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An Ounce of Prevention: Texans Speak Up for Immunizations

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**StDavid's
FOUNDATION**

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The Immunization Partnership would like to thank the local champions and partners who assisted with the planning and implementation of the 2010 stakeholder meetings. We truly appreciate the following: Austin Travis County Health and Human Services Immunization Unit, Mexican American Cultural Center, Cameron County Department of Health and Human Services Immunization Department, University of Texas at Brownsville, Coalitions & Planning Community Council of Greater Dallas, Children's Medical Center, Immunize El Paso, Ysleta Independent School District, United Way of Greater Houston, Immunization Services Galveston County Health District, Hidalgo County Health and Human Services, Texas A&M Health Science Center, Immunization Collaboration of Tarrant County, Tarrant County Medical Society Alliance & Foundation, Tarrant County Public Health Immunization Outreach, The Women's Center of Tarrant County, Metro Health-Immunization Division Outreach and Education Program, and the San Antonio River Authority.

Above all else, we wish to acknowledge the generous support of St. David's Foundation. Without their guidance and enthusiasm, this project would not be possible. We are very grateful for their investment in the health of Texas.

LETTER FROM THE CEO

Greetings from The Immunization Partnership,

On behalf of the Board of Directors and staff of The Immunization Partnership (TIP), I would like to express our sincere appreciation to our donors, stakeholders and individuals who made this publication possible. We hope that this document is useful and enlightening for stakeholders of all types. Preparing for this publication, The Immunization Partnership visited ten different cities across Texas in the spring and summer of 2010. During these meetings, it was truly inspiring to meet hundreds of outstanding, dedicated front-line immunization champions. The commitment and passion for protecting Texans against vaccine-preventable diseases was uplifting and encouraging. Thanks to you, Texas no longer has one of the lowest immunization rates in the country. Resources allocated at the state level, coupled with the tireless labor of the front-line immunizers have resulted in a dramatic increase in immunization rates, placing Texas in the top 12 highest rates in the nation. Considering the size, diversity and border challenges of Texas, this is a miraculous feat, which required coordination and cooperation on many levels. In true Texas form, the immunization community banded together to achieve our common goals.

Even with our enormous achievements, there is still work to be done. Maintaining high immunization rates requires constant vigil and attention. Pertussis (whooping cough) is on the rise, the number of vaccine exemptions has nearly tripled, and we recently experienced a pandemic flu outbreak. There has never been a more important time for Texans to recommit to building a community free from vaccine-preventable diseases. The immunization status of individuals can affect the health of the entire community because vaccine-preventable diseases will reemerge unless there is a protective shield of immunized individuals to prevent disease outbreaks. Unless all of us are protected through immunization, none of us are protected.

The Immunization Partnership is honored and humbled by the immense support and enthusiasm shown by the community. From legislators to school nurses, from public health officials to foundations, from medical societies to immunization coalitions, Texas has demonstrated a truly inspirational dedication to our common cause: preventing what's preventable. Thank you for the work that you do each day to create a healthy community. Working together, we can realize our vision of a community free from vaccine-preventable diseases.

Sincerely,



Anna C. Dragsbaek, J.D.
President & CEO
The Immunization Partnership

ABOUT US

The Immunization Partnership

The mission of the Immunization Partnership is to eradicate vaccine-preventable diseases by developing and coordinating our communities' resources through public and private partnerships throughout the state of Texas. Our vision is a community free from vaccine-preventable diseases. All of our projects and programs are developed in concert with achieving the organization's mission.

The Immunization Partnership has three main focus areas that address both the root causes of low immunization rates and the far-reaching policy issues that impact immunization rates in Texas. These three focus areas are:

- Educating families and healthcare providers about immunizations
- Supporting the use of electronic health records and Immunization Information Systems to document immunizations and identify children and adults who are not fully protected
- Advocating for laws and policies on a local, state and national level that promote high immunization rates

For more information, please visit www.immunizeUSA.org.

St. David's Foundation

St. David's Foundation invests in a healthy community through funding, hard work, and initiatives to better care for the underserved and uninsured. As a joint owner of St. David's HealthCare, the Foundation achieves its goals by investing the proceeds from the hospitals back into the Central Texas community. From its beginning in 1924, St. David's HealthCare has now grown to include six hospitals, four surgery centers, and four urgent care clinics reaching from Georgetown to Kyle.

Each year the Foundation directly gives millions to the community through grants to numerous agencies, local safety net clinics and the highly acclaimed St. David's Dental Program. By funding initiatives in six key areas, St. David's Foundation can focus on improving the health and healthcare of all Central Texans today and for years to come.

