

Immu-News

Immunization Initiatives Listserv July 2009

Parent or Patient-held Immunization Records—Do you use them and how useful are they?

Welcome to **Immu-News**, the Immunization Initiatives listserv, a monthly resource for the community of participants in this project. For now, this is post-only listserv (in other words, you will get only one e-mail per month in your mailbox, instead of floods of daily discussions) but we hope to evolve into a more interactive form, something that will truly be of service to you as each of you searches for ways to improve your ability to record and access immunization data, to increase immunizations provided to your clients, and thus to improve the health of your community.

Our topic for this month is introduced by Dr. Jennie McLaurin, MCN's Migrant Health Specialist and the Project Director for the Immunization Initiative. We include examples and a source for patient-held immunization records, and two articles on the topic. Please feel free to send responses, comments, thoughts, and ideas to the listserv administrator at kath@healthletter.com. If you send comments, we will follow up with your responses and ideas in the next listserv.

Immu-News is also pleased to feature **Grounded in Practice**, highlights from the real world clinics participating in Immunization Initiatives. We begin with San Benito Health Foundation in Hollister, CA. We invite you to send suggestions, stories, examples of things that have worked to improve immunization practices in your clinic. Send your ideas to kath@healthletter.com

To subscribe or unsubscribe to the Listserv, please see the information at the bottom of the page, and pass the word to other staff in your clinic. **Immu-News** is available online at the Migrant Clinician Network's website. Go to www.migrantclinician.org/immunizations.html

Grounded in Practice

San Benito Health Foundation Community Health Center has made immunizations a priority.

SBHF has been seeing patients for 35 years and attended to over 8,600 patients in calendar year 2008. However, the organization has experienced a 28% increase in patient service demand since July 2008 and approximately 950 new patients each quarter of FY 09. SBHF expects to exceed last year's 8,000 patient count. For many years SBHF has served a relatively young population that works in agriculture, a subsidiary of agriculture or construction industries. Many of their patients can be defined as migrant or seasonal farmworkers. Patient population has been changing recently given the state of the nation's economy. SBHF has seen an increase in unemployed patients. San Benito staff

includes 2 pediatricians, FNP, OBGYN, family physician, MA's, 2 dentists and a registered dietician. SBHF offers full dental, and medical clinics as well as WIC services.

Screening

- ▶ SBHF asks every child about immunizations. If a child is too sick to receive a vaccine, a follow up appointment is scheduled that day.
- ▶ SBHF includes adults. They ask all qualified patients about Pneumococcal, Annual Flu and Tetanus vaccines. The Chief Medical Officer is also in the process of reviewing current state of the art practices for the adult population to enhance immunization services available for their adult clients.

Monitoring-

- ▶ Every month SBHF reviews 100% of the records for children who visited the clinic the previous month to see if children are UTD. If not the staff calls and sends a post card reminder if there is no answer. They are having success with reminder cards; they've seen an increase of patients who are coming into the clinic with reminder cards.
- ▶ They use BARR (Bay Area Regional Immunization Registry) 100% of the time for adolescents and children 0-18. Lack of communicating registries is a big impediment to serving those who move outside of BARR (There are 10 registries in the state of California alone). The staff hopes that any new federal support for immunizations and prevention in the form of EMR will include mandates for interoperable registries.
- ▶ They are conducting quarterly BARR reports for 24-35 month olds using CDC's Co-CASA software (we will highlight this software in an upcoming issue of Immu-News.) They share these reports and set immunization goals at staff meetings.

San Benito emphasizes the importance of staff communication in reaching goals.

- ▶ They cross train staff to ensure all staff is familiar with clinic programs. Thus the staff is able to provide consistent education to patients about clinic programs and services and ensures that patients are receiving the same message from all staff members. As patients hear about services, they will spread this information and more patients will enroll in services.
- ▶ A core value for San Benito is for staff to believe in prevention. Getting buy-in from staff is extremely important and makes it easy to incorporate initiatives because staff is motivated.
- ▶ SBHF holds frequent staff meetings and they share immunization rates (for 24-35 mo olds) at each meeting and compare the current rate to their overall goal for the year. Sharing data helps staff feel involved and motivated to reach a goal. This is an evolving process, takes time, but is worth the effort.

Parent-or Patient-held immunization records

What role do parents and patients have in maintaining immunization records? In an ideal, systems-based world, we wouldn't rely on individual practices to ensure basic public health services are accomplished. Rather, we would use automated recall, regulatory enforcement, and required national registries. However, our present US immunization practices do not include any of these with any sort of consistency. While our vets and dentists all have automated recall systems, few of our primary care offices send patients reminders for immunizations. This fact hit home in a personal way just this past month, as this writer was preparing to send her son off to college. The pediatrician's office, the only source of primary care for the majority of county residents, had an incomplete immunization record and did not ever receive records from the previous office in another state. Additionally, there was no state registry that reliably had this information, nor did the NC registry communicate with other state registries. We were told the practitioners rely upon the school nurses to ensure immunization completion. But this only works for mandatory vaccines, and even then incompletely, as new vaccines get added. It was unclear whether all doses of vaccines had been given, despite the patient's mother being a pediatrician and an immunization expert! Too often, the shots had been given without also giving the patient a portable, up-to-date, record for verification.

