

*Report and Recommendations of
the GTMRx National Task Force*

Building Vaccine Confidence in the Health Neighborhood

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GTMRx National Task Force

Building Vaccine Confidence in the Health Neighborhood

The GTMRx Institute convened a national task force to identify key issues and offer guidance to build vaccine confidence in local communities. The goal of the task force is to inform the strategies to engage teams at the community level to work collaboratively and communicate effectively about vaccination during current and future pandemics by:

1. Engaging care teams in the local community
2. Coordinating with schools, religious organizations and employers
3. Collaborating with local, state and federal agencies
4. Communicating to ensure effective, efficient and engaged community response

We believe that the health neighborhood is essential and fundamental when implementing programs to build vaccine confidence.

This document is a companion [report](#) to the March 2021 GTMRx National Task Force report entitled “Background and Resources to Build Vaccine Confidence in the Health Neighborhood.” The report contains a set of recommendations from task force members designed to overcome barriers and build vaccine confidence in local communities today and in the future.

Note: After much discussion during their work, the Task Force adopted the term “health neighborhood” to clarify the scope and focus of its work.

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Executive Summary

To spare ongoing suffering and death amid the COVID-19 pandemic, it is crucial to get as many people vaccinated as possible in the United States and worldwide. Given that so many Americans remain hesitant about being vaccinated, it is also critical to boost their confidence in the vaccines.

Responding to this need, the Get the Medications Right Institute empaneled a Task Force of national leaders across a broad spectrum to develop recommendations to address vaccine hesitancy and bolster vaccine confidence. Represented on the Task Force were the fields of public health; health care, including primary care, nursing and pharmacy care; employers; nonprofit organizations focused on equity and related issues; academia, including a specialist in social marketing; and others (see Task Force list, page ii). The Task Force initiative was sponsored by the Johnson & Johnson Corporation, no employees or affiliates of which served on the task force; in addition, Johnson & Johnson did not engage in any of the Task Force's deliberations or advance or approve any of its recommendations.

The Task Force met on five occasions during the spring of 2021. It first reviewed the existing literature on vaccine hesitancy and took stock of developments around the COVID-19 vaccines, as set forth in a March 2021 [report, *Background and Resources to Build Vaccine Confidence in the Health Neighborhood*](#). The Task Force then developed recommendations divided into two categories: Short-term recommendations to boost COVID-19 vaccine confidence for the remainder of 2021 and longer-term recommendations to address confidence in vaccines beyond the COVID-19 pandemic.

Based on the existing evidence, the Task Force concluded that efforts to boost vaccine confidence nationwide will be most effective if they are informed by an overarching strategy but are carried out at the community level, where they can best be adapted to local populations, considerations and circumstances. Such localized efforts can best build on existing relationships, founded on trust, to address individuals' fears and concerns and to boost vaccine confidence. Ideally, these efforts will build what could be described as "civic muscle," lasting beyond the COVID-19 pandemic to tackle broader immunization goals along with other local health issues.

As a result of its deliberations, the Task Force made the following short-term recommendations:

1. Communities across the country should convene a broad group of stakeholders and local community members to create robust plans for enhancing vaccine confidence.
2. These organizations and individuals should be convened as "coalitions of the willing" across the local "health neighborhood," as broadly defined. The health neighborhood should be understood to include the broad array of organizations and individuals who have a stake in the community's health: Hospitals and health systems, including both civilian institutions as well as those of the military and the Veterans' Health Administration; primary care physicians and other clinician providers, including nurse practitioners and registered nurses, physicians' assistants, pharmacists and other key health team members; community health centers, including but not limited to Federally Qualified Health Centers; pharmacies; health insurers; employers and local businesses; the local health or public health department and affiliated public health entities; other branches of local government; social services agencies and providers; military and veterans' organizations; faith-based organizations; civic organizations; schools, school boards and parent/teacher organizations and municipalities; higher education institutions; and other non-health care partners as deemed appropriate.
3. These "health neighborhood" groups should unite with the goal of boosting vaccine confidence through "collective impact." The [collective impact model](#) assumes that members will rise above their individual

agendas and reach beyond their professional silos and build collective approaches to complex problems. They should be led by a “backbone” organization, such as a health system, a local health department or other recognized and trusted local group, such as United Way. The backbone organization should assist the “health neighborhood” groups in developing a common vision and strategy to guide vaccine confidence-building efforts; finding and tapping available sources of funding support; and conducting other needed activities as outlined in the full Task Force report.

4. The health neighborhood groups and the backbone organizations in each community should develop a plan to create local “Vaccine Confidence Leagues” to carry out local confidence-building efforts. These Leagues should focus on person-to-person outreach, mobilizing the efforts of trusted messengers such as physicians and nurses, pharmacists, faith leaders, respected civic and tribal leaders and organizations and enterprises that play key roles in communities, such as barber shops and hair salons. All of these entities should commit to listening respectfully to individuals’ concerns and to addressing them honestly, truthfully, and in an environment of trust, to build vaccine confidence. The Task Force has identified a number of existing tools that can assist in these efforts (see appendix to the full report).

The Task Force members believe that if enough communities can create Vaccine Confidence Leagues, substantial inroads can be made in extending COVID-19 vaccination beyond current levels. The work of the Leagues could become especially important later this year, when children below the age of 12 are likely to become eligible for COVID-19 vaccination. Yet the work of the Leagues should not end there. Once formed, the Leagues can and should undertake important long-term work to promote vaccine confidence for all childhood and adult vaccines and protect individuals and families from a range of preventable illnesses. They could also play an important role in advancing health and promoting equity within communities.

As a result, looking beyond the COVID-19 pandemic, the Task Force made the following long-term recommendations to create the broader environment in which uptake of vaccines can be expanded and further vaccine-confidence-building work continued:

1. The local health neighborhood coalitions and Vaccine Confidence Leagues created to address COVID-19 vaccine confidence should continue on, beyond the pandemic, to advance access to, uptake and use of all adult and childhood vaccines and to address other health needs in their communities.
2. Because it is likely that new vaccines will be developed rapidly in the future, especially in the event of future pandemics, vaccine developers and the US Food and Drug Administration should work to limit the amount of time that vaccines are subject to emergency use authorization (EUA) and speed the appropriate final market approval of vaccines. Doing so will mitigate public concerns that EUA authorization entails regulatory oversight that is not as rigorous as final approval. In addition, the FDA and others should take steps to educate the public about vaccine studies and the development and approval process.
3. The federal government and states should undertake broad measures to improve and connect the nation’s multiple immunization information systems (IIS) to create a more robust, real-time national vaccine information infrastructure. Many of the nation’s IIS suffer from years of underinvestment and the capabilities of these systems vary greatly across states. States should adopt consistent standards for which providers are required to report information about vaccinations, and providers should have greater capability to query systems to determine who has been vaccinated. The data contained in IIS should be subject to strict privacy and security standards, but at the same time, individuals should be allowed to “opt out” of whether they want their personally identifiable information about vaccines to be disclosed to providers or other information requesters.
4. The Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP) publishes [recommendations](#) on immunizations for children and adults. The Affordable Care

Act (ACA) mandates that all vaccines recommended by ACIP be provided by all commercial health insurers and self-insured health plans at no out-of-pocket costs to beneficiaries. Nonetheless, consumer cost-sharing for vaccines is still a reality for many Medicaid beneficiaries in states that have not expanded their Medicaid programs under the ACA, as well as for many Medicare beneficiaries who may face cost-sharing requirements imposed by prescription drug plans when beneficiaries receive vaccines covered under Part D of Medicare (these include all ACIP-recommended vaccines except those for influenza, pneumonia and hepatitis B, which are covered under Part B of Medicare). The Task Force recommends that the executive branch and Congress enact legislation to bar all cost-sharing by beneficiaries of any public health insurance in the United States for receipt of any ACIP-approved vaccines.

5. Providers administering vaccines may be paid very different rates by public and private health plans, depending on the type of provider and negotiated provider contract rates. Federal and state officials should examine these overall systems of payment to providers for vaccine administration and determine equitable formulas that are consistent with the notion that there should be broad access to and administration of vaccines.
6. Vaccine deliveries to some locations, such as large health systems or public health agencies or retail locations, are often prioritized over deliveries to others, such as smaller primary care practices. The reasons are complex and often have to do with decisions made by states and counties or business decisions made by vaccine distributors and suppliers. The federal government and states should work with state and local governments and vaccine distributors to eliminate these disparities in vaccine deliveries in the interests of assuring broad vaccine access.
7. Multiple policy proposals to advance childhood immunizations should be adopted, as follows:
 - a. All nonmedical exemptions—personal, philosophical or religious—from immunization requirements for children should be eliminated at the state level, as supported by the groups cited [here](#) by the Immunization Action Coalition.
 - b. Once COVID-19 vaccines receive emergency use authorization for administration to children below age 12, states should initiate pilot programs to vaccinate children in schools and develop evidence over time to determine whether adding COVID-19 vaccines to the list of state-required childhood vaccination is appropriate. The CDC’s Advisory Committee on Immunization Practice, ACIP, should also consider this question and issue its recommendation as soon as practicable.