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SUMMARY OF RECOMMENDATIONS

In 2010, The Immunization Partnership engaged Texas immunization stakeholders in statewide meetings and a Web-based survey, the purpose of which was to empower them to advocate on behalf of positive policy change. Other objectives were to discuss immunization topics on the national and state front, voice immunization challenges, share advocacy strategies, and identify priorities for education and advocacy. Approximately 412 Texans participated in the meetings, and 536 completed the survey. The stakeholder meetings and survey culminated in the Texas Immunization Summit in Fort Worth, Texas.

Several key recommendations arose from the stakeholder discussions and survey responses:

1. Modify the process by which Texans consent to be included in the registry
2. Allow seamless interfaces between the Immunization Information Systems and other health information systems, including electronic medical records
3. Enhance the state immunization registry, ImmTrac, with specific features related to reporting, data quality and data entry, and user-functionality/user-friendliness
4. Improve influenza vaccination rates among healthcare workers
5. Provide high-quality education to people who are vaccine-hesitant
6. Support vaccination strategies in border communities through education and use of Immunization Information Systems
7. Use lessons learned from the H1N1 experience to better prepare for future pandemics
8. Reduce costs and increase reimbursement for vaccines
9. Promote strategies to reduce pertussis (whooping cough) incidence
10. Increase access to adult vaccines

BACKGROUND AND PURPOSE

Immunization Rates in Texas

Over the past several years, immunization rates in Texas have steadily increased. In 2008, 79% of 2-year-old children completed the 4:3:1:3:3:1 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella) of immunizations, as compared to 77% in 2007 and 65% in 2002.

Texas exceeded the nationwide rate of 76% in 2008.¹ This improvement can be attributed to a multi-disciplinary approach involving enhanced public awareness and provider education about vaccinations, expanded use of Immunization Information Systems, and increased access to immunization services. According to the Centers for Disease Control and Prevention (CDC), Texas is now ranked 12th nationwide in the immunization rate of infants under three years of age.

Although immunization rates are on the rise, many Texans are still at risk. Within the last five years, we have seen a startling increase in the incidence of pertussis (whooping cough). In 2009, Texas reported 3,358 cases of pertussis compared to 954 cases reported in 2006.² The Central Texas region and Williamson County have experienced higher increases than average for both the United States and all of Texas.³ Furthermore, the rising number of people claiming exemptions for reasons of conscience in Texas is of great concern. The total number of exemptions claimed in the past five years has more than tripled. In the '09-'10 school year, 19,050 exemptions were claimed as compared to 6,770 exemptions claimed in '05-'06. Across the nation, states are reporting outbreaks of vaccine-preventable disease in areas with high rates of exemptions. Vaccination rates for many vaccines, including influenza, continue to be low. At the end of January 2010, only 25% of Texas children aged 6 months to 17 years had been vaccinated against the H1N1 influenza virus, one of the 5 lowest immunization rates in the nation (Range: 21% - 85%).⁴ In addition, when considering all individuals who were vaccinated against H1N1, Texas ranked fourth from the bottom at 16%.

Our Activities and Accomplishments

2008-2009

In 2008, The Immunization Partnership conducted a Web-based survey and eight statewide stakeholder meetings, culminating in the 2nd Texas Immunization Summit. The meeting series was a tremendous success: over 125 stakeholders voiced their concerns and identified key immunization policy issues.

In 2009, The Immunization Partnership and collaborative partners supported the following pieces of legislation, which aim to promote critical vaccinations in vulnerable populations and enhance our state's vaccine delivery system.

- SB 346 by Chairwoman Jane Nelson (R - Flower Mound): Adults may now enter their information into the state immunization registry, ImmTrac.
- SB 347 by Chairwoman Jane Nelson (R - Flower Mound): Allows Texas to share information with other states if there is an emergency in Texas that forces Texans to surrounding states.
- HB 4189 by Chairman Patrick Rose (D - Dripping Springs): (a.k.a. the Jamie Schanbaum Act) Effective January 2010, any student entering a dormitory for the first time must have the meningitis vaccine.

The Immunization Partnership also successfully advocated for a revision to the school immunization requirements in Texas. The rule now ensures that all students entering 7th grade be immunized with one dose of meningococcal vaccine, a booster dose of Tdap (tetanus, diphtheria, and pertussis), and two doses of varicella (chickenpox) vaccine.

