ISSUE BRIEF #1

LA County Children's Health Disparities

Vaccine Catch-Up and Misinformation

How do we improve access to and provision of immunizations to promote children's health?

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In Collaboration with

HMA

Introduction

Led by L.A. Care and Children's Hospital Los Angeles (CHLA), and with support from First 5 LA, HealthNet, and Molina, the Los Angeles County Children's Health Disparities Roundtable was convened in November 2023. The roundtable event brought together local leaders to discuss four rising challenges in children's health, with a particular focus on engaging populations that have been historically under-resourced and who often receive services in fragmented care environments.

Local leaders were divided into four working groups to wrestle with a particular challenge facing children and youth in LA County today:

- **Building Resiliency**: How can we improve the systems of care to improve well-being and address children's mental health needs?
- **Vaccine Catch-up and Misinformation:** How can we improve access to and the provision of immunizations to promote children's health?
- **Supporting Children and Youth Involved in the Child Welfare System:** How can we improve the quality, appropriateness of supports, and ease of access to care to address the unique needs of children involved in the child welfare system?
- **Children with Complex Medical Needs Transitioning to Adulthood:** How can we facilitate the continuation of critical support as children with complex medical needs age out of care eligibility?

The four resulting policy briefs present recommendations specific to LA County, recognizing that work in the County has statewide implications and relevance. The workgroup planning and discussions were grounded in the evolving policy and service delivery landscape, particularly for Medi-Cal beneficiaries, and the emerging new opportunities to support children and youth. A consistent theme across the four convenings was the need to engage trusted community partners who can facilitate and promote engagement in care.[1] Recommendations were informed by facilitated workgroup discussions with support from Health Management Associates (HMA) consultants who provided subject matter expertise and drafted policy briefs. Workgroups were charged with developing recommendations that:

- Focus on strategies and actions that are tailored to the specific needs in LA County
- Promote initiatives that can be undertaken in the next two to three years to address gaps and challenges in the current systems of care
- Maximize and reflect opportunities to improve the systems of care, given the known and anticipated changes in the publicly funded systems of care

Members and contributors to each of the workgroup are listed in the Appendix of each report.

[1] Community partners or organizations sometimes are referenced as "backbone" organizations.

Understanding the Evolving Systems of Care

Nationwide and statewide, there has been increased recognition of the need to broadly address children's health following the pandemic. The pandemic highlighted disparities and exacerbated preexisting inequities in access to and engagement in services that promote the physical and mental health of children and youth.

The fact is publicly insured children tend to receive fewer preventive healthcare interventions. The comprehensive benefit package known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is available to children and adolescents younger than 21 years old, who have Medicaid (Medi-Cal) or Medicaid expansion Children's Health Insurance Program (CHIP) coverage.[2] EPSDT requirements are intended to ensure that children and adolescents receive appropriate screening, preventive, dental, mental health, developmental, and specialty services; however, young children insured through Medicaid are less likely to receive regular preventive care than those with commercial insurance.[3]

A similar pattern of inequity for children in the Medi-Caid safety net exists regarding mental health services. In California, despite more than 30 percent of adolescents reporting feelings of depression and over 10 percent having considered suicide, fewer than 5 percent of children and youth younger than age 21 in the Medi-Cal system have received mental health services.[4] The recent audit of the California Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) issued in November 2023 concerning DHCS's timely access monitoring of specialty mental healthcare and substance use treatment plans found that *significant numbers of County-managed Medi-Cal plans are not in compliance with DHCS standards*. The audit concluded:

> "DHCS is missing opportunities to ensure that qualifying children receive the behavioral health care services to which they are entitled."[5]

[2] EPSDT is required for Medicaid programs and Medicaid expansion CHIP programs but is not required in states with private CHIP programs.

[3] Children insured through Medicaid managed care are less likely to receive their recommended well-child visits at 15 months old than children in households with commercial insurance (57% vs. 81%). Source: National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCW). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/.

[4] Sources: California Children's Trust. The California Children's Trust Initiative: Reimagining Child Well-Being. November 2018. Available at: https://cachildrenstrust.org/wp-content/uploads/2018/11/PolicyBriefReimaginngChildWellBeing.pdf; and California Children's Trust. Data & Backgrounders. Available at: https://cachildrenstrust.org/our-work/data-backgrounders/#map.

[5] Department of Health Care Services and Department of Managed Health Care. Children Enrolled in Medi-Cal Face Challenges in Accessing Behavioral Health Care. Report 2023-115. November 2023. Available at: https://information.auditor.ca.gov/pdfs/reports/2023-115.pdf.

California's Medi-Cal system is undergoing substantial changes in response to both statewide and national trends through two major initiatives shaping the health and well-being of children and youth. The first, California Advancing and Innovating Medi-Cal Act (CalAIM), is intended to improve the entire continuum of care, streamline services, and ensure equity across the Medi-Cal program. Integrated with other DHCS preventive and wellness strategies (e.g., 50 by 2025), and with a particular focus on maternal and pediatric care services, CalAIM initiatives leverage managed care plans to ensure assessments and supports for children and youth by addressing the most vulnerable populations through enhanced care coordination and community supports.[6] Concurrently, the Children's and Youth Behavioral Health Initiative (CYBHI), is a comprehensive, multi-departmental effort to increase the availability and access to behavioral health services for California's children, youth, and families. CYBHI is expanding access points, the behavioral health workforce and services, and reforming reimbursement opportunities, through a significant, one-time investment, new Medi-Cal benefits, and innovative payment strategies.

