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Introduction

Current barriers in immunization access, delivery, and financing in Colorado led to the passage, in 2013, of Colorado’s Senate Bill 13-222 (SB222) which directed the Colorado Department of Public Health and Environment (CDPHE) to establish a taskforce that would make recommendations on improving the immunization system by leveraging public-private partnerships to provide affordable, sustainable, and geographically diverse solutions that address immunization barriers across Colorado. The taskforce was also charged with addressing barriers in immunization delivery in private practices, including high upfront cost of vaccine purchase and inventory management, as well as insurance contracting and billing for Local Public Health Agencies (LPHAs).

As a result, the SB222 taskforce developed and released a number of recommendations in 2014. One of these recommendations was to promote models in public-private partnership—including private practice health care providers, public health agencies, schools, pharmacies and others—to deliver immunizations in practices and communities where it is not feasible to provide them in a typical medical home setting.

This brief examines promising and innovative partnerships in Colorado for delivering childhood immunizations. It should be noted that significant differences exist in how immunization providers serve urban versus rural communities. While many of the same barriers exist, the size and location of the community results in a variety of solution models. Information in this brief was captured through conversations with officials at LPHAs scattered throughout Colorado who oversee innovative partnerships with private practices and schools in order to provide immunization services to their patients and community.

Background

Prior to Affordable Care Act (ACA) implementation and changes in the Federal Section 317 Program in 2013, LPHAs served as the safety net vaccine provider for both publically and privately insured patients. The Vaccines For Children (VFC) Program is a federally-funded entitlement program that provides low or no-cost immunizations to eligible children. VFC vaccine is made available through all Colorado LPHAs and a network of nearly 600 private and public health care providers serving eligible children throughout Colorado. According to the US Centers for Disease Control and Prevention (CDC), over 475,000 (37%) of children in Colorado are eligible to receive vaccines through the VFC program and the majority of these children, over 344,000 (27%), are also eligible for Medicaid.

The Section 317 Program was created in 1962 to provide additional vaccines to states to serve un- and under-insured adults, to respond to public health emergencies such as outbreaks or natural disasters, or
to be used at the state’s discretion. Until a 2013 national policy change, Colorado primarily used 317 programs as a safety net source of vaccine for all patients regardless of their insurance status. The result of these efforts meant that each year, the Immunization Branch of the Colorado Department of Public Health and Environment (CDPHE) distributed over 1 million doses of vaccine, valued at nearly $43 million through these programs.

The 2013 regulation changed the rules which govern the 317 program and, now, prohibit privately insured patients from receiving the vaccines through this program. Patients instead must access vaccines through their insurance. LPHAs wanting to continue to serve this population must now purchase and administer private vaccine and submit claims to insurance providers.

As a result, many LPHAs increased their role in administering vaccines without new resources to support these activities. Specifically, LPHAs now communicate changes to patients to help them understand new policies, understand their insurance benefits, identify vaccine resources and locations, and enroll in coverage sources if eligible. LPHAs also purchase and manage inventory of private vaccines and develop billing systems and reimbursement procedures.

A handful of Colorado counties participated in the Reimbursement Immunization Opportunity (RIZO) project, funded through CDC, to address the challenges of initiating insurance provider contracts and developing billing systems. CDPHE also provided grants to some counties to cover the initial upfront purchase of vaccines. The results of the RIZO project were mixed. Some counties obtained contracts with all Colorado insurance providers and continued to provide full immunization services to both public and privately insured patients while other counties could only assess their needs and no longer offer vaccines to patients with private insurance.

Even with its shortcomings, the RIZO project highlighted the need for LPHAs to provide immunization billing services. The majority of patients served during the project were 18 years of age or younger (60%) and nearly half were eligible for VFC (47%). Over one-third (34%) had either private insurance or public insurance other than Medicaid. In addition, nearly 20% of patients had issues getting immunizations at a doctor’s office. They were referred to the LPHA because the practice did not offer immunizations (12%), the patient did not have a medical home (6%), or they could not get an appointment (1%). The main reason patients chose LPHAs was cost (34%).

Overall, a new culture change ensued. To administer private stock vaccines, many LPHAs changed their capacity and processes. LPHAs were not accustomed to collecting insurance information for vaccine administration billing, managing insurance contacts, or purchasing and maintaining private vaccine stock. Currently only about 17% of LPHAs in Colorado are administering vaccines to privately insured patients.