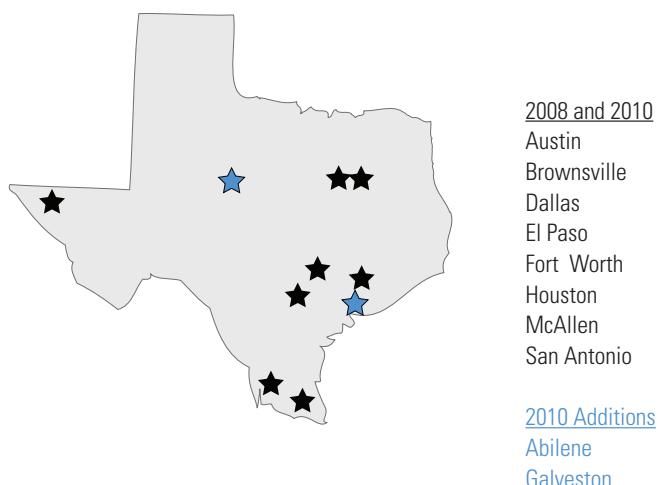
2009-2010

Given our past successes, The Immunization Partnership hosted ten stakeholder meetings and administered a Web-based survey in 2010, concluding with the Texas Immunization Summit. All three of these projects support The Immunization Partnership's overarching vision to establish a community free of vaccine-preventable diseases.

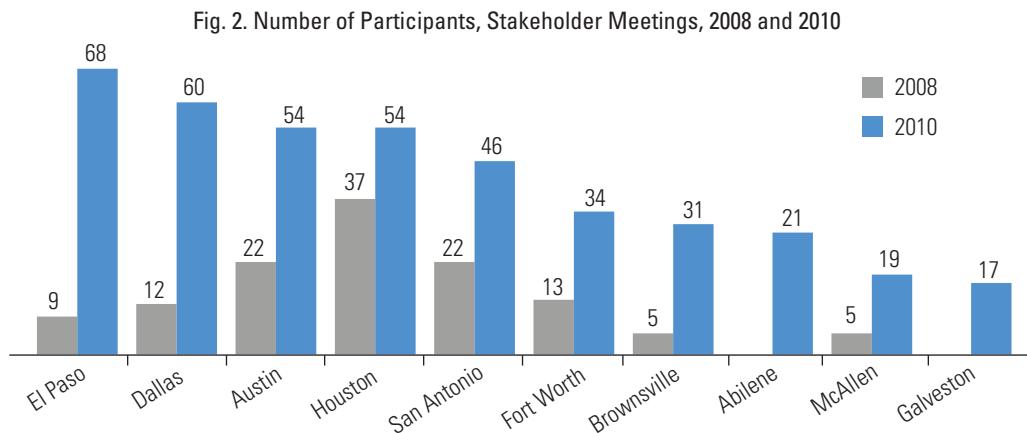
Stakeholder Meetings

Ten stakeholder meetings took place between March and June 2010. The meetings were designed to reach both rural and urban communities, including Abilene, Austin, Brownsville, Dallas, El Paso, Fort Worth, Galveston, Houston, McAllen, and San Antonio (Figure 1).

Fig. 1. Location of Immunization Stakeholder Meetings, 2008 and 2010



Over 400 people participated in the meetings, a 230% increase over the meetings that took place in 2008 (Figure 2). Meeting participants included parents, healthcare providers, state agency personnel, and representatives from local fire stations, hospitals, foundations, medical associations, local public health officials, and non-profit organizations.



The objectives of the 2010 stakeholder meetings were to: 1) review immunization topics on the national and state front, 2) discuss immunization challenges and identify priorities for 2011, and 3) share advocacy strategies and techniques with participants.

The feedback from the meetings was overwhelmingly positive. Virtually all of the participants believed the meetings increased their understanding of several key topics and issues (Figure 3).

Figure 3. Percentage of Stakeholders Who "Agreed" or "Strongly Agreed" with Statement, Immunization Stakeholder Meetings, Texas, 2010

The policy issues discussed were key issues of importance	96%
I was given the opportunity to raise questions and voice concerns	96%
The meeting increased my understanding of national and state policy issues	95%
The issues raised during the stakeholder meeting were thoroughly addressed	94%
The meeting increased my understanding of the differences between lobbying/advocacy	94%
The meeting increased my understanding of the legislative process	93%
The meeting increased my understanding of direct lobbying activities	91%
The meeting increased my access to immunization and vaccine information	91%

Web-Based Survey

In June 2010, The Immunization Partnership administered a Web-based survey, the purpose of which was to learn about local concerns and priorities related to the provision of vaccines and immunization policy. Survey findings also helped The Immunization Partnership identify and prioritize enhancements to the state immunization registry, ImmTrac.

Some 536 immunization stakeholders completed the survey, a 415% increase in participation over the 2008 survey. Respondents came from 105 towns and cities across Texas. Of respondents, 38% attended at least one of the stakeholder meetings. Respondents included Immunization Information System users, healthcare providers, state agency personnel, and representatives from hospitals, foundations, medical associations, local public health officials, and non-profit organizations.

The survey addressed the following topics: 1) enhancements to the state immunization registry, ImmTrac, 2) electronic medical records and electronic sharing of information, 3) influenza, 4) vaccine financing, and 5) concerns specific to the border region. Respondents were asked to prioritize issues and had the opportunity to raise additional concerns and ideas.

