and siblings are also protected when they accompany children who are 5-11 to their medical visits. But equipping vaccination sites to administer doses to clients or patients of varying ages raises important safety concerns that need to be proactively addressed.



Integrate and Equip Local Health Departments

Integrate local health departments (LHDs) and other key vaccine providers and community stakeholders into local planning to address operational challenges, effective coordination, consistent communication, and messaging, and ensure an approach to rollout with health equity at the center of the approach.



Clear, Consistent Communication Centered in Racial Health Equity

Clear, proactive, and unified communication across government agencies and all participants in the roll out for 5-11 will be critical to success. Such coordination requires planning and information dissemination strategies that are language appropriate, culturally appropriate, scientifically accurate, simple to digest, and timely.



Ensure Local Trusted Messengers Are Equipped With Clear Consistent Communication

Ensure that community based organizations, community health worker and promotora networks are adequately resourced and equipped with culturally appropriate and scientifically accurate information to do outreach to children, families, and communities, especially those who have experienced a disproportionate burden of COVID illness and other impacts, before and during the vaccine rollout.



Build on Bright Spots and Learnings From Local Communities

Build on learning, infrastructure, best practices and research from adult COVID vaccinations and routine childhood immunizations where public health, health care, community based organizations and community based workforce worked in concert to educate, combat misinformation and increase vaccination rates.



vaccineequitycooperative.org