It sounds so old fashioned, but statistics prove: The most reliable source of vaccine information on any particular individual is that individual! Contrary to popular belief, parents DO carry portable vaccination records when given them. This is particularly true for immigrant families, who are used to carrying important documents and who realize the potential of revaccination if records are unavailable to the local provider. A clinic survey done in NC by this author, at a large migrant health center serving a migrant population of 40,000, found that over 92% of mothers of preschoolers had an immunization record with them at the time of appointment. Was it current? It sometimes wasn't. But that was the provider's fault for not filling it in at each visit. The fact remains that the mothers did carry the cards at all visits. One barrier to vaccination success is the resistance of parents to seek vaccines when they feel providers have over-vaccinated their child in the past. (See "Immigration and Immunization: Details from a Focus Group Conducted with Migrant Women from Latin America" in May 2009 Immu-News. <http://www.migrantclinician.org/toolsource/resource/focus-group-immigration-and-immunization.html>) A simple completion of a vaccination record at every visit, made as a routine quality improvement practice, could literally change the success rates of immunization programs aimed at underserved mobile population. Do you provide updated cards? Print off registry records for patients? Let us know! --Jennie McLaurin MD, MPH 1.

1. Patient or parent-held immunization records from the Immunization Action Coalition. If you don't have your own versions of patient-held vaccination records, there are three different types available through IAC:
 - a. Adult Immunization Record
<http://www.immunize.org/adultizcards/adultizcard.pdf>

- b. Lifetime Immunization Record
<http://www.immunize.org/images/LifetimeCard.pdf>
- c. Child and Teen Immunization Record
<http://www.immunize.org/shop/views/pediatriccard.pdf>

Click on the links to view these cards, and click on the following link to order: <http://www.immunize.org/shop/#recordcards>. Each is printed on rip-proof, smudge-proof, water-proof paper and is credit card-sized when folded.

2. Immunization Coverage Levels Among 19- to 35-Month-Old Children in 4 Diverse, Medically Underserved Areas of the United States Jorge Rosenthal, Lance Rodewald, Mary McCauley, Stephen Berman, Matilde Irigoyen, Mark Sawyer, Hussein Yusuf, Ronald Davis and Graham Kalton *Pediatrics* 2004;113:e296-e302 DOI: 10.1542/peds.113.4.e296 “UTD status at 3 months and parent-held cards were shown to be strong predictors for being UTD at 19 to 35 months of age” (p 6).

For the pdf: <http://pediatrics.aappublications.org/cgi/reprint/113/4/e296> The online version of this article, along with updated information and services, is located on the World Wide Web at: <http://www.pediatrics.org/cgi/content/full/113/4/e296>

The abstract is printed in full below: see red typeface for information related to parent-held immunization records.

BACKGROUND: The National Immunization Survey demonstrates that national immunization coverage in 2002 remained near the all-time highs achieved in 2000. However, that survey cannot detect whether coverage is uniformly high within relatively small areas or populations. The measles resurgence in the early 1990s revealed that coverage was low in some areas, particularly among inner-city children from racial and ethnic minority groups. Today, identifying areas with low childhood-vaccination coverage remains important, particularly if these areas are at risk for the introduction of disease. In 1995, the Centers for Disease Control and Prevention launched a congressionally mandated demonstrated project now called the Childhood Immunization Demonstration project of Community Health Networks. This mandate specified an assessment to determine whether a network of primary care providers affiliated with university teaching hospitals could assume a public health responsibility for raising immunization levels among preschoolers in medically underserved communities. Communities with federally designated health professional shortage areas were invited to submit proposals, and 4 were selected: Detroit, MI, New York, NY, San Diego, CA, and rural Colorado.

OBJECTIVES: To measure immunization coverage among preschool children in the 4 selected medically underserved areas and determine predictors of coverage levels.

DESIGN AND SETTING: Surveys in the 4 areas were based on stratified cluster probability sample designs in which clusters of dwelling units were selected and all households in selected clusters were screened for the presence of children aged 12 to 35 months. Immunization histories were obtained from parents and providers for these children. For each age-eligible child, the information collected on utilization of immunization health services included a listing of all clinics or offices ever used for the child's well-child care and/or for obtaining immunizations. Information was also collected on whether the child currently had health insurance (public and/or private) and whether the child had a medical home. A child was classified as having a medical home if the survey respondent reported a source of well care that was the same as the source of sick care and that this place was not an emergency department.

PARTICIPANTS: Children 12 to 35 months of age in Detroit, New York, San Diego, and rural Colorado.