STAKEHOLDERS' PRIORITIES

I. Modify the Consent Process for Inclusion in ImmTrac

Background

Immunization Information Systems (IIS) help parents, providers, and health plans keep track of vaccination histories by consolidating immunization information into one reliable source. These confidential, computerized systems have numerous benefits. They: 1) provide immediate access to current immunization status, 2) save money by ensuring that individuals get only the vaccines they need, 3) improve office efficiency by reducing the time needed to gather and review immunization records, and 4) allow for an efficient and effective response in the event of an outbreak, pandemic or other public health emergency.⁵

Immunization providers in Texas use ImmTrac, the system developed by the Texas Department of State Health Services (DSHS), and other local Immunization Information Systems. Local IIS systems include the San Antonio Immunization Registry System and the Tarrant County Immunization Registry. They also use TWICES (Texas-Wide Integrated Client Encounter System), which maintains immunization history data for children served by public and private clinics, bills Medicaid through the Texas Medicaid and Healthcare Partnership, and reports immunization data to ImmTrac.

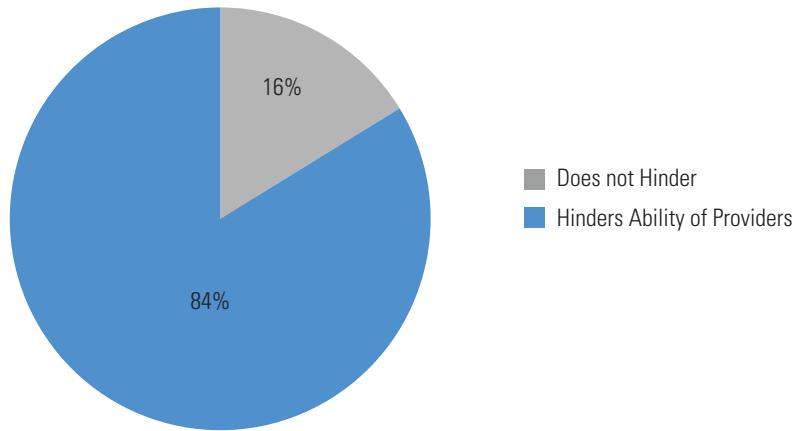
A primary barrier affecting the use of ImmTrac is the manner in which consent is obtained. Texas uses an opt-in process, which requires consent to be included in the registry. Texas is one of only five states that uses this model. Most states use an opt-out process, meaning that people who choose not to have their children's immunization information in the registry can request that it be excluded. Studies show that 95% of people approached in a health setting choose to opt-in to the system.⁶ However, per the current statute in Texas, consent must be gathered on all individuals, including those who consent to be included and those who wish to be excluded (5%). The state also requires that all consent information be verified prior to inclusion or exclusion in the registry, thereby creating a system in which people must effectively consent twice to inclusion.

Managing the consent process is expensive. The annual costs of the current opt-in system to all involved are more than \$1.3 million. In comparison, the total cost of a proposed opt-out system are estimated at \$110,714. Each child's record in an opt-out system costs 29 cents, approximately one-tenth of the current opt-in cost of \$2.24 per child to consent all newborns and children in clinical settings.⁷

What Stakeholders Say

In addition to being expensive, a great majority (84%) of immunization stakeholders who took the survey believe that the current process of obtaining consent, or opt-in, for ImmTrac hinders the ability of healthcare providers to access immunization information and thus provide quality healthcare (Figure 4).

Fig. 4. Percentage of Stakeholders Who Believe Current Process of Obtaining Consent for Texas Immunization Registry Hinders Ability of Healthcare Providers to Access Immunization Information, 2010



"Opt-in costs more money and more resources than opt-out. Because the State is experiencing a budget shortfall, it is unclear to me why we don't move to an opt-out system. Opt-out would contribute to better health outcomes and save our state a lot of money."

Recommendations

1. **Increase the efficiency of the immunization registry.** Texas can save millions of tax dollars by creating an opt-out immunization registry. Because the costs of an opt-out system are substantially lower than the current opt-in system, moving to an opt-out IIS would allow limited dollars to go to critical healthcare needs and to making substantial improvements to the current ImmTrac system.
2. **Protect the privacy of immunization records included in the registry.** Ensure that all records included in the registry are secure and protected against commercial use.

II. Link Immunization Information Systems and Health Information Technology

Background

When Immunization Information Systems (IIS) were introduced in the early 1990s, there were few interfaces between registries and other health systems, with the exception of some state-established connections to birth data contained in Vital Records Systems. Today

nearly 80% of the 53 state and city immunization registries support exchanges of data from vital records to immunization systems.⁸ Technological advancement now allows for two-way or bi-directional data transfers between IIS and other third-party sources like practice management and billing systems.