I. Introduction

An important juncture is at hand in the struggle to control the COVID-19 pandemic. As of June 3, 2021, [136 million Americans have been vaccinated](#) against the SARS-CoV-2 virus. The administration of President Joseph R. Biden has announced a target of having 70% of U.S. adults vaccinated by July 4, 2021. With at least one of the vaccines now authorized for their use, pre-teens and teenagers are now being vaccinated; what's more, with clinical trials to establish safety and effectiveness of the vaccines in even younger children under way, it is likely that they will also be able to be vaccinated later this year.

However, as millions of Americans are still declining to be vaccinated, it is no longer a given that the United States will eventually reach “herd” or “community” or “population” immunity: the [indirect protection from an infectious disease](#) that a population has when enough of them have developed immunity either through vaccination or previous infection. There is no precisely known level at which population immunity from SARS-CoV-2 would occur, but it has generally been thought to be when 70% or more of the population has been vaccinated or has acquired immunity via a previous infection.

The likelihood that the nation—and in particular, specific regions of the country—will not achieve population immunity in the near term raises several critical concerns.

First, transmission of the virus, and resulting illness and death, will continue to take place in the United States despite recent positive trends of falling infection rates and hospitalizations. Second, as transmission continues, the potential exists for new variants of the virus to emerge that may be even more transmissible and lethal than the several that are now circulating almost worldwide. Third, as the pandemic rages in other parts of the world, “no one is safe until everybody is safe” and until the pandemic is brought under control elsewhere, in large part through widespread vaccination. Fourth, given uncertainties about the duration of the immune response from COVID-19 vaccines, it is possible, if not likely, that even those who have already been vaccinated will need additional immunizations or “booster” shots as the SARS-CoV-2 virus continues to evolve and remain endemic in the environment.

It thus remains critically important to continue the drive for vaccination against COVID-19 and to address the lack of confidence in vaccines demonstrated by roughly [32% of US adults](#) are vaccine hesitant. As outlined in a [recent GTMRx report](#), this lack of vaccine confidence is not a new phenomenon but has taken on new urgency and different manifestations during the COVID-19 pandemic. [Key drivers of COVID vaccine hesitancy](#) include fear that the vaccines will produce harmful side effects; concerns about how quickly the vaccines were developed once the pandemic began; distrust of political leaders' motives and economic motives of pharmaceutical companies; religious objections; and conspiracy theories, such as that the vaccines were manufactured to allow tracking of personal data.

To devise a plan for addressing vaccine confidence, the Get the Medications Right Institute, a not-for-profit organization focused on optimal and appropriate use of all medications and vaccines, empaneled a task force of distinguished national leaders across the spectrum of public health, health care and academia (see commission roster, page ii). The effort was sponsored by the Johnson & Johnson Corporation, which stipulated that the Task Force should focus broadly on building vaccine confidence across the entire group of COVID-19 vaccines, not just the Johnson & Johnson's Janssen COVID-19 vaccine that received emergency use authorization from the U.S. Food and Drug Administration in February 2021. No employees or affiliates of Johnson & Johnson served on the Task Force, nor did any participate in the Task Force's deliberations or advance or approve any of its recommendations.

The Task Force was charged by the GTMR Institute and the group's own leadership as follows:

1. Taking account of all that is known about the best ways to build confidence about vaccines and address vaccine hesitancy and the populations among whom building confidence is most urgent, develop a set of recommendations for steps that should be taken as quickly as possible in communities and “health neighborhoods” (described further below) across the United States.
2. Compile and disseminate a report and recommendations.

The Task Force met five times during the spring of 2021 and developed the recommendations that follow (see pages 22-23 for task force meeting dates and descriptions). The Task Force divided its recommendations into two phases: A set of short-term recommendations to boost COVID-19 vaccine confidence over the duration of 2021 and long-term recommendations to address confidence in vaccines broadly, beyond the current pandemic. The Task Force did not address a host of incentives outside the confidence-building domain to induce more people to be vaccinated, such as West Virginia’s offer of \$100 savings bonds to young adults who are vaccinated or other similar inducements, such as Ohio’s million-dollar lottery.

The Task Force believes that if communities adopt the short-term recommendations, substantial progress can be made over the course of the year in driving up the number of vaccinated Americans. The work of the Leagues could become especially important later this year, when children below the age of 12 are likely to become eligible for COVID-19 vaccination, and many parents and other family members are likely to have concerns. Yet Vaccine Confidence Leagues’ efforts should not end with the COVID-19 pandemic. With [25 viral families comprising 120 different viruses known to infect humans](#), it is possible, if not likely, that pathogens with the potential to cause pandemics will continue to emerge—necessitating ongoing development and administration of multiple vaccines well into the future. What’s more, substantial gains can be had by preventing disease through increased uptake of childhood and adult vaccinations across a number of infectious disease states.

As a result, once formed, the Leagues can and should undertake the important long-term work to promote vaccine confidence for all childhood and adult vaccines. They could also play an important role in advancing health and promoting equity within communities, as described further below.

II. Recommendations: Addressing COVID Vaccine Confidence in 2021

The Task Force’s deliberations were informed by two perspectives in particular: The need to accomplish collective impact within communities to address vaccine confidence and to accomplish that impact by mobilizing stakeholders across the broad “health neighborhood” within communities. The [“collective impact” model](#) assumes that a core group of community leaders will rise above their individual agendas and build a “coalition of the willing” to formulate a collective approach to a complex problem. In the context of the health neighborhood, this would mean that members would not be confined to their normal professional silos and would recognize that multi-professional and cross-sector efforts would best achieve the greater good.

As the two social sectors leaders and thinkers John Kania and Mark Kramer wrote in their seminal article in the *Stanford Social Innovation Review* in 2011, “collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants.” The Task Force believes that in communities and neighborhoods across the United States, entities should come together to create this common agenda and plan for enhancing vaccine confidence in their area. The Task Force also believes that collective impact activities can and should be conducted with an eye to racial and ethnic justice and equity and should be guided by the important questions raised here ([also see diagram below](#)).

Seeing Collective Impact Efforts with a Racial Justice Lens



SOURCE: Race Matters Institute

A. The Need for a “Backbone” Organization

A core principle of collective impact is the need for a “backbone” or coordinating organization to assemble the “coalition of the willing” and undertake [the following core activities](#):

1. Guide the articulation of a vision and strategy
2. Support aligned activities

3. Establish shared measurement practices
4. Build public will for the effort
5. Advance policy to support the effort
6. Identify and mobilize funding as needed, including by serving as fiscal intermediaries for the receipt of grants or other funding that will in turn be used to support community-level activities

The backbone organization could be a local health system; the local health or public health department; local medical societies or charities; a local organization such as the Rotary or Lions Club; a religious institution or other faith-based group; an employer/economic business group; an academic entity; or another entity that plays an important civic, cultural and/or health care role in the community, including tribal organizations. Typically, a backbone organization begins its work by convening key stakeholders and community members to first, understand the “lay of the land” locally and exchange information about activities already under way; and second, identify specific problems and consider solutions. Third, it works to draft plans and assign accountability—in this case, to build vaccine confidence among targeted groups or populations.

Glossary of Terms

BACKBONE ORGANIZATION: A coordinating entity that convenes community members and supports and facilitates their collective impact. Various entities, including civic and nonprofit groups and others, may serve as backbone organizations. A backbone organization guides development of a vision and strategy; supports aligned activities; establishes shared accountability and measurement practices; builds public will; advances policy changes when necessary; serves to identify and tap sources of funding and may serve as the fiscal intermediary to obtain funding and channel it to community members.

COLLECTIVE IMPACT: A model of collaboration that assumes members will rise above their individual agendas, reach beyond their professional silos and build collective approaches to complex problems. This model should recognize the critical roles that grassroots organizations play in communities and be attentive to important questions about advancing equity across racial and ethnic lines.

HEALTH NEIGHBORHOOD: The broad array of organizations and individuals who have a stake in a given community’s health: Hospitals and health systems, including both civilian institutions as well as those of the military and the Veterans’ Health Administration; primary care physicians and other clinicians

and providers, including nurse practitioners and registered nurses, physicians’ assistants, pharmacists and other key health team members; community health centers, including but not limited to Federally Qualified Health Centers; pharmacies; health insurers; employers and local businesses; the local health or public health department and affiliated public health entities; other branches of local government; social services agencies and providers; military and veterans’ organizations; faith-based organizations; civic organizations; schools, school boards and parent/teacher organizations and municipalities; higher education institutions; and other non-health care partners as deemed appropriate.