OUTCOME MEASURE: Community-wide up-to-date (UTD) immunization coverage levels at 19 to 35 months of age, defined as receipt of 4 doses of diphtheria and tetanus toxoids and pertussis vaccine, 3 doses of poliovirus vaccine, 1 dose of measles, mumps, and rubella vaccine, 3 doses of Haemophilus influenzae type B vaccine, and 3 doses of hepatitis B vaccine (the 4:3:1:3:3 series).

ANALYSIS: We examined the association between coverage level and independent variables and performed chi² and t tests to determine whether differences observed within and between groups and sites were significant.

RESULTS: The overall response rate for eligible children ranged from 79.4% to 88.1%. Coverage levels for most individual vaccines were >90% in all sites except Detroit. Coverage for the 4:3:1:3:3 series was significantly higher for children in New York (84%) and San Diego (86%) than for children in Detroit (66%) and rural Colorado (75%). Demographic risk factors related to UTD immunization status varied by site. Although differences in coverage levels by ethnicity varied by site, differences were not significant. In Colorado and New York, coverage was slightly lower among Hispanic than white children (71% vs 76% and 83% vs 91%, respectively). In San Diego, coverage was lower among whites, compared with Hispanics (76% vs 85%). Coverage was also lower for African American than white children only in New York (75% vs 91%). However, in San Diego and Colorado, children receiving their vaccinations from private providers had lower coverage levels than children receiving their vaccinations from other providers (78% vs 91% and 71% vs 57%, respectively). In all 4 sites, children for whom respondents reported having an immunization card at the time of the interview were more likely to have higher series coverage

levels than children for whom a parent-held card was not available. Also, children who were UTD at 3 months of age had significantly higher vaccination-series coverage levels than children who were not UTD at 3 months of age. In addition, the vaccination coverage was lower for children in Detroit whose parents reported problems accessing the health care system because lack of transportation (46%), compared with those who did not report such problems (65%); however, this difference did not reach significance ($\chi^2 = 6.0$). In Colorado, the small proportion of children in families without a phone had a lower vaccination coverage level (58%) than those in households with a phone (75%) ($\chi^2 = 6.3$). In all sites, children who were UTD at 3 months of age and had a parent-held vaccination card were more likely to be UTD at 19 to 35 months of age.

CONCLUSIONS: Preschoolers in these medically underserved areas were not at uniform risk for underimmunization. Because they were designated as health professional shortage areas, the 4 sites in this study were expected to have low immunization-coverage rates. However, this was not the case. In fact, coverage in 3 of the 4 areas was quite high compared with US national figures (73%); only Detroit had a much lower UTD rate (66%). Efforts are needed to improve methods to identify areas with low immunization coverage so that resources can be directed to places where interventions are needed. Our results reveal that an area's need for childhood immunization interventions is not well predicted by a low number of providers per capita. Other criteria must be developed to predict areas or populations with low immunization coverage. Understanding more about the characteristics of children/provider pairs for children who are UTD at 3 months and more about the role of parental hand-held cards, along with finding strategies to improve immunization delivery by providers in Vaccines for Children Program facilities, suggest potentially productive avenues for increasing and sustaining high coverage levels.

3. Estimating vaccination coverage using parental recall, vaccination cards, and medical records. P Bolton, E Holt, A Ross, N Hughart, and B Guyer Public Health Reports 1998 Nov–Dec; 113(6): 521–526. For a pdf of the full article, go to:

<http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1308435&blobtype=pdf>

Objective: To compare estimates based on vaccination cards, parental recall, and medical records of the percentages of children up-to-date on vaccinations for diphtheria, tetanus, and pertussis; polio; and measles, mumps, and rubella.

Method: The authors analyzed parent interview and medical records data from the Baltimore Immunization Study for 525 2-year-olds born from August 1988 through March 1989 to mothers living in low-income Census tracts of the city of Baltimore.

Results: Only one-third of children had vaccination cards; based on medical records, these children had higher up-to-date coverage at 24 months of age than did children without cards. For individual vaccines, only two-thirds of parents could provide information to calculate coverage rates; however, almost all provided enough information to estimate coverage for the primary series. For each vaccine and the series, parental recall estimates were at least 17 percentage points higher than estimates from medical records. For children without vaccination cards whose parents could not provide coverage information, up-to-date rates based on medical records were consistently lower than for children with cards or with parents who provided coverage information. Conclusions: Population-based vaccine coverage surveys that rely on vaccination cards or parental recall or both may overestimate vaccination coverage.

Immu-News is a project of the Migrant Clinicians Network. The Immunization Initiative is funded by the Centers for Disease Control and Prevention. The Immu-News Listserv is a support service for clinics participating in the project. This is a post-only listserv, and postings will come from Immunization Initiative staff about once a month. If others at your clinic would like to be on the listserv, or if you have questions about the listserv or resources listed here, or if you would like to add something to the posts, please contact Kathryn Anderson, administrator, at kath@healthletter.com. You can also contact the listserv administrator if you would like to subscribe or unsubscribe from the list.