The next generation of data exchange involves electronic medical records (EMR) and IIS. The American Recovery & Reinvestment Act contains incentives for Medicare and Medicaid providers who display a “meaningful use” of EMR technology. The criteria, although not fully defined, requires that the technology electronically record, retrieve, and transmit immunization information to immunization registries.⁹ As the demand for EMRs increases and providers make the transition to electronic systems, it is imperative that they also examine the interoperability with IIS. A seamless connection between IIS and EMR systems will integrate data more efficiently, reduce redundancies, improve documentation processes, save administrative time, and offer greater continuity of care.

Many states across the nation are optimizing the use of their IIS by aligning with other health information systems. Texas has joined the nation on this health information technology journey—DSHS is working collaboratively with consultants and stakeholders across the state to move ImmTrac to a more robust application. The Web-based survey conducted by The Immunization Partnership engaged stakeholders to provide feedback on how to make ImmTrac more efficient, functional, and user-friendly. The Immunization Partnership will present all feedback to DSHS to incorporate into the new Texas Immunization Registry.

“We can achieve cost savings and better care with information sharing, and, at the same time, continue to protect privacy.”

- Anna Dragsbaek,
President/CEO, The
Immunization Partnership

What Stakeholders Say

When asked to identify enhancements for the new Texas Immunization Registry, survey respondents prioritized the electronic sharing of data. Of ImmTrac users, 88% said that having “improved data sharing between the new system, local registries, and school health record systems” is “very important” to them (Figure 5).

Figure 5. Percentage of ImmTrac Users Who Ranked Potential Enhancements Related to Electronic Sharing of Data as Very Important, 2010*

Ability to:

Have improved data sharing between new system, local registries, and school health record systems	88%
Send immunization records from an EMR directly to new system	84%
Send a patient’s consent for inclusion in the registry directly from your EMR to the new system	80%
Access immunization data in the new system directly from your EMR	79%
Use the new system to report adverse events to the CDC	75%

* Respondents were asked to rank potential enhancement on scale of importance from 0 to 10, 10 being the most important. Rankings of 8-10 are considered “very important.”

"I am a school nurse - I love getting into ImmTrac to see who has updated shots, but I often do not have the time to update ImmTrac on all the other shots I have a record of. It needs to be easier to share what we each have record of."

- Survey Respondent

Stakeholders made specific suggestions on how to improve data sharing and linkages. Many cited the need for improved coordination between systems. Stakeholders in San Antonio offered suggestions on how to enhance linkages between ImmTrac and its local registry, SAIRS (San Antonio Immunization Registry System). Users suggested using Health Level Seven (HL7)¹ messaging to transmit information and to allow bi-directional data sharing/reporting. They also recommended designing the new system so that it downloads information into electronic medical records.

One physician explained that he would like ImmTrac to "mesh" with his electronic medical record system, but the cost of developing a solution is too high for his practice. To improve ImmTrac data exchange, the physician suggested that DSHS assign a staff member to medical practices across the state to troubleshoot issues related to electronic sharing of data.

In addition to linking with electronic medical records, many providers want the new Texas Immunization Registry to link to other health databases, in order to establish a more efficient continuum of care. Stakeholders said they would like to see an interface between immunization and cancer, newborn and birth registries. When the survey asked ImmTrac users what additional child health screening features they would like to see in the new Texas Immunization Registry, over half (51%) said they would like to see tuberculosis testing results with readings. About a third said they want the newborn (36%) and lead screening (33%). Fourteen percent (14%) said they currently do not want additional child health screening features (Figure 6).

Figure 6. Childhood Screening Features Desired by ImmTrac Users, 2010

Tuberculosis testing results with readings	51%
Newborn screening	36%
Lead screening	33%
Body Mass Index	26%
Newborn hearing	25%
Asthma screening	23%
Early Periodic Screening, Detection and Treatment	21%
None	14%
Other	9%

**Sum is greater than 100% because some respondents suggested more than one feature.*

Recommendations

- Policymakers in Texas should ensure that IIS interfaces with other health information systems.** Electronic medical records, health information exchanges, and

¹ HL7 (Health Level Seven) is a standard series of predefined logical formats for packaging health care data in the form of messages to be transmitted among computer systems.

"Work towards using ImmTrac as a one stop shop for daycares, schools, and providers. Allow daycare centers to flag kids who attend the facility so it can generate a report that shows who needs what."

- Survey Respondent

public health information systems are critical supports to a high-quality and cost-efficient healthcare system.

III. Identify Enhancements for the New Texas Immunization Registry

Background

Registries in other states have the necessary functionality to streamline the delivery of immunization services. Michigan is considered the gold standard. For instance, its state registry has the functionality to link with Medicaid data, run critical reports, and incorporate data quality tools, all of which lead to more efficient delivery of care. In order to incorporate other healthcare goals and to ensure maximum efficiency with health systems, it is imperative that the new Texas Immunization Registry adopt some technical enhancements.