VACCINE CONFIDENCE LEAGUES: Community organizations across a given health neighborhood that unite to advance vaccine confidence in the local area. These Leagues should focus on person-to-person outreach, mobilizing the efforts of trusted messengers such as physicians and nurses, pharmacists, faith leaders, respected civic and tribal leaders and organizations and enterprises that play key roles in communities, such as barber shops and hair salons. All of these entities should commit to listening respectfully to individuals’ concerns and to addressing them honestly, truthfully, and in an environment of trust, to build vaccine confidence.

Around the Health Neighborhood

WITH SUPPORT FROM THE CDC, the National Nurse-Led Care Consortium, a non-profit that works to improve community health through nurse-led care, is bolstering nurses' own COVID-19 vaccine confidence—and empowering them to speak with patients—by providing information about the vaccines' benefits, safety and effectiveness. In addition, the organization's online Nurse-Led Forum for Vaccine Confidence allows members to pose questions about vaccine hesitancy and share strategies for building confidence in COVID vaccines.

SOURCE: <https://nurseledcare.phmc.org/>

WITH SUPPORT FROM THEIR ELECTED OFFICIALS, primary care physicians across Pennsylvania have come together to promote the safety of COVID-19 vaccines and to help reassure the public that vaccination is an effective strategy to fight the pandemic. The physicians stress the importance of patient education, emphasizing that engagement and understanding are the basic tools for addressing patient concerns. Among the novel strategies employed by one primary care physician at Geisinger Health is a “Mythbuster” podcast that combats COVID-19 misinformation by providing accurate information to the public.

SOURCE: <https://www.pocorecord.com/story/news/coronavirus/2021/02/08/sen-ca-sey-and-medical-professionals-discuss-covid-19-vaccines/4402119001/>

IN MILWAUKEE, WI, Hayat Pharmacy has vaccinated more than 34,000 people, many of whom were reached in local barbershops, at their places of employment, in grocery stores, churches, bars and, for disabled residents, at home. The independent pharmacy chain's small size and knowledge of the community allowed it to move fast, including a collaboration with a local school that allowed Hayat to borrow the gym and transform it into a mass vaccination walk-in clinic.

SOURCE: <https://www.wisn.com/article/small-milwaukee-pharmacy-gets-34000-covid-19-vaccine-doses-into-arms/36322978#>

A backbone organization and the resulting “**Vaccine Confidence League**” effort should not displace the activities already under way in the area to build vaccine confidence but should work instead to extend and augment them. They should be inclusive of any other community members and grassroots organizations that have already undertaken efforts to build vaccine confidence. The leadership of the backbone organization should be especially attentive to the importance of being seen as trustworthy in the eyes of stakeholders and respectful of their perspectives and points of view. In short, the backbone organization should be instrumental in building “civic muscle” by convening all those in the community who have a stake in the community's health.

In addition to convening the organizations that will develop the local vaccine confidence-building plan, this backbone organization should be in a position to lend at least some administrative support to the actual confidence-building efforts, which will be carried out by the Vaccine Confidence League described below.

B. Convening the “Health Neighborhood”

The [background report](#) prepared for the GTMRx National Task Force on Vaccine Confidence emphasized that successful efforts to encourage confidence in COVID-19 vaccines would need to address the concerns of vaccine-hesitant populations at the individual and local level. Many people have specific views, questions and concerns about the vaccines, all of which must be listened to and addressed. Although these concerns may be individual, addressing them will be a collective activity to meet the broad goal of “herd” or population or community immunity. The group of local stakeholders who could form the “coalition of the willing” assembled by the backbone organization—and who have a shared desire to promote health, as well as vaccine confidence and community immunity—can best be described as “the health neighborhood.”

The origins of the concept of a “**health neighborhood**” lie in what was originally known as a “[medical neighborhood](#),” defined as “a clinical-community partnership that includes the medical and social supports necessary to enhance health.” Given the broad array of entities that have a stake in enhanced vaccine confidence at this critical time of the pandemic response, the Task Force broadened the definition beyond its original and somewhat more clinical context to encompass a diversity of actors and perspectives.

Thus, health neighborhoods should be understood broadly to include the following stakeholders:

- Hospitals and health systems, including both civilian institutions as well as those of the military and the Veterans' Health Administration

Around the Health Neighborhood

- Primary care physicians and other clinicians and providers, including nurse practitioners and registered nurses, physicians' assistants, pharmacists and other key health team members
- Community health centers, including but not limited to Federally Qualified Health Centers
- Pharmacies
- Health insurers
- Employers and local businesses
- The local health or public health department and affiliated public health entities
- Other branches of local government
- Social services agencies and providers
- Local immunization coalitions or similar groups
- Military and veterans' organizations
- Faith-based organizations
- Civic organizations
- Schools, school boards and parent/teacher organizations and municipalities
- Higher education institutions
- Other non-health care partners as deemed appropriate

The Task Force recommends that these stakeholder groups in each health neighborhood be brought together under the auspices of the designated “backbone” organization. That entity will call the initial meetings of the “health neighborhood” stakeholders and spearhead efforts to formulate the community-wide plan for enhancing vaccine confidence. As noted above, this backbone organization may itself be a health department or system, medical society, a civic group such as the Rotary Club, an employer/business group, a religious organization or interfaith group or another entity that plays an important civic and/or health care role in the health neighborhood and that has sufficient size, standing and respect in the community to convene the effort to develop a vaccine-confidence-enhancement plan. This resulting plan will unite the work of the stakeholders in Vaccine Confidence Leagues that will carry out the necessary activities to increase vaccine confidence in the local area.

KAISER PERMANENTE is supporting the East Bay Community Foundation to provide COVID-19 vaccination outreach in the African American community in Oakland, CA. The Foundation coordinates 12 community-based organizations that are working together to deliver effective messaging to prevent the spread of COVID-19 and increase vaccination confidence and uptake, especially at non-traditional points of access. The Foundation also serves as a connector that ensures the experience of community members informs the design and implementation of equitable state and federal programs, including vaccine distribution.

SOURCE: <https://about.kaiserpermanente.org/our-story/news/announcements/supporting-equitable-covid-19-vaccine-education>

IN ERIE, PA, the Minority Community Investment Coalition coordinates a partnership among community centers, the Urban Erie Community Development Corporation and other stakeholders to counter misinformation, doubt and mistrust about COVID-19 vaccination. The coalition brings vaccine clinics to locations people trust, focusing on people of color, new Americans and other underserved populations in Erie. Leaders emphasize the importance of expanding vaccination in neighborhoods with access challenges, ensuring that the opportunity for vaccination is available for everyone who wants it, and showing people who are “on the fence” that vaccines are safe for them and their families.

SOURCE: <https://www.goerie.com/story/news/coronavirus/2021/03/02/covid-19-daily-update-coronavirus-cases-erie-county-and-statewide/6883310002/>

Around the Health Neighborhood

THE AMERICAN PUBLIC HEALTH ASSOCIATION and the Tulane School of Public Health and Tropical Medicine have assembled 60 African American experts from the National Academy of Medicine to serve as trusted messengers to encourage African Americans to get vaccinated. The team is addressing barriers related to vaccine hesitancy, racial and economic inequity, as well as long-time shortcomings within our nation's public health infrastructure. The group emphasizes the need to identify and solve problems that make it harder for disadvantaged populations to schedule their appointments, including lack of internet and public transportation access and jobs with shift hours that limit scheduling abilities.

SOURCE: <https://apha.org/News-and-Media/News-Releases/APHA-News-Releases/2021/COVID-19-vaccination-testimony>

THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS has a vaccine communications toolkit to assist its members to build COVID-19 vaccine confidence and encourage staff and the communities they serve to get the vaccine and help protect themselves and their communities. The NACHC's toolkit includes ready-made social media content for Facebook, Instagram and Twitter and it is available in nine languages including Hmong, Somali, Tagalog and Vietnamese.

SOURCE: <https://www.nachc.org/coronavirus/covid-vaccine-communications-toolkit/#toolkit>

BASED IN NORTH CAROLINA, the Latinx Advocacy Team & Interdisciplinary Network for COVID-19 (LATIN-19) is a multi-sector group of academic institutions, health care systems, public health departments, public school systems, community-based organizations, government and faith communities. The group not only offers COVID-19 outreach and education and COVID-19 testing and vaccination, but it also addresses food insecurity, housing, legal issues and immigration, all issues that can impact vaccine access and uptake.