In addition to changes in public safety net vaccine funding and services, changes are also underway in private vaccine access and delivery. With expansion of healthcare coverage by the ACA, all insurance companies are now required to cover Advisory Committee on Immunization Practices (ACIP) recommended immunizations. This is part of a package of “essential benefits” that all compliant insurance plans must now offer to beneficiaries. The ACIP is composed of medical and public health experts that create recommendations to control and reduce new cases of vaccine preventable diseases in the U.S. population and review safety of vaccines.
Since implementation of the ACA is ongoing, some insurance plans with grandfathered status do not cover vaccines. However, by January 2016 all grandfathered plans will cease to be available. Until then, grandfathered plans require patients to pay part or all of immunization costs on their own due to co-pays and high deductibles. In 2013, 36% of those who get health insurance coverage through their employer were still enrolled in a grandfathered health plan. Another issue with the ACA is that “first dollar coverage” for immunizations requires a visit to an “in-network” health care provider. This creates a gap in certain regions of Colorado where in-network providers cannot be found or may not offer immunizations. Finally, despite gains in insurance coverage afforded by the ACA, the Colorado Health Institute estimates that 390,000 or 8.0% of Colorado’s population of 0 – 64 year olds will still be uninsured by 2016.

Despite these newly covered benefits, some private practices, primarily in low-volume or rural areas, are struggling with the upfront cost and administrative burdens of providing vaccines. On an increasing basis, they are considering, or have already stopped providing vaccines. These burdens include the increasing number of required and recommended vaccines, the increasing costs to purchase vaccines, the increasing costs to manage and store vaccines, the growing needs for inventory and dose accountability, data management, and data interoperability. Costs and reimbursement issues are often cited as a prime concern for vaccine administrators. The cost of fully vaccinating a child in 1985 was about $45; currently, that cost is now closer to $2,200. Further, a 2008 study published in Pediatrics found large differences in both prices paid for vaccines and amounts reimbursed from insurance companies, ranging from $3 to $90 per dose depending on the type of vaccine and the insurance carrier. The same 2008 study found that 6% of those who provide primary care report they do not provide any immunizations due to these concerns and that as many as 7% of pediatricians and 34% of family physicians seriously considered discontinuing providing all vaccines to private patients. In addition, more than half reported that their practice had experienced a decrease in profit margin from providing pediatric immunizations in the previous three years and that nearly half of the practices had delayed purchasing a new vaccine due to financial issues and missed an opportunity to immunize children in their care.

Innovative Partnerships and Best Practices: Small Volume and Rural Private Practices

Rural communities face unique immunization delivery challenges compared to large urban areas. These challenges include few local health care providers to deliver immunizations, limited LPHA hours to offer immunizations (e.g., only one day a week), small patient volume, and large distance to travel for immunizations. Local providers rely heavily on LPHAs for experience and knowledge of vaccine delivery.

With changes in 317 funding prohibiting LPHAs from providing free vaccine to clients with private insurance, some rural local practices are faced with providing immunizations for the first time. However, some express concern about this, noting that LPHAs already do a good job and have the expertise. Rural areas have a limited number of private practices and may struggle with managing all the ACIP recommended vaccines and keeping up with

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**SHOTS FOR TOTS AND TEENS SUCCESS STORY**

- Provided 2,189 free or low-cost vaccines to 855 children in 2015. Over a 30% increase over 2014 numbers.
- Utilized a total of 800 volunteer hours to operate monthly clinics.
- Distributed more than 6,000 flyers and reached more than 100,000 Coloradans with paid radio advertisements.
current guidelines and recommendations. For example, Prowers County Health Department receives frequent calls on how to properly catch up a child when the child is behind in immunizations. In addition, sometimes parents are uncomfortable bringing a healthy baby to a health care provider where sick children are present and prefer to receive immunizations at an LPHA. To counter the challenges, rural LPHAs have developed innovative practices and partnerships with local health care providers to cover the geographic spread.

Below are examples of promising practices that address barriers to immunization delivery in small volume and rural private practices.