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Note: Each paper will additionally have a list of participants for recognition at the back.

[6] Bold Goals 50 x 2025 focused largely on children and women's preventive services. Source: Department of Health Care Services. Comprehensive Quality Strategy. 2022. Available at: https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf.

Current Context of Vaccine Penetrance

Routine childhood vaccinations are a critical tool in the prevention of infectious disease. While there has been significant progress in improving vaccine coverage in California over the past decade, challenges remain, particularly with respect to disparate vaccine acceptance and access for historically underserved communities. The COVID-19 pandemic these gaps, with routine childhood vaccination rates decreasing significantly across the United States. One analysis documented a 62 percent decrease in routine vaccine administration for infants (younger than 24 months old) and a 96 percent decrease in routine vaccine administration for children/adolescents (ages 2−18) between 2019 and 2020.[7] Of note, COVID-related declines in vaccination were most pronounced for children enrolled in Medicaid.[8] In addition, childhood vaccination disparities were greater among Black/African American and Latine children when compared with White and Asian children.[9]

In LA County, vaccine coverage for children entering kindergarten dipped during the pandemic because of issues resulting from disruptions in healthcare services, the unwinding of continuous Medi-Cal coverage, and changes in vaccine acceptance, but has since rebounded to near pre-pandemic levels.[10] As pandemic disruptions receded and well-child visits rebounded, data trends indicated some recovery in vaccination rates nationally, though some challenges resulting from the pandemic persist. The evolution of attitudes toward vaccines has been uneven, with vaccine hesitancy persisting at higher levels in communities of color.[11] These challenges add to the difficulties in vaccine acceptance, access, and coverage that existed prior to the pandemic.

Decreased vaccination rates over the last several years have been linked to a number of factors, with COVID-related disruptions in the healthcare delivery system and vaccine misinformation most prominent. Notably, lack of trust and confidence in vaccines has come about as a result of widespread vaccine misinformation through social media and other internet platforms. This situation has intensified preexisting delivery system challenges, resulting in declining vaccinations and increased incidences of preventable diseases. This difficulty is highlighted by documented decreases in pro-vaccine and increases in anti-vaccine attitudes in the early stage of the pandemic. [12]

[7] Cunniff L, Alyanak E, Fix A, Novak M, Peterson M, Mevis K, Eiden AL, Bhatti A. The Impact of the COVID-19 Pandemic on Vaccination Uptake in the United States and Strategies to Recover and Improve Vaccination Rates: A Review. *Hum Vaccin Immunother*. 2023;19(2):2246502. doi: 10.1080/21645515.2023.2246502.

[8] Hill HA, Yankey D, Elam-Evans LD, Singleton JA, Sterrett N. Vaccination Coverage by Age 24 months Among Children Born in 2017 and 2018 - National Immunization Survey - Child, United States, 2018-2020. MMWR Morb Mortal Wkly Rep. 2021;70(41):1435–1440. Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7041a1.htm.

[9] Teasdale CA, Borrell LN, Shen Y et al. Missed Routine Pediatric Care and Vaccinations in US Children during the First Year of the COVID-19 Pandemic. *Prev Med*. 2022;158:107025. Available at: https://pubmed.ncbi.nlm.nih.gov/35318030/.

[10] Los Angeles County Department of Public Health. Shots for School Immunization Assessment, 2017-2022.

[11] Lin C, Pikuei T, Terry TC. Moving the Needle on Racial Disparity: COVID-19 Vaccine Trust and Hesitancy. *Vaccine*. 2022;40(1):5–8. doi: 10.1016/j.vaccine.2021.11.010.

[12] Missed Routine Pediatric Care and Vaccinations in US Children during the First Year of the COVID-19 Pandemic.

Challenges Facing Routine Vaccination

Delivery System

Workgroup members described a vaccine distribution system that is piecemeal and complex, posing challenges to the general distribution channels and highlighting important innovations in vaccine distribution and delivery that emerged during the pandemic. The complexity of the vaccine delivery system can lead to extended delays in getting vaccines where they are needed. Furthermore, within the process of vaccine implementation, the system is designed such that the responsibility falls upon individuals to understand and manage the complexities of vaccine scheduling and compliance. Vaccine access is limited because distribution is primarily through providers or pharmacies. These barriers are stacked upon the challenges families face in accessing primary care, including the need to secure time off from work to attend appointments, as well as transportation and language/cultural barriers.[13]

The complexity of the current vaccine delivery system creates barriers for both providers and consumers. To meet needs across the age span, providers must stock different types of vaccines. Vaccine resources and reimbursement vary by age and immunization type (e.g., Vaccines for Children [VFC] program, drug coverage pathways for specialty monoclonal antibody immunizations, pharmacy vaccine administration for some vaccines, etc.). Consequently. clinics must keep track of multiple supplies for specific patients, which can result in practices not having the vaccine needed for certain patients. For example, administering the flu vaccine can necessitate stocking a high dose product for the elderly, a preservative-free product for younger patients, and specific supplies for the VFC program, Vaccine Preventable Disease Program (VPDP), and commercial insurance.