SOURCE: <http://latin19.org/what-we-do/>

As the Vaccine Confidence Leagues seek to identify groups and individuals lacking vaccine confidence, they should tailor their strategies for addressing them. In addition, it will be important that the Vaccine Confidence Leagues align with the following principles:

1. The backbone organization and the Vaccine Confidence Leagues will be open and inclusive of all those in the community who share the goal of improved health and well-being. Although conventional health care actors will be at the heart of the effort, other community members who play important cultural and service roles should be part of it as well.
2. Vaccine Confidence League members will come together as a collective, building on important work that is already under way by any of its members to craft a community plan to enhance vaccine confidence in an environment of care, compassion and mutual respect. The latter attributes—care, compassion and respect—will extend to any attitudes or relationships with unvaccinated people and populations.
3. The Vaccine Confidence Leagues will set aspirational goals and work to hold the collective group and its individual members accountable for success.
4. Vaccine Confidence League members will have clear roles, share common goals and exhibit mutual trust. They will, to the best of their ability, share information and knowledge with each other to identify those in the community who have not yet received COVID-19 vaccines and who appear to be most lacking in vaccine confidence and also to formulate the best strategies for reaching these people, enhancing their confidence in vaccines and identifying and guiding them to an administration site. The goal should be creating a common repository of information—one that Vaccine Confidence League members can both input information into and pull information out of—about who has been vaccinated and what progress has been achieved.
5. As important as it is to get as many people in the community vaccinated against COVID-19, the Vaccine Confidence Leagues will not consider their work done when this goal alone is achieved. Rather, they will also seek to ensure that all individuals have follow-up care beyond the vaccine if needed and that there is tracking of any adverse events. They will also seek to create long-lasting systems to ensure vaccine access and confidence in all manner of recommended childhood and adult vaccines in the future.

Around the Health Neighborhood

6. The Vaccine Confidence Leagues should consider whether they wish to combine efforts to spur confidence in COVID-19 vaccines with other short-term efforts to address vaccine use and uptake—for example, for influenza and pneumonia vaccines among adults and for routine vaccines given to children and adolescents that have seen a decline in use during the pandemic, such as those for tetanus, diphtheria and pertussis and meningitis.

To our knowledge, harnessing the capacities of health neighborhoods to promote vaccine uptake in the United States has not been done before. Although this novel approach offers important opportunities to build vaccine confidence—first at the level of individual communities and over time, on a national scale—it will undoubtedly also come with many challenges. Health neighborhoods are not necessarily strictly defined by geography or municipal boundaries. Whether in heavily populated urban areas or more dispersed rural settings, in many parts of the country it may be difficult to imagine that a true “health neighborhood” actually exists. All the same, extensive research on social determinants of health has demonstrated that neighborhood-level factors have a strong impact on the health of individuals and populations. In addition, local communities formed around health neighborhoods are most likely to understand the local context, to operate in an environment of trust and to have the skill and patience to build relationships and address the concerns of local citizens.

It is for these reasons that the Task Force believes that these local health neighborhood members and stakeholders must be identified, organized and ultimately brought together in communities across the nation to work toward the common goal of promoting vaccine uptake.

C. Recommended Procedures for Vaccine Confidence Leagues: Initial Steps

A. At an initial meeting or meetings, the Vaccine Confidence League in each community should undertake the following steps to assess local vaccine confidence, as well as vaccine supplies and availability:

1. Assess local COVID-19 vaccine takeup, the local vaccine administration effort and available community resources for conducting vaccinations including vaccine supply, personnel and vaccine locations, drawing baseline data from the state or local health department and immunization information systems (IIS). The CDC’s [Rapid Community Assessment Guide](#) is a useful resource to assist communities in this effort. (Also see long-term recommendations for how these IIS should be improved to

WITH SUPPORT FROM FEMA, the city of Detroit’s health department deployed canvassers to knock on doors in predominantly African American neighborhoods where vaccination rates were low. Detroit’s door-to-door campaign is part of a larger effort to connect residents to vaccination sites across the city. Canvassers focus on letting people know “where to go, what to do and who to call.” Detroit’s strategy to build vaccine confidence in minority communities meets people where they are—at their front doors.

SOURCE: <https://www.usnews.com/news/us/articles/2021-05-04/detroit-educating-residents-on-where-how-to-get-vaccines>

TO ADDRESS THE disproportionate representation of conservatives among people who are hesitant about COVID-19 vaccination, the de Beaumont Foundation supported a series of public service announcements featuring Republican doctors in Congress. In the PSAs, the physician-lawmakers share their reasons for getting vaccinated, urging listeners to talk with their doctors and do the same. By acting as trusted messengers, the GOP physicians can reach other conservatives who may have persistent concerns about vaccination.

SOURCE: <https://www.washingtonpost.com/health/2021/05/03/vaccine-hesitant-americans-change-minds-debeaumont-foundation/>

Around the Health Neighborhood

THE SPOKANE VA MEDICAL CENTER

turned a mobile primary care center into a rolling COVID-19 vaccine clinic to reach vaccine hesitant and rural Veterans in a vast area from eastern Washington through the Idaho Panhandle into northwestern Montana. A key feature of the mobile vaccination program is Mark Sheldon, an emergency room nurse at the Spokane VA and a Gulf War combat Marine. Although Sheldon knows that pressure tactics do not work with some hesitant Veterans, he is a trusted messenger who understands what concepts resonate with his peers. One Veteran who was vaccinated by Sheldon's team commented, "It's a duty to myself and a duty to my community. I'm a veteran. Duty is what it's about."

SOURCE: <https://www.washingtonpost.com/politics/2021/04/17/veterans-coronavirus-vaccine/>

THE COMMUNITY ENGAGEMENT ALLIANCE (CEAL) AGAINST COVID-19 DISPARITIES

program is an NIH-funded effort to assist 21 grantee organizations to strengthen COVID-19 vaccine confidence and access in communities of color. CEAL seeks to foster community engagement, coordinate educational outreach, and promote inclusivity in public health and research initiatives. By supplementing national messaging about COVID-19 with education and outreach that is conducted on the local level by trusted sources, CEAL programs are well-positioned to understand and address the issues that drive vaccine confidence in their communities. In Philadelphia's CEAL program, for example, the CEAL coalition's efforts will facilitate access to COVID-19 testing and vaccines, and promote participation in clinical trials among underserved communities in the region.

SOURCES: https://www.eurekalert.org/pub_releases/2021-05/uops-pnp051921.php

<https://www.nih.gov/news-events/news-releases/nih-invest-29-million-address-covid-19-disparities>

allow for greater access to immunization information in the interests of expanding vaccine use and uptake).

2. Determine whether vaccine supply is flowing to all sites of service equitably and in a timely manner. It is understood that in an increasing number of localities, vaccine supply outstrips demand so that the supply of vaccine itself is not the rate-limiting factor in local vaccination efforts. Nonetheless, the Vaccine Confidence League should assure itself that there are adequate stocks of specific vaccines to meet the needs of targeted populations and that those supplies are accessible by those who would provide vaccines, including clinical entities and practices.
3. Encourage state and local efforts to steer more vaccines to clinical settings, even if doing so runs some short-term risk of vaccine wastage until changes in bulk packaging and cold storage requirements are made. Although states and the federal government have made efforts to steer more vaccine supplies to these settings, these efforts have been limited by bulk packaging, storage requirements, and use guidelines for the COVID-19 vaccines.
4. Determine whether there are preferences among unvaccinated populations for one-shot versions of the vaccines or for the two-shot versions and the implications given existing vaccine availability and supply.
5. Enumerate and assess what activities are already under way in a community to expand vaccine use and access and to build confidence and make certain that those conducting these activities are included in the Vaccine Confidence League. In particular, Vaccine Confidence Leagues should determine whether there are active, federally funded "[COVID-19 Community Corps](#)" efforts under way—including designation of any individuals as "Community Corps" trusted experts and voices—who should be included in devising any vaccine confidence-building plan.
6. Assess whether certain individuals and groups have the requisite capacities to obtain vaccines. Are there adequate communications channels and registration capabilities to allow individuals and groups to sign up for vaccines as necessary? Can people get themselves to locations of vaccine administration—for example, do they have or lack transportation for doing so? Vaccine Confidence Leagues should also consider alternative distribution modalities if possible, such as mobile vans.

Around the Health Neighborhood

7. Given the factors described above, determine how large a share of the population in a given area has been vaccinated and what groups or populations continue to experience relatively lower vaccination rates and why. Here again, state and local public health agencies will be useful sources of information, as will fact-gathering among regional stakeholders.
8. If at all possible—given time constraints, the relative lack of interoperability among information systems and privacy considerations—determine whether there are ways to share information among stakeholders as to which individuals and groups in the community remain unvaccinated. (See below for longer-term recommendations about improving the functionality and capabilities of vaccine information systems.)
9. Seek to determine to what degree lack of vaccine confidence plays a role in the lower vaccination rates identified.
10. Discuss whether it is possible to target a particular population for the purposes of building-vaccine-confidence or whether the lack of confidence is more broadly dispersed across multiple groups or populations.