Recommendations

- 1. Improve user-capabilities and user-friendliness.** When asked on the survey to prioritize enhancements, 83% of ImmTrac users said that an easier search for a patient's record is "very important" to them. Eighty-two percent (82%) said the ability to enter five or more immunizations on a patient is "very important" (Figure 7).

Figure 7. Percentage of ImmTrac Users Who Ranked Potential Enhancements Related to User-Capabilities and User-Friendliness as Very Important, 2010*

Ability to:

More easily search for patient's record	83%
Enter five or more immunizations on a patient	82%
More easily add new patients	78%
Gather information offline and upload data at the end of the day during influenza clinics, health fairs, or public health emergencies	75%
More easily reset passwords	65%

"I use ImmTrac to gather HEDIS data. I wish the search function was a little more forgiving."

- Survey Respondent

- 2. Enhance reporting features.** Of ImmTrac users, 80% prioritized the following two enhancements: 1) alerts for staff about minimum intervals for patients on 'catch-up' schedules and 2) 'next dose due' for patients with upcoming appointments. Respondents also suggested streamlining the electronic reporting capabilities, so that providers have a more accurate depiction of unvaccinated individuals. One valuable suggestion was automating the Texas Vaccines for Children program reporting and acquisition (Figure 8).

Figure 8. Percentage of ImmTrac Users Who Ranked Potential Enhancements Related to Reporting as Very Important, 2010*

A report showing:

Alerts for staff about minimum intervals for patients on “catch-up” schedules	80%
“Next dose due” for patients with an upcoming appointment	80%
“Doses administered” during public health emergencies	67%
How many patients received an immunization after receiving a reminder or recall notice	65%
Immunization rates for a specific clinic by age, vaccine series or single antigen	63%

**Respondents were asked to rank potential enhancement on scale of importance from 0 to 10, 10 being most important. Rankings of 8-10 are considered “very important.”*

- 3. Improve data quality.** Stakeholders offered several suggestions for improving data quality. Of ImmTrac users, 79% wanted the ability to update patient addresses and mark patients as duplicates (Figure 9). Other comments voiced during the stakeholder meetings included: 1) using bar coding to scan necessary information such as lot number and manufacturer, 2) modifying the de-duplication module to avoid records unnecessarily being merged, and 3) establishing a more efficient manner of matching records, specifically between IIS and EMRs.

Figure 9. Percentage of ImmTrac Users Who Ranked Potential Enhancements Related to Data Quality as Very Important, 2010*

Ability to:

Update patient addresses	79%
Mark patient records as duplicates	79%
Edit existing vaccine information	75%
Produce a report that shows a patient’s missing information (address, phone number, lot number)	70%

**Respondents were asked to rank potential enhancement on scale of importance from 0 to 10, 10 being most important. Rankings of 8-10 are considered “very important.”*

- 4. Improve data entry capabilities.** Stakeholders suggested including the following components in the new system: 1) allow users to enter several immunization histories for the same date, 2) use scanned drivers’ licenses to capture personal information, and 3) make inputting data more user-friendly. Stakeholders indicated that they struggle to enter data into ImmTrac due to limited staff and resources.

IV. Increase Vaccination Rates among Healthcare Workers

Background

The Centers for Disease Control and Prevention and other leading health authorities recommend that healthcare workers (HCWs) receive annual influenza vaccinations. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) instituted a new infection control policy that requires Critical Access Hospital, Hospital and Long Term Care accreditation programs to offer influenza vaccination to staff, volunteers, and licensed practitioners with close patient contact. JCAHO's standards aim to establish an annual influenza vaccination program and improve access to vaccinations on-site.¹⁰ The American Hospital Association encourages any medical facility or health department that provides direct patient care to formulate a comprehensive immunization policy for all healthcare workers.¹¹ Despite the stances of these health authorities, voluntary immunizations for influenza among HCWs in the U.S. have hovered around 43%.¹² According to stakeholders, influenza coverage among HCWs in Texas varies widely, ranging from as low as 40% to as a high as 90%. Low immunization coverage among HCWs is thought to be a source of hospital-acquired influenza infections, which can lead to higher healthcare costs and patient morbidity and mortality.¹³

What the Stakeholders Say

Why are rates so low? Several stakeholders believe there is a lack of knowledge among HCWs about the importance of influenza vaccination and the risk for exposure to and possible transmission of vaccine-preventable diseases. Our online survey cited additional reasons why HCWs choose not to vaccinate, including a belief that the flu vaccine is unsafe or doesn't work, a belief that they are not at risk, a fear of needles, inconvenience, apathy, and a belief that the flu vaccine causes the flu. Of the HCWs surveyed, 12% chose not to get vaccinated against seasonal influenza, and of those, 26% indicated that it was due to vaccine safety concerns.