**Promising Practices: Small Volume and Rural Private Practices**

- Denver Public Health serves as a resource for nearby counties. Denver Public Health has clinic hours five days a week and bills for both private and public insurance.
- Lake County works 10-hour days, four days a week. The extra hours in the evening allow parents to bring in children after their normal work day.
- In Teller County, the LPHA offers immunizations and conducts well-child visits two days per month inside a private practice. Teller County developed a Memorandum of Understanding with family practices to bill for privately insured patients while the LPHA administers the immunizations.
- To ensure good record keeping and documentation of immunizations, LPHAs develop relationships with local health care providers. Teller County provides two copies of immunizations given, one for patient and one to give to their primary care provider. This gives practices a clear sense of services provided without feeling any disruption to the medical home.
- Lake County calls their patients 1-2 days before their next scheduled immunization visit to remind them to come in.
- With frequent staff turnover, one LPHA creates a “cheat sheet “for nurses on how to give combination vaccines and how to adhere to the ACIP schedule.
- Kit Carson and Prowers County build strong relationships with schools and parents so they fully understand the importance of immunizations and clarify any misconceptions. In addition, engagement with health care providers ensures they have a unified message on immunizations for all involved.
- Kit Carson County requests patients to follow-up with their insurance company to pay for their vaccination instead of coming out of the public health department’s budget. They make a mutual quest and understand “they’re all in this together.” They educated the public about why following up with their insurance company is so important; if the insurance company does not properly pay the public health department may go bankrupt.
- One LPHA utilizes the Immunization Action Coalition’s ([www.immunize.org](http://www.immunize.org)) questionnaire to ensure each patient receives comprehensive health screening before each immunization visit.
• Boulder County Health Department hands each patient Vaccine Information Statements regardless of whether they choose to get all the vaccines.
• In Prowers County, when a patient calls to make appointment, they ask for the patient’s insurance information and their private health care provider. If the patient has a medical home, the LPHA recommends it is best to get their immunizations at their medical home.
• Gunnison County trained three local practices on how to set up a vaccine delivery system. They taught staff how to contract for VFC, how to follow immunization schedules, phone numbers to call, how to enter data into CIIS, and provided a resource list for VFC and CDPHE. As a result, the private practices now see privately insured children.

Further Opportunities and Considerations
• Create mentoring opportunities with established providers.
• Develop resource list for quick access to key information.

Innovative Partnerships and Best Practices: Urban Areas

Urban areas also face unique circumstances. They serve a larger, more diverse population with many health care providers. Now that more patients are insured under the ACA and they can now access care in a medical home, some LPHAs no longer serve patients with private insurance. In addition, restrictions in the use of 317 funds for patients with insurance has resulted in some LPHAs accepting some or all insurance plans which can confuse or frustrate patients. Patients may not know which health care provider to go to for the insurance they have.

Many LPHAs lack dedicated time and resources for administrative services and to fulfill requests to perform immunization clinics. One urban LPHA estimated they would need at least one FTE to establish insurance provider contracts and submit and track insurance claims. One county stated that their immunizations hours are stretched to the limit with 2-3 times more time spent on vaccine inventory management than five years ago. While many schools districts request immunization clinics for their students, only a few can be performed each year due to the significant amount of time required to plan, identify children missing immunizations, obtain consent, etc. Under-resourced LPHAs struggle to
serve a large, diverse population. With multiple constraints, LPHAs have created innovative, one-time partnerships or long-term sustainable initiatives to fill these gaps.

- The Shots for Tots and Teens Program is a partnership between Aurora Fire Rescue, Denver Public Health, Tri-County Health Department, local Rotary Clubs, Denver Paramedics, and the Colorado Children’s Immunization Coalition. It is a highly successful program that reaches un- and under-insured children outside schools and family practices at convenient Saturday clinics in Aurora and Denver. The locations were selected after research showed which zip codes were most likely to face challenges in accessing immunizations.

- Tri-County Health Department (TCHD) utilizes a text message and/or voicemail system to remind patients they are due for immunizations and/or remind them of an upcoming appointment. TCHD also utilizes Call-Em-All (www.call-em-all.com) broadcasting service which offers various pricing packages. After using the system for six months, they received a 25% increase in call backs for more information.

- To increase adult vaccinations, one county health department set up contracts with employers and charged employers for vaccinations through their insurance company. They started with flu vaccine clinics as a way to get in the door and then expanded to other immunizations.

- Jefferson County partners with their Health Communications team to identify best messaging and create innovative ways to reach out through social media.

Further Opportunities and Considerations

- Local private practices are the best resources to promote immunizations. They can create patient handouts and advertisements to increase awareness about immunizations and how to get vaccinated.