Among groups that should be considered are:

- a. Racial/ethnic groups
- b. Health care workers
- c. People of specific political affiliation or belief
- d. People of specific religious affiliation or belief
- e. People of specific cultural affiliation or belief
- f. Members of the military or Veterans' groups
- g. Different age groups (young, old)
- h. Women of child-bearing age; pregnant and lactating women
- i. Parents of children who are or who will soon be eligible for vaccination
- j. People who experience homelessness
- k. Other groups as defined by local circumstances

THE BIDEN ADMINISTRATION has launched a series of initiatives to boost vaccine uptake in communities of color, including plans to recruit 1,000 Black-owned barbershops and beauty salons across the country. This national effort builds on the successful example of local barbers and hairstylists in Prince George's County, Maryland, who have taken the lead in addressing vaccine confidence among their predominantly Black and Latino clients.

SOURCES: <https://www.washingtonpost.com/health/2021/05/30/barbershop-coronavirus-vaccines/>

<https://www.washingtonpost.com/health/2021/06/02/biden-barbershop-salon-coronavirus-vaccine-initiative/>

LEVI RICKERT is an American Indian journalist and tribal citizen of the Prairie Band Potawatomi Nation, as well as Publisher and Editor of Nativenews online. Rickert writes, "Vaccine hesitancy is the result of fear, distrust and even ignorance—or a combination of all three. As Native Americans we have been distrustful of both the government and some modern medicine. Obviously, everyone has to decide for themselves. However, we as Native people have been taught to think beyond ourselves. We do things for the good of family and community... My hope is that we, as Native people, overcome any hesitancy we have for the vaccine for the good of our tribal communities and the world at large."

SOURCE: <https://nativenewsonline.net/opinion/breaking-through-the-covid-19-vaccine-hesitancy-wall>

Around the Health Neighborhood

THROUGH A NOVEL PARTNERSHIP

between CDC and the U.S. Department of Agriculture's National Institute of Food and Agriculture, Land-grant Universities and the Cooperative Extension System will deliver immunization education to the communities they serve to improve vaccine confidence. Early examples of this partnership's contributions to promoting vaccine confidence include:

- University of Vermont Extension staff made repeated visits to farms to build vaccine acceptance by first talking about the pandemic in general terms, then discussing the importance of testing and by discussing the vaccine itself.
- Extension staff working in tribal communities are focusing on helping residents overcome fear and dispelling myths, using culturally appropriate information that integrates native wisdom and western science.

SOURCE: <https://nifa.usda.gov/press-release/usda-nifa-cdc-and-cooperative-extension-team-vaccine-education-rural-america>

THE COMMONWEALTH OF MASSACHUSETTS

took special steps to make information about prior COVID-19 vaccinations available to health insurers within the state, so that the plans could contact members who had not already been vaccinated and inform them about vaccination options. Guidance was devised to assure confidentiality and security of this information and ensure that it was used only for the express purposes prescribed.

SOURCE: <https://www.mass.gov/doc/mi-is-data-sharing-order-dph/download>

11. Discuss whether it is necessary or desirable to prioritize any of the above groups for vaccine-confidence-building efforts.
12. Assess whether the need exists for additional education of, and information for, health care provider organizations and individual clinicians who may administer the vaccines. For example, confusion remains about the standards under which the U.S. Food and Drug Administration (FDA) issued emergency use authorizations (EUA) for the COVID-19 vaccines and how these standards differ from final FDA approval. It will be important to allay any concerns among clinicians themselves that the vaccines are unsafe or lacked adequate FDA review. Similarly, education that advances understanding about the relatively small number of adverse events associated with the vaccines will be helpful as well.
13. Consider whether special incentives—either prizes, food items or other—would be helpful in attracting more people to become vaccinated. Determine whether there are community organizations that could make such incentives available.
14. Draft the overall plan for the local vaccine-confidence-building effort, assigning specific roles to various stakeholder-members with their agreement and input that build on and augment their existing activities. The roles and responsibilities assigned to specific stakeholder-members should be as simple and as clear as possible.
15. Be attentive to the important role that non-health-care stakeholders, such as employers, can play in engaging and educating populations such as employees, enhancing vaccine confidence and assuring vaccine uptake. They may also conduct on-site vaccination clinics, and employers can also grant workers paid time off to obtain vaccines outside the job.
16. Determine if specific funding is needed to support the vaccine-confidence-building effort, and if so, identify potential sources of funding and make inquiries or formal requests for support or connect Vaccine Confidence League members to those potential funding sources. If the backbone organization itself receives funding as a fiscal intermediary, it should then channel that support to the most need-worthy individuals and organizations.

17. Determine whether any local policies or policy changes would support the effort and if so, seek to implement these changes.
18. Build public support for the effort by working with trusted local institutions and community groups, local media organizations and/or through social media to “socialize” the community-wide effort to build vaccine confidence.

D. Crafting Messages and Recruiting Messengers

Multiple attempts to boost vaccine confidence have demonstrated the need to “meet people where they are” along the “vaccine acceptance continuum.” As a result, it should be kept in mind that enhancing vaccine confidence will be a “retail” as opposed to a “wholesale” effort (or a “ground game,” as some have said, evoking the notion of one-on-one contact, as in many sports) that will most likely require deep and potentially ongoing conversations with individuals and groups. There will also be no single confidence-inducing “message” that will apply to all individuals or groups. Experience from social marketing also suggests that, rather than attempting to lecture or force knowledge onto people about vaccines, it is better to listen to their concerns and attempt to address or remove any obstacles that people believe stand in the way of them being vaccinated.

Thus, to devise its “retail” or “ground game” vaccine confidence-building efforts, the Vaccine Confidence Leagues should undertake the following steps:

1. Identify and develop a list of “trusted members” within the community whose voices and views about vaccines will be listened to, trusted and respected. If necessary, the Vaccine Confidence Leagues should develop a process for any additional training of these individuals in communicating about vaccines and a plan for deploying them in the community and neighborhoods to build vaccine confidence.
2. Assess, select and distribute toolkits, scripts and other guides to its members for conducting conversations about vaccine acceptance and consider which messages will resonate the most with targeted individuals and groups. (See the useful tools and briefs in the Appendix to this report.) The Vaccine Confidence League or its component entities may wish to adapt or tailor some or all of these tools and messages to local populations or needs. Messages should also include what to say in response to anti-vaccination sentiments, as distinct from the doubts and misinformation that may be found among those who lack vaccine confidence and can be moved to a position of greater confidence.
3. In addition to developing plans for person-to-person conversations to boost vaccine confidence—which could be considered a “retail” approach—the Vaccine Confidence League can consider what if any “wholesale” community and neighborhood activities could also prove helpful in communicating overarching messages across communities, as follows:
 - Creation of prominently displayed signage, banners and/or billboards
 - Creation of local advertising, public service announcements and other communications featuring trusted community members
 - Social media messages from trusted community members

E. Creating a Timeline, Metrics and Accountability

1. The Vaccine Confidence League should set aggressive, “stretch” goals and timelines for accomplishing the vaccine confidence-building efforts. It should devise and execute a regular process of community and neighborhood self assessment and full and transparent reporting to members.
2. The Vaccine Confidence League should ask each participating entity or organization to articulate specific goals and commitments, such as a target number of individuals counseled or a target volume of vaccines delivered.
3. The Vaccine Confidence League should consider adopting mechanisms to track the degree to which vaccine confidence-building efforts are succeeding in advancing equity, as the [state of Maryland did](#) using the Vaccine Equity Index for tracking improvements in vaccination rates among the state’s Black and LatinX populations.
4. Recognizing that Vaccine Confidence League activities may continue into the fall of 2021 and beyond, the Leagues should consider whether they wish to add influenza vaccine and standard childhood vaccine confidence-building efforts to their roster of activities, and if so, when. The Leagues should also develop any plans for continuing efforts in the future to accommodate the potential development and availability of COVID-19 booster vaccinations.

F. Obtaining Funding to Support the Work

The Vaccine Confidence Leagues should take steps to determine the availability of funding to support vaccine confidence building work, including the following:

- a. Ascertain the availability of any federal funding that can translate into support at the local level. For example, through the recently enacted American Rescue Plan and other federal funding sources, \$3 billion has been made available to states, territories and some large cities to support local health departments and community-based organizations in launching new programs and initiatives intended to increase vaccine access, acceptance and uptake. These grants were awarded in early April 2021 and monies from them may still be available. Vaccine Confidence Leagues should check with their state and local health departments for additional information.
- b. Determine what other resources may be available at the local level to support vaccine confidence-building efforts. Vaccine Confidence Leagues should check with their local United Ways, local wellness funds and other community foundations about funding opportunities and should also determine whether local hospitals and health systems have community benefit dollars that can be put toward these efforts.