Innovative responses to the need for rapid, population-based immunization in the face of the COVID pandemic led to temporary improvements in the delivery system. COVID vaccine distribution was bolstered by the availability of free vaccinations, as well as key policy changes that took vaccination out of the healthcare system and into the communities it was intended to reach. This effort included both changes in who could administer vaccines and the role of public health in vaccine ordering and distribution. These changes allowed for the centralized distribution of vaccine products and related supplies, and centralized data capture, These changes brought vaccination deeper into communities and improved the system's capacity to provide them in accessible locations through organizations and providers that community members trusted and could easily access. Unfortunately, many of these policy changes have now been rolled back, which has returned the system to a pre-COVID state.

[13] Williams E, Burns A, Rudowitz R, Drake P. KFF. The Impact of the Pandemic on Well-Child Visits for Children Enrolled in Medicaid and CHIP. KFF. March 18, 2024. Available at: https://www.kff.org/medicaid/issue-brief/the-impact-of-the-pandemic-on-well-child-visits-for-children-enrolled-in-medicaid-and-chip/.

Misinformation and Trust

The workgroup identified mistrust in healthcare and its associated systems, particularly from individuals living in underserved communities, as a key limitation in reaching all community members. Historical patterns of medical racism dating back to the Tuskegee Syphilis Study and other ongoing evidence of systemic racism and oppression provide a partial explanation of why individuals from underserved communities may find it difficult to believe that healthcare providers and systems are prioritizing their best interests. This mistrust can be compounded by ubiquitous misinformation on social media and elsewhere. The workgroup observed the danger of misinformation spread online and the need to better translate science to a variety of audiences by delivering vaccination messages through channels that community members trust, such as community-based organizations (CBOs) and other identified community partners.

Data

Challenges with data complicate efforts to improve vaccine administration. These include issues around access, sharing, accuracy, and completeness of vaccination data, as well as the limitations of exchanging data in an organized and effective way to key stakeholders and community members. It is important to highlight that data sharing is critical to ensure accurate record-keeping at the individual and population levels, facilitate inventory management, and provide epidemiologic analyses of vaccine coverage, distribution, and acceptance.

Effective January 2023, California AB 1797 requires that providers enter vaccine information into the California Immunization Registry (CAIR), including race/ethnicity information, with the goal of improving data exchange and coordination in California's vaccine administration. However, the slow uptake among practices in integrating this into their workflow is compounded by numerous emerging policy and implementation challenges, which collectively impede its effectiveness in addressing the challenges related to vaccine coverage and access. Examples include:

- The legislation does not require practices to back-enter previously administered vaccines.
- Inconsistencies in the coding/terminology used in entering vaccines result in duplicate entries.
- Lack of interfaces and interoperability between records and data systems that are necessary for data sharing (e.g., a provider needs to know when a respiratory syncytial virus (RSV) vaccine is given to an expectant mother, as that impacts whether her infant needs the vaccine).
- Difficulties matching patient names, which limits providers' capacity to identify the appropriate medical record.
- Manual data entries that often lead to inaccuracies.
- Lack of guidance and standardization around how race and ethnicity data are collected.
- Data that is not sufficiently granular to capture distinct population groups within broad categories, making meaningful decisions around disparities by population difficult.

Additionally, increasing the effectiveness of communicating vaccine data and information would provide the opportunity to combat the aforementioned issue of vaccine misinformation. Workgroup members highlighted the value of pairing data with personal stories and finding consistent ways to communicate data with trusted messengers. These messengers can then collaborate on the most effective ways to share this information within their communities.

Recommendations

The following recommendations are offered to address the identified challenges and increase vaccine coverage in LA County:

Recommendation 1: Invest in organized education dispelling vaccine myths.

Strategies should focus on lifting up community partners with established voices within their communities, focusing on the role of trusted messengers in sharing information to decrease vaccine hesitancy. **It will be essential to provide resources for trusted community providers (schools, parent groups, family ambassadors, and other CBOs) to serve as a consistent partner and resource for patients**, rather than providing one-time, short-term funding for a specific urgent need, which limits partner capacity to build and maintain effective infrastructure.

Recommendation 2: Create a resource repository accessible to partners and community members with digestible, up-to-date information about vaccine safety.

Resources should be informed by community need and provided in the languages and literacy levels best suited to the audience they are intended to reach.

Recommendation 3: Invest in data system improvement.

Investments should incorporate capacity building for providers to improve the utility of existing vaccine registries and streamline vaccine tracking and coordination. Additionally, data system improvements should include expansion of the capacity to collect detailed race and ethnicity information, including expanding the categories collected and allowing for more than one race to be selected.

Appendix

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