- Private practices or LPHAs could collaborate and develop a resource list and mechanism to refer patients when a provider cannot see a patient based on insurance status. The resource list can include contact information of providers of nearby counties, LPHAs, which insurance they accept, hours, where provider is located, and relevant clinics. (e.g., Shots for Tots and Teens, VFC clinics, etc.)

- Create a mentorship opportunity where experienced health care providers and immunization champions share best practices with struggling providers to increase immunization rates in accordance with regulations.

Schools as Immunization Outreach and Awareness Providers

Schools serve as a major resource in immunizing children and identifying which children do not have up-to-date immunization records. Engagement between LPHAs and schools is critical to identify best ways to vaccinate children. Several barriers exist for forging partnerships and conducting immunization clinics. (1) With limited staff capacity at both schools and LPHAs, fewer immunization clinics can be performed than requested. It takes significant time to gain parental consent and plan clinics. (2) The ratio of school nurses to students in Colorado is below the national best practice average at 1:750. In Gunnison County, there is one school nurse for 1,900 children. With more students to serve than nurses can handle, nurses lack time to check immunization rates. As a result, students may be halfway through the school year before they are notified that their immunizations are missing. Currently, almost 20% of students in Colorado are of unknown immunization status because nurses have no record on file. With recent outbreaks, some schools have become more receptive to partnerships with LPHAs. One LPHA
mentioned that it took daily activity for almost six years to build a strong partnership between their LPHA and school.

Starting in December 2016, new Board of Health rules require schools to annually collect immunization and exemption rates and report this to CDPHE. As a result, nurses will prioritize immunization work. This coupled with new processes and enhancements to CIIS, schools will be relieved of a lot of burden to obtain immunization status. The annual results will be made available to the public on the CDPHE website.

Below are some examples of promising practices that highlight the benefits of schools as immunization enforcers.

**Promising Practices: Schools as Immunization Enforcers**

- Gunnison County times school immunization clinics with kindergarten registration and back-to-school night.
- Gunnison County proactively reaches out to nearby child care centers and reviews immunizations records. The intent is to catch kids before they go to kindergarten. They successfully reach about 50% of the children.
- Tri-County Health Department sends “unvaccinated/expulsion letters” to parents around the time of school breaks. The letter informs the family when the next clinic will be offered during “X” break.
- During disease outbreaks, one LPHA adds a paragraph to the school newsletter indicating what parents can do to get their child fully vaccinated. This generates discussion and has been a huge success in getting children up to date.
- Denver Public Health has an employee who serves as a liaison to the school. The liaison can access the school system and identify students who are non-compliant. Then, the liaison works with the school nurse to coordinate clinics. This solution was initially funded through CDC and, subsequently, continued through reimbursable funds.
- Kit Carson County puts vaccine consent forms and information on immunizations on their school website and announces when they will be on site to complete the consent forms.
- In rural areas, LPHAs advertise immunization week and back-to-school clinics through the local newspaper, which is well-read by residents.
- Kit Carson County travels monthly to each town and provides immunization clinics. They write letters to parents and request billing information and copies of insurance card when the parents send back the consent form. Kit Carson County mentions on the consent form that no one denied service with inability to pay.
- LPHAs train school nurses on how to use CIIS, in particular how to look up students and do an accurate search to identify children from their school and look up their immunization status.

**Further Opportunities and Considerations**

- Develop best practice guidelines for LPHA and school partnerships for immunization clinics.
- LPHA staff sit on an advisory committee for new and upcoming school based health centers.
- The first step to developing more partnerships is to forge more collaboration between school administrators and LPHAs to support school clinics.
Improving Logistics and Administrative Issues

Complicated logistics and administrative constraints result in patients being turned away and fewer practices providing immunizations. Due to regulations, vaccine stocks are tracked and maintained separately based on recipient’s insurance type. VFC is a public entitlement program and, therefore, requires specific storage and handling regulations which feel burdensome to some health care providers. All LPHAs in Colorado have been delegated as VFC providers.

Since VFC stocks must be kept separately from private stock vaccine, inventory management takes significant time to perform. LPHA immunization hours are already stretched to the limit. For example, one immunization manager spends two to three times more time managing inventory than five years ago. It is easy to pull doses from the wrong stock. In Gunnison County, one private practice wanted to offer VFC but decided it was too much work. While TCHD utilizes multiple websites to order, bill, and reconcile stocks.