G. Creating a Sustainability Plan and Contemplating Longer-Term Engagement

In the ideal world, the gathering of the health neighborhood through the backbone organization and the creation of the Vaccine Confidence League in each community will not be a short-term effort. Rather, it should be formalized into longer-term, sustainable partnerships at the community level that address broader health issues and community concerns. Some of these concerns may continue to be COVID-related—such as diminished rates of childhood immunizations during the pandemic—but others will bear on multiple health- and disease-related issues, including the need to address social and economic determinants of health. These partnerships will also play a vitally important role in creating the robust long-term environment in which general vaccine use and uptake will occur far more broadly, as discussed in greater detail in the following section of this report.

III. Longer-Term Recommendations for Enhancing Confidence in All Recommended Vaccines

As noted above, the Task Force believed that efforts to enhance confidence in all adult and childhood vaccines should continue beyond the COVID-19 pandemic and in the context of an environment that is supportive of expanding vaccine access and uptake nationwide. It thus divided its long-term recommendations into several categories: First, addressing considerations around vaccine development and approval and advancing public understanding of the process; second, creating a more robust and useful immunization information infrastructure to track vaccine administration nationwide; and third, undertaking actions proposed by other groups to expand access and uptake of both childhood and adult vaccines. Although these measures by themselves will not directly address vaccine confidence, they would contribute to a broader environment in which regular vaccine use will be more widespread and routine. This “norming” effect could, over time, work to bolster vaccine confidence more broadly across the population.

A. Considerations for Future Vaccine Development and Approval

Although the relatively novel approaches behind some COVID-19 vaccines have been under development and study for years, the fact that vaccines specific to the SARS-CoV-2 virus were developed and deployed quickly elicited fears, doubts and skepticism among a portion of the U.S. public. In addition, there was public confusion about the FDA’s granting of EUA to COVID-19 vaccines and some suspicion that the FDA had imposed far lower standards on vaccine developers in the interest of getting vaccines to market quickly. Although the FDA took multiple steps to clear up these public misapprehensions, the confusion remains.

Assuming that future vaccines may also be developed and deployed quickly, particularly in the event of new pandemics, the FDA’s authority to grant EUA of new vaccines is likely to be used again as well. The Task Force therefore recommends that manufacturers and the FDA work together to build efficient processes by which full FDA approval for vaccines can follow EUA as quickly as possible when vaccines have met the necessary safety, efficacy and regulatory thresholds. In addition, FDA, vaccine developers and others should work to improve the public’s understanding of the vaccine development and approval process overall, including EUA designation.

B. Improving Vaccine Data Infrastructure

To create a superior knowledge base of who is and who is not being vaccinated, the Task Force endorses steps to improve and connect the nation’s multiple IIS at the state and regional level to create a more robust, real-time vaccine information infrastructure. The American Rescue Plan authorized substantial support for improving the nation’s immunization infrastructure, including \$7.5 billion for activities to plan, prepare for, promote, distribute, administer, monitor and track COVID-19 vaccines. These important efforts will be part of a process to create a national [“Immunization Gateway,”](#) described as “a data exchange hub that enables efficient data exchange between critical immunization information systems across the nation.”

The Gateway is not a hub in the sense that it will not store immunization information; rather, it is more like a “router” that connects most—though not all—of the immunization information systems that now exist among the states and some major cities. Organized by the Department of Health and Human Services and the CDC and Prevention, and to be administered under the aegis of the Association of Public Health Labs, the Gateway will enable health care provider organizations and individual clinicians to query these immunization systems to obtain a patient’s full immunization

history from any IIS to which they are connected. In addition, consumers will be able to access the Immunization Gateway through easy-to-use data tools to obtain their own immunization records and ensure that their vaccinations are up to date.

The Task Force endorses creation of the Immunization Gateway, but believes that it and the entire set of IIS systems should be made far more robust. For example, clinicians can query an IIS about whether a specific patient has been vaccinated, but there is not an efficient process in place across all the nation's IIS to allow them to "bulk query" the systems about the vaccination status of all of their patients. In fact, some states IIS that do normally allow the bulk query function had to turn it off because they were swamped with such queries during the COVID-19 pandemic. Thus, although it is possible to query IIS to find de-identified vaccination data and determine generally where there are "pockets of need," it is not always possible to obtain a list of patients by name who have not been vaccinated.

What's more, many of the nation's IIS suffer from years of underinvestment. As other organizations have [noted](#), "IIS capabilities today vary vastly across states and many systems desperately need [additional financial and operational] support." There is also uneven and inconsistent reporting into IIS from different vaccine providers. During the pandemic, for example, COVID-19 vaccines have been administered by many long-term care facilities, community pharmacies, primary care clinics and others, many of which experienced operational obstacles in reporting vaccination data into IIS.

As a result, the Task Force endorses calls to pursue the framework set out in the proposed Immunization Infrastructure Modernization Act of 2021 (HR 550), introduced by Rep. Annie Kuster (D-NH) and Rep. Larry Bucshon, M.D. (R-IN). If adopted into law, this bill would authorize additional funding for the following purposes:

- ✓ Conducting an assessment of current capabilities and gaps among immunization provider organizations and clinicians
- ✓ Expanding enrollment and training of immunization providers in the use of IIS
- ✓ Supporting real-time immunization record data exchange and reporting; enhancing the interoperability of immunization information systems and enabling data exchange among different jurisdictions, through advanced technology platforms
- ✓ Improving the security of data collection, maintenance and analysis; also enhancing the security of exchange of immunization record data, both in terms of inputting data into IIS and obtaining data out of them

In addition to the endorsements above, the Task Force makes these recommendations:

- For the Immunization Gateway to be a truly effective national resource, more progress must be made to standardize data collection, use, access and management across the component IIS systems. This will allow for more complete and accurate vaccination records and simplification of and access to identified data for qualified health care provider organizations and clinicians.
- In addition, there is variation among states in terms of which health care providers are required to report information about vaccinations of patients—a fact that creates gaps in terms of the accuracy of vaccination tallies among states. Federal funding to improve IIS should be tied to whether a state agrees to require all providers to report vaccinations according to an agreed-upon national standard.
- There is currently underutilization of IIS for retrospective studies to determine vaccination rates across the nation for multiple vaccines. Thus, in addition to being accessible by clinicians on behalf of specific patients, and by individuals themselves, the information exchanged through the Immunization Gateway should be able to be

accessed by qualified entities to determine overall utilization and take-up of vaccines at the population level and on a de-identified basis. At present, some states welcome having independent entities that are not health care providers access their IIS for this purpose, but others do not. Until the COVID-19 pandemic, the federal government was not able to obtain aggregate national data on vaccination rates for this reason. The government was thus forced to negotiate with many states during the pandemic to receive it. A process for qualifying entities wishing to conduct such research and information gathering should now be created roughly along the lines of what is required to become a “qualified entity” to receive and use Medicare claims information. (See here: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/QEMedicareData>.)

- As currently constituted, the Immunization Gateway is largely a voluntary effort to create a hub that brings together the required state-level IIS and other immunization information systems. However, requiring mandatory compliance among all IIS through future legislation should be held out as a potentially necessary next step if a compliance target (e.g., 99.9% of all vaccinations given in the US being captured in the data hub) is not achieved within a specified period of time.
- Individual privacy and security of all protected and personally identifiable health information must be protected throughout all aspects of the Immunization Gateway, as set forth [here](#) by the Centers for Disease Control and Prevention.
- Separately, all states and municipalities have laws and policies pertaining to the privacy of IIS as well. Some states and municipalities require that people “opt in” to have their vaccination information, or that of their children, included in the IIS, which creates systems that are challenging and costly to maintain. States that have moved to “opt out” policies—which means that all individual vaccination information is included in the IIS unless people specifically request that it not be—have found that relatively few people do opt out. For the sake of consistency of information across the states, as well as to minimize unnecessary operational costs and complexity, increased federal funding to states for IIS improvement should be linked to states and municipalities adopting “opt out” policies across the board.
- As the National Quality Forum has recommended, enhanced health care quality measures that focus on vaccines, and a measurement priority that focuses on providers submitting data, will “help drive [vaccine] uptake and enable the health care community to have more visibility into a patient’s vaccination status.” Further discussion of this topic is available in the NQF’s recent [report](#) on the subject.