"A vaccine is like a glove—another form of protection in the hospital. It protects me. It protects the patient."

- Nurse, Pflugerville, Texas

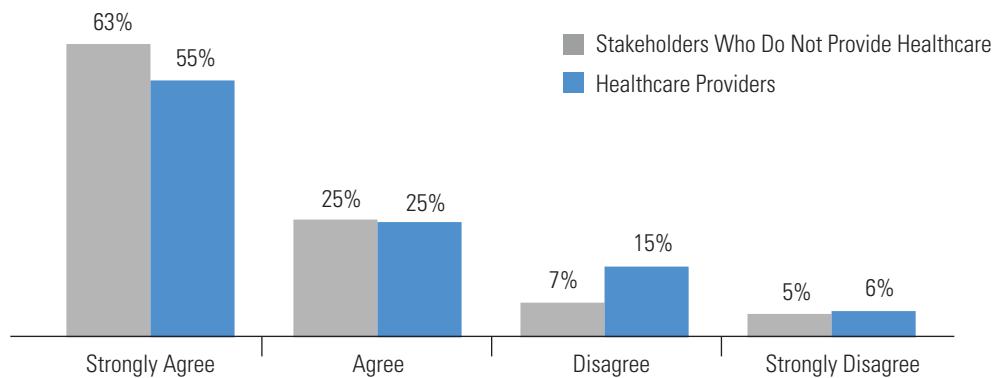
Recommendations

- 1. To dispel myths and misperceptions about influenza and the vaccine, increase outreach and education for all providers.** Several people suggested mandatory educational sessions. Messages included educating HCWs about 1) the importance of vaccination, 2) how vaccinations protect patients and reduce unnecessary risk, 3) disease processes and transmission, and 4) potential implications that could result from declining vaccinations.
- 2. Make the vaccination more convenient to access.** Successful components might include expanded vaccination clinic hours or mobile clinics to reach all staff.

3. **Encourage DSHS to publicly recognize facilities that reach a certain percentage of vaccinated HCWs.** Benchmarking incentivizes other facilities to set and reach targets. The Joint Commission Resources, an affiliate of the Joint Commission, launched a similar program with its Flu Vaccination Challenge in 2008-2009. Of participating hospitals, 94% met or exceeded the benchmark vaccination rate, and influenza immunization rates among HCWs in participating facilities improved by 14% during the season.¹⁴

4. **Institute mandatory vaccination/declination policies.** Mandatory vaccination has been identified as a best practice for improving influenza coverage. Many facilities across Texas and the U.S. instituted such policies and saw dramatic increases in rates. When survey respondents were asked, "To what extent do you agree that hospital policy should require its HCWs to get an influenza vaccine each year," 84% agreed with the statement. Non-healthcare providers (63%) were more likely than healthcare providers (55%) to "strongly agree" with the statement (Figure 10).

Fig. 10. Extent to which Stakeholders Agree that "Hospital Policy Should Require its Healthcare Workers to Get a Flu Vaccine Each Year," 2010



V. Educate People Who Are Vaccine-Hesitant

Background

Although the majority of people in the U.S. accept routine vaccination recommendations, there is a growing minority who are vaccine-hesitant and either delay vaccination or refuse vaccination entirely. There are a myriad of issues that contribute to vaccine hesitancy. Many question the safety or content of vaccines, the effects that they can have on immune systems, or the necessity of vaccinations in general, given that many vaccine-preventable diseases are no longer prevalent in the U.S.

Many of the concerns about vaccine safety stemmed from Andrew J. Wakefield and his colleagues, who published a paper in *The Lancet* in 1998, suggesting a link between the MMR (measles-mumps-rubella) vaccine and autism. The article was fully retracted in January 2010, and Andrew Wakefield lost his license to practice medicine in the United Kingdom. However, Mr. Wakefield continues to spread misinformation from his current home city of Austin, Texas, making outreach and the dissemination of scientifically correct information critical for the health of Texans.

As a result of Wakefield's now discredited publication, many people began to refuse vaccinations. Others opted for alternative schedules, whereby vaccines were split (single antigens were administered) or delayed to prevent potential immune system overload or vaccine injury. Several people began questioning the validity of the information provided by the government and other health officials. At the same time, anti-vaccine groups attracted media coverage, vocalized their opposition through the Internet, and distributed damaging misinformation.

Spurred by unfounded safety concerns, many states, including Texas, expanded their vaccine exemption policy. Texas allows for medical, religious, and personal belief exemptions. Over the past several years, Texas reported a significant rise in the number of parents refusing vaccination for their children due to personal beliefs (Figure 11).