Carrying private stock vaccines requires a huge upfront cost, approximately $12,000. LPHAs and private practices must identify funds to cover the cost until reimbursement is received from insurance companies which may take weeks or even months. For underinsured patients in Kit Carson County, the real cost of vaccines is hard and difficult for families to bear. A full childhood series may cost over $2,192 out of pocket. To mitigate some of the burden, the 317 grant program gave vaccine starter kits to certain counties for the initial purchase of private vaccines. However, not all counties accessed this program.

Below are promising practices for inventory management and elimination of upfront cost to purchase vaccines.

Promising Practices: Inventory Management and Elimination of Upfront Cost to Purchase Vaccines

Inventory Management

- Within a health care provider facility, LPHAs have been successful using correct stock by using multiple color labels to distinguish between VFC and private stock and to distinguish vaccine population type, e.g., child/adolescent versus adult. They also utilize the left side of the fridge for VFC vaccine and the right side for private stock.
- For offsite clinics, Prowers County uses multiple coolers to distinguish between different vaccine stocks.
- Successful LPHAs and practices perform inventory management on a monthly basis for VFC and private stock. They regularly pull reports to determine rates of vaccine usage and are proactive and take into account upcoming clinics that may change their normal rates.
- For offsite vaccine clinics, one LPHA offers only one vaccine at a time.

Upfront Cost

- LPHAs engaged their County Administrator on the importance of immunizations and secured funding through budget process for upfront purchase of vaccines. For example, during this transition Gunnison County carried the public health department and supplied enough funds for initial purchase of private vaccine stock.
- Kit Carson County supports families to pay what they can actually afford without anyone being denied services. For example, one family paid $20/month until their entire bill was fully paid off.
The County Administrator was supportive of ensuring that all patients who showed up could be vaccinated.

Further Opportunities and Considerations

- Proactive/pre-planning for patient: At time of appointment, the LPHA or private practice requests insurance information, determines insurance eligibility, and based on insurance determine what vaccine stock is used.
- The SB222 taskforce is evaluating private sector solutions that would eliminate the upfront purchase cost of vaccines.
- Create resources to better understand how much a provider should pay for a vaccine. Evaluate group purchasing options.

Improve Billing Mechanism for Private Stock Vaccines

After implementation of the ACA, LPHAs were put in the position to develop a mechanism to collect for immunizations delivered to privately insured patients. The RIZO Project streamlined the contracting process for LPHAs to develop and execute contracts with insurance companies to obtain reimbursement for vaccines and administrative costs associated with immunization delivery. The project was successful for some counties but not others. For participating small and rural counties, the RIZO project was a huge success and paved the way to offer private vaccinations in their county. However, for participating urban counties, the grant only assisted with feasibility and lost progress when the grant ran out.

LPHAs are confronted with several obstacles in initiating insurance contracts and developing billing mechanisms. First, when initiating insurance contracts, LPHAs and private practices are treated in the same manner. Insurance providers require an MD and 24 hours, 7 days per week coverage. This is unrealistic for rural LPHAs who mostly only staff public health nurses. As a result, some insurance companies will not contract with LPHAs and do not consider LPHAs for in-network status. For example, Tri-care (military insurance) will not accept any billing without an MD on site. This creates frustrations for grandparents who take care of their grandchildren while their parents are on deployment. Second, negotiating contracts with insurance companies takes substantial time and is resource dependent. One county mentioned it took almost six months to negotiate one insurance contract. Negotiation typically involves several corporate layers which may be difficult for LPHAs to navigate. Third, it is time consuming to track and submit billing claims. For a rural county with only one immunization clinic per week, they do not have time to check eligibility for private insurance. This is even worse during flu season. In addition, reimbursement time frame differs by insurance contractor varying from one to ten weeks.

Below are promising practices to address insurance contract requirements, contract negotiations, and tracking and submitting claims:


Contract requirements

- LPHAs can educate insurance companies on the role local public health agencies play in vaccination delivery and how this differs from private practices.
• LPHAs can program an after-hours message and provide instructions on where to go for after-hours care. For example, Teller County created an MOU with local hospital to provide emergency services for after-hours care for patients.