C. Broadening Childhood and Adult Vaccine Use and Uptake

The Task Force recommends that multiple issues in vaccine payment and distribution should be addressed in the interests of expanding vaccine access and uptake, as follows:

1. The Affordable Care Act (ACA) mandates that all vaccines recommended by the CDC’s ACIP be provided by all commercial health insurers and self-insured health plans at no out-of-pocket costs to beneficiaries. Nonetheless, consumer cost-sharing for vaccines is still a reality for many Medicaid beneficiaries in states that have not expanded their Medicaid programs under the ACA, as well as for many Medicare beneficiaries, who may face cost-sharing requirements imposed by prescription drug plans when they receive vaccines covered under Part D of Medicare (these include all ACIP-recommended vaccines except those for influenza, pneumonia and hepatitis B, which are covered under Part B of Medicare). The Task Force recommends that the executive branch and Congress enact legislation to bar all cost-sharing by beneficiaries of any public health insurance in the United States for receipt of any ACIP-approved vaccines.

2. Providers administering vaccines may be paid very different rates by public and private health plans, depending on the type of provider and negotiated provider contract rates. Federal and state officials should examine these overall systems of payment to providers for vaccine administration and determine equitable formulas that are consistent with the notion that there should be broad access to and administration of vaccines.
3. Vaccine deliveries to some locations, such as large health systems or public health agencies or retail locations, are often prioritized over deliveries to other sites, such as smaller primary care practices. The reasons are complex, and often have to do with decisions made by states and counties or business decisions made by vaccine distributors and suppliers. The federal government and states should work with state and local governments and vaccine distributors to eliminate these disparities in vaccine deliveries to providers in the interests of assuring broad vaccine access.
4. Multiple policy proposals to advance childhood immunizations should be adopted, as follows:
 - a. Those supported by groups cited [here](#) that would eliminate all nonmedical exemptions—personal, philosophical or religious—from immunization requirements at the state level. According to the [National Conference of State Legislatures](#) (NCSL), at present, “all school immunization laws grant exemptions to children for medical reasons,” such as preexisting immunocompromised status. In addition, 44 states and Washington D.C. “grant religious exemptions for people who have religious objections to immunizations. Currently, 15 states allow philosophical exemptions for children whose parents object to immunizations because of personal, moral or other beliefs.”
 - b. No state currently requires children to receive a COVID-19 vaccine for school entry, according to NCSL. This policy is appropriate so long as vaccines are not authorized for use in children below the age of 12. However, in the event COVID-19 vaccines do become authorized for younger children, states should initiate pilot programs to vaccinate children in schools and develop evidence over time to determine whether adding COVID-19 vaccines to the list of state-required childhood vaccination is appropriate. The CDC’s ACIP should also consider this question as soon as practicable.

IV. Conclusion

The Task Force members believe that, if enough communities can create the Vaccine Confidence Leagues described above, substantial inroads can be made in extending COVID-19 vaccines far more broadly throughout the US population. Although Vaccine Confidence Leagues will undertake extremely important work to bolster vaccine confidence this year—and in particular, when children below the age of 12 become eligible for COVID-19 vaccines, and considering many parents and family members have concerns about vaccine safety—their work should not end there.

Once formed, Vaccine Confidence Leagues can also undertake important longer-term work to address vaccine confidence in all childhood and adult vaccines. In tandem with the long-term recommendations detailed above, these efforts could raise vaccination rates across the board to protect individuals and families from a range of illnesses. In addition, by assembling members of the “health neighborhood” and forging new connections among them, all of these efforts could lay the groundwork for longer-term efforts to advance health and health equity within communities. The result would constitute a positive and lasting outcome for the nation and the achievement of at least one silver lining in the aftermath of a deadly and destructive pandemic.

APPENDICES

1. Task Force Meeting Summaries

Task Force Meeting Summaries GTMRx National Task Force Building Vaccine Confidence in the Health Neighborhood

Task Force Meeting 1 on Tuesday, April 6 from 10:30 am - 12:00 pm EST | GTMRx and Bipartisan Policy Center (BPC) National Event, “Building Vaccine Confidence During COVID-19: The Role of the Medical Neighborhood” ([recording](#))

On April 6, 2021, The Bipartisan Policy Center and the Get the Medications Right Institute (GTMRx) convened a panel discussion to identify ways to build vaccine confidence and overcome vaccine hesitancy in local communities. During the session, GTMRx announced the formation of a new [National Taskforce: Building Vaccine Confidence in the Medical Neighborhood](#). In order to offer a “level-setting” tool for the Task Force as they begin crafting recommendations to overcome barriers and build vaccine confidence in local communities, GTMRx has commissioned a report: [Background and Resources to Build Vaccine Confidence in the Health Neighborhood](#). The national event co-sponsored by GTMRx and BPC kicked off the Task Force’s work showcasing ways in which key players in the health neighborhood could help bolster vaccine confidence. Speakers brought expertise from diverse sectors to explore key elements to improve vaccine confidence including: building trust, empowering healthcare personnel and engaging communities and individuals.

Speakers:

Opening remarks:

- [Bill Frist](#), MD, Former Senate Majority Leader; Senior Fellow, BPC
- [Donald M. Berwick](#), MD, MPP, Former Administrator; CMS; Founder, Institute for Healthcare Improvement
- [Katherine H. Capps](#), Executive Director and Co-Founder, GTMRx Institute
- [Anand Parekh](#), MD, Chief Medical Advisor, BPC
- [Karen Remley](#), MD, MBA, MPH, FAAP, Director, CDC’s National Center on Birth Defects and Developmental Disabilities; Deputy Incident Manager, CDC’s COVID-19 Response).

Panel discussion

- moderated by [Susan Dentzer](#), Senior Policy Fellow, Robert J. Margolis Center for Health Policy
- Panelists:
 - [Sree Chaguturu](#), MD, Chief Medical Officer, CVS Caremark
 - [Lisa Fitzpatrick](#), MD, MPH, MPA, Founder and CEO, Grapevine Health
 - [Bruce Gellin](#), MD, MPH, President, Global Immunization, Sabin Vaccine Institute
 - [Howard M. Haft](#), MD, MMM, CPE, FACPE, Executive Director, Maryland Primary Care Program).

Task Force Meeting 2 on Tuesday, April 20 from 12:00 - 1:00 pm EST

Task Force members discussed short-term recommendations about creating local ‘Vaccine Confidence Leagues’ with the help of the “medical neighborhood” and determining priority populations and vaccine access issues. Regarding long-term recommendations, they discussed creating a public-private vaccine registry to track vaccine uptake. In addition, prior to the meeting, members were asked to describe their organizations’ vaccine confidence efforts and share resources and use cases on efforts to develop vaccine confidence strategies.

Task Force Meeting 3 on Tuesday May 4 from 3:00 - 4:30 pm EST

Task Force members discussed guiding principles for Vaccine Confidence Leagues and their comments on a draft of the Task Force’s short- and long-term recommendations. In addition, the group agreed upon the definition, principles and list of possible members involved in the “health neighborhood.”

Speaker: [LaTreace Harris](#), MPH, Deputy Lead, Data Monitoring and Reporting Section, COVID-19 Vaccine Task Force, Centers for Disease Control and Prevention

- *Topic:* Harris discussed strategies to identify and target those who remain vaccine hesitant. Harris described the [Immunization Gateway \(IZ Gateway\)](#)—a hub that facilitates exchange of immunization data among immunization information systems (IISs), provider organizations and consumer applications (IZ Gateway [information sheet](#)).

Task Force Meeting 4 on Tuesday, May 25 from 3:00 - 4:30 pm EST

The Task Force affirmed its stance on vaccination of as many as possible in the U.S. and worldwide and to expand utilization and uptake of all adult and childhood vaccines by strengthening IIS. The group agreed that bringing together a broad group of stakeholders across their local “health neighborhood” to create robust plans and person-to-person outreach will ensure enhanced vaccine confidence. This entails listening respectfully and addressing individuals’ concerns.

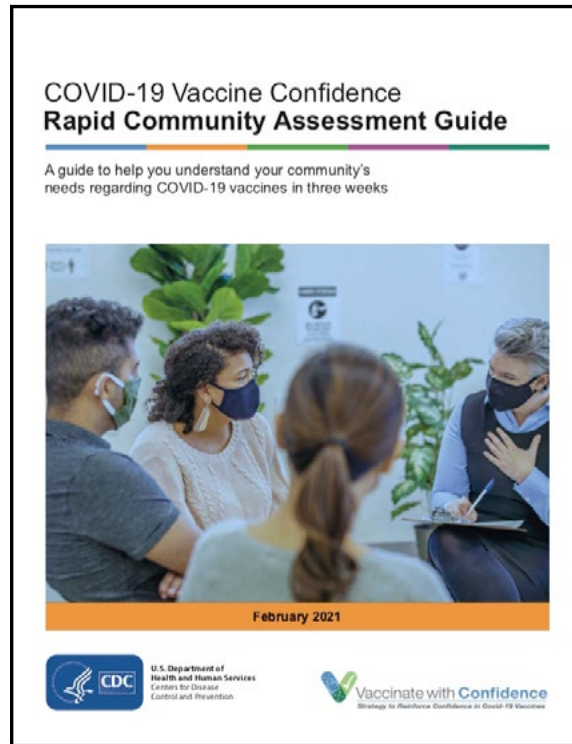
- *Speaker:* [Karen Minyard](#), Ph.D., MN, CEO, Department of Public Management and Policy, Georgia Health Policy Center
- *Topic:* The role of backbone organizations in fostering collective action. Minyard delved into how “backbone organizations” can help align different sectors to change mindsets, practice and policy in order to improve vaccine confidence, especially in the context of racial and health equity.