Figure 11. Percentage of K-12th Grade Students Invoking the Personal Belief Exemption, Texas, 2005 - 2010

School Year	Total Exemptions	Percent Change from Previous Year
2005 to 2006	6,770	-
2006 to 2007	9,326	37%
2007 to 2008	10,011	7%
2008 to 2009	12,633	26%
2009 to 2010	19,050	50%

Source: *Self-Reported by Public ISDs and Accredited Private Schools, Annual Report of Immunization Status, DSHS, Immunization Branch*

Such mistrust, coupled with widespread misunderstanding, contributed to a resurgence of vaccine-preventable diseases that vaccines had once virtually eliminated. In 2008, the U.S. saw its largest measles outbreak since 1997. The majority of the cases were among unvaccinated individuals. This year, several states, including Texas, reported rising numbers of pertussis (whooping cough) cases, many identified in pocketed, unvaccinated communities. California is currently undergoing a statewide epidemic—as of August 2010, over 3,000 cases of pertussis have been confirmed, and 8 deaths have been reported, seven were infants younger than two months of age.

What the Stakeholders Say

Vaccine skepticism continues to grow in Texas. Survey data revealed that 91% of respondents believe that “misinformation or lack of knowledge about vaccines” is a “somewhat” or “very important” barrier to increasing immunization rates in Texas. During the stakeholder meetings, immunization providers cited the increase in new vaccines administered to be a contributing factor to the growing confusion and hesitancy about vaccines. This skepticism was more recently noted as the nation prepared for its arrival of the new H1N1 vaccine. Concerns about the overall safety and importance of the vaccination swept through Texas. Several stakeholders identified one of their largest challenges during the H1N1 pandemic to be a lack of education and knowledge.

Recommendations

1. **Increase outreach and education to those skeptical about vaccines.** Suggested efforts included working collaboratively with schools, parent-teacher associations, and civic leaders to disseminate education.
2. **Respond in a customer-focused manner.** Encourage providers to validate patient concerns and to always respond in a respectful and sensitive manner when questions about vaccines are raised.
3. **Illustrate the impact of non-vaccination.** Use emotional, personalized stories of those who have been affected by vaccine-preventable diseases to demonstrate that vaccine benefits outweigh risks.
4. **Use the media to dispel myths.** Profile vaccine-preventable disease stories and educate the public through public service announcements, television shows like *Frontline* on PBS, or publications like *Vaccine Preventable Diseases: The Forgotten Story*.

VI. Support Border Communities

Background

The United States-Mexico border stretches 2,000 miles from the southern tip of Texas to California. This dynamic region is medically underserved. Its population has pressing health and social conditions, higher uninsured rates, high rates of migration, inequitable health conditions, and a high rate of poverty.¹⁵ Some border cities, such as El Paso and Ciudad Juarez, are separated by a very short distance. “From an epidemiologic perspective, the border population must be considered as one, rather than different populations on two sides of a border; pathogens do not recognize the geopolitical boundaries established by human beings.”¹⁶

Migration across the border is high. Many cross the border for work or school, to visit family and friends, or to seek medical treatment. Partly due to movement across the border and poor environmental conditions, the border communities have been at higher risk of certain vaccine-preventable diseases, including diphtheria, measles, mumps, rubella, and Hepatitis A.¹⁷ The consequences of these conditions were recently made apparent by the importation and quick transmission of the H1N1 virus. Such an outbreak could be mimicked by any vaccine-preventable disease in vulnerable, border communities.

What the Stakeholders Say

Providers in El Paso and the Rio Grande Valley face many challenges servicing the immunization needs of their communities. Barriers cited during the meetings included: 1) poor immunization compliance due to transience, 2) limited resources to vaccinate border families, 3) lack of awareness about immunizations, and 4) poor coordination of immunization documentation across the border.

The survey asked people what they believe is the biggest barrier to immunizing children and adults living in Texas near its border with Mexico. One-third (33%) said lack of documentation on immunization histories, and about one-third (32%) said misinformation or lack of knowledge about vaccines among families (Figure 12).

Figure 12. Biggest Barrier to Immunization Among People Living in Texas near the Mexican Border, 2010

Lack of documentation on patients' immunization histories	33%
Misinformation or lack of knowledge about vaccines among families	32%
People's fear of having their records in ImmTrac/fear of being deported	15%
Lack of access to immunization providers	14%
Other	6%

According to stakeholders, families cross the border to seek medical treatment. Some travel to the U.S. to receive vaccines that are not readily available in Mexico, e.g., varicella, meningococcal, and HPV, while others travel back to Mexico, where vaccines are cheaper. Heavy back-and-forth migration makes it difficult for providers to follow up on immunizations and ensure full protection. Respondents said access is also an issue, and more immunization clinics and providers are