**Contract negotiation**
• LPHAs can negotiate reimbursement fees just like private providers. LPHAs do not have to accept the initial rate the insurance provider suggests. This was a successful endeavor for Gunnison County.
• LPHAs should perform cost analysis before negotiating rates. LPHAs need to know cost to purchase vaccines, time for inventory management, and immunization delivery. LPHAs should be informed and have information available in order to negotiate appropriate service rates. For example, Prowers County added 6% to vaccine cost and now maintains clear books and a sustainable business model. In six months, after instituting the practice, they were out of the red.

**Tracking and submitting claims**
• LPHAs should verify insurance eligibility at time appointment is made. While this is a cultural shift and extra time commitment for LPHAs, those agencies who perform this have higher rates of reimbursement and can accurately plan for vaccine stocks needed. The drawback is that the insurance may not be accurate when the patient comes in for their appointment.
• LPHAs can develop a check-out form that lists all the immunization codes and corresponding CPT codes to allow for faster billing submission.
• Kit Carson County emphasizes to patients the importance of following up with their insurance company to pay the vaccination billing claim. The patients call their insurance company requesting immunization coverage, acknowledge that they pay their coverage monthly, and indicate they may change insurance companies if it is not covered. About half of patients called their insurance company asking them to pay. Patients were very proactive about it.
• Gunnison County utilizes an online system for electronic billing. The system only took a few weeks to set-up. The company takes a percentage of each claim and is very cost effective for the county. Separately, Gunnison uses the Medicaid web portal.

**Future Opportunities**
• Insurance billing is new for some local public health agencies. LPHAs should consider if other services they may offer (e.g., family services) will also be billable to insurance companies. If this is the case, LPHAs should consider negotiating contracts for both services at the same time. This way they avoid going through the same negotiating process again when adding a new service.
Private providers should not assume immunizations are part of their contract. Providers should ask insurance companies what the fee schedule is for and double check their contract.

The SB 222 taskforce is evaluating vendors that offer billing services for insurance claim submission and tracking.

Third party billing services offer training on revenue management online and through in-person workshops. Concepts include:

- How to do business
- Where to adopt best business practices
- Before visit: contract, credential, set fee
- When schedule or before visit: collect demographics and insurance info
- During visit: point of service collection: collect co-pays
- After visit: understand coding, fill-out claim form, “work the claim” (technology to send and track claim, and ensure you get paid)

Hire an FTE to stay on top of sending, tracking, and following-up on insurance claims.

What’s Next

With changes from the ACA and 317 grant program, both local public health agencies and private practices created innovative partnerships and best practices to combat these changes. The overall theme indicated that LPHA and private practices must collaborate and inform their patients, their communities, their schools, and insurance companies and fellow public health and private providers to achieve higher immunization rates in their rural and urban areas. The attitude is that we are all in this together and have a role to play.

The Senate Bill 222 Vaccine Access Taskforce continues to actively tackle the recommendations developed in 2014. The Taskforce recognized many barriers to immunization delivery including significant time and resources to negotiate contracts with insurance companies, significant upfront costs to purchase vaccines, significant time to submit and track insurance claims, lost doses, and increased burden to perform vaccine inventory management.

In 2015, the Taskforce vetted several private companies to see how their solutions may reduce barriers to immunization delivery in Colorado. The Taskforce moved forward and initiated a six-month pilot study with VaxCare Corporation, a company that offers services targeted at eliminating barriers to immunization delivery. The study will measure VaxCare’s ability to work with local public health agencies and private practices to meet at least one of the following goals: initiate or re-start the provision of vaccinations, provide all ACIP recommended vaccines to their relevant population rather than just some, and manage the provision of vaccines through a sustainable business model. The Taskforce hopes VaxCare will be a viable solution for Colorado and increase overall health care provider satisfaction to offer and deliver immunizations. Pilot study results will be released mid-2016.

In 2016, the Taskforce will develop a resource hub for health care providers. The hub will contain the list of vetted vendors and their service offerings, the results of the VaxCare Evaluation Study, how to become a successful immunization provider, and resources for providers to access the most up to date information on immunizations and immunization delivery.
With the evolving role of LPHAs and increasing financial burden on private practices, the Taskforce continues to seek ways to alleviate these challenges and layout a new path for moving forward. It is crucial to ensure access to vaccines in both rural and urban settings and with patients with public and private insurance. The innovative partnerships and best practices in this brief show the creative styles to build collaborations and increase immunization rates in Colorado.