Task Force Meeting 5 on Tuesday, June 8 from 3:00 - 4:30 pm EST

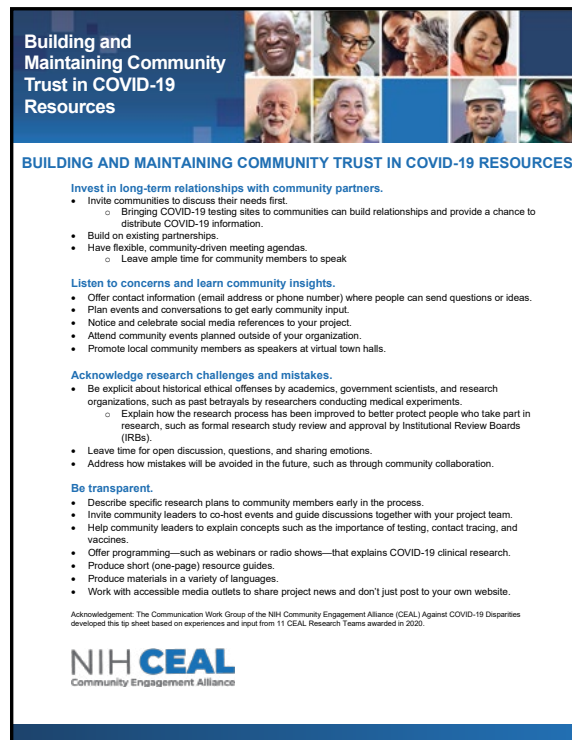
After meeting 4, Task Force members were asked to review and comment on the draft report. These edits and suggested revisions were compiled, reviewed and incorporated into the final version of the report. During the meeting, the group further discussed the final document, ‘*Report and Recommendations of the GTMRx National Task Force: Building Vaccine Confidence in the Health Neighborhood*’.

- *Speaker:* [Bechara Choucair](#), MD, Vaccinations Coordinator, White House COVID-19 Response Team
- *Topic:* Overview of the White House efforts designed to build vaccine confidence.

2. The Centers for Disease Control and Prevention’s COVID-19 Vaccine Confidence Rapid Community Assessment Guide <https://www.cdc.gov/vaccines/covid-19/vaccinate-with-confidence/rca-guide/downloads/CDC-RCA-Guide-2021-508.pdf>



3. The National Institutes of Health established the Community Engagement Alliance (CEAL) Against COVID-19 disparities. CEAL offers extensive resources to communities, including the tip sheet below, which provides guidance on building trust in COVID-19 resources. CEAL resources can be found at the link below: https://covid19community.nih.gov/sites/default/files/2021-02/Community_Trust_in_COVID-19_Resources.pdf



4. The de Beaumont Foundation’s “Cheat Sheet” on language that is effective in improving vaccine confidence is presented below, and can be downloaded from:

https://debeaumont.org/wp-content/uploads/2020/11/Poll-Toolkit_1pger.pdf

CHANGING THE COVID CONVERSATION
Communications Cheat Sheet

Effective communication is always important in public health, but it's never been more important to understand the perceptions of Americans and modify your language accordingly. These recommendations are based on the "Changing the COVID Conversation" poll, conducted by Frank Luntz in partnership with the de Beaumont Foundation, Nov. 21-22, 2020. Learn more at debeaumont.org/changing-the-covid-conversation.

TIPS

- FOCUS ON THE BENEFITS OF SUCCESS, NOT JUST THE CONSEQUENCES OF FAILURE.**
 - We understand that people are tired, but public health measures are not the enemy — they are the roadmap for a faster and more sustainable recovery.
 - Scientists and medical professionals are developing and preparing to distribute a safe and effective vaccine that will help us return to normal day-to-day activities.
- EMPHASIZE THAT THE SCIENCE IS SETTLED.**
 - The science is clear. There is no doubt that mask wearing, hand washing, and social distancing reduce the spread of COVID-19 and saves lives.
- DON'T EXPECT PEOPLE TO TAKE PUBLIC HEALTH MEASURES BECAUSE IT'S GOOD FOR THEM. SPEAK TO THE CONSEQUENCES OF NOT TAKING THESE MEASURES.**
 - Because COVID-19 is highly infectious, one infection can quickly grow into an outbreak that could shutter a neighborhood, community, or entire city.
- DON'T LET POLITICS OR PARTISANSHIP SLIP INTO YOUR MESSAGING, BECAUSE THAT WILL HARM YOUR CREDIBILITY. KEEP YOUR LANGUAGE NEUTRAL AND REPEATEDLY EMPHASIZE "EVERY" AND "ALL."**

Use These Words MORE:

- the pandemic
- eliminate/eradicate/get rid of the virus
- social distancing
- an effective and safe vaccine
- protocols
- face masks
- essential workers
- personal responsibility
- a stay-at-home order
- public health agencies
- policies that are based on facts/science/data

Use These Words LESS:

- the coronavirus
- defeat/crush/knock out the virus
- physical distancing
- a vaccine developed quickly
- orders/imperatives/decrees
- facial coverings
- frontline workers
- national duty
- a government shutdown
- government health agencies
- policies that are sensible/impactful/responsible

Sample Language

SHORT: We all have a responsibility to slow the spread of COVID-19. It is imperative that we protect each other by doing things like wearing masks and practicing social distancing so we can return to a strong economy and normal day-to-day activities.

LONGER: We all want a return to normal, and we all want the economy and our schools to open. And we also want to protect our family and friends from the pandemic. Our finest medical researchers are clear: if we fail, there will be even worse consequences for our families and our economy. We all have a personal responsibility to slow the spread of the pandemic and eliminate the virus as quickly as possible. Therefore, it's imperative that we take an effective, fact-based approach... by doing things like wearing face masks and practicing social distancing. Let's do what needs to be done now so we can return to a strong economy and normal day-to-day activities.

de Beaumont
THE COMMUNITY HEALTH PARTNER

5. The National Quality Forum report, “Opportunities for Advancing Adult Immunization Through Quality Measurement,” at [https://www.qualityforum.org/Publications/2021/04/Opportunities_for_Advancing_Adult_Immunization_Through_Quality_Measurement.aspx#:~:text=The%20National%20Quality%20Forum%20\(NQF,in%20adult%20immunization%2C%20and%20develop](https://www.qualityforum.org/Publications/2021/04/Opportunities_for_Advancing_Adult_Immunization_Through_Quality_Measurement.aspx#:~:text=The%20National%20Quality%20Forum%20(NQF,in%20adult%20immunization%2C%20and%20develop)
6. Sample state COVID-19 vaccine fact sheet from the North Carolina Department of Health and Human Services: https://covid19.ncdhhs.gov/vaccines/7-things-you-should-know-about-covid-19-vaccines?gclid=C-j0KQCjw2NyFBhDoARIsAMtHtZ4przLgDsK7HqH3Z3k-YuMty4X6BWVWLkjuOhp4mnX3BGIYPMm9MalaAgGCEALw_wcB
7. The resources of the Immunization Coalitions Network, at <https://www.immunizationcoalitions.org/>, include an extensive collection here: <https://www.immunizationcoalitions.org/resource-repository/>



Our **VISION** is to enhance life by ensuring appropriate and personalized use of medication and gene therapies.

Our **MISSION** is to bring critical stakeholders together, bound by the urgent need to optimize outcomes and reduce costs by getting the medications right.

ABOUT THE GTMRX INSTITUTE The GTMRx Institute is a catalyst for change that brings critical stakeholders together, bound by the urgent need to get the medications right. We are physicians, pharmacists, caregivers, health IT innovators, drug and diagnostics companies, consumer groups, employers, payers and health systems—aligned to save lives and save money through comprehensive medication management, or CMM. By showcasing evidence and innovation, we motivate practice transformation and push payment and policy reform. Together, we ACT to champion appropriate, effective, safe and precise use of medication and gene therapies.

Learn more at gtmr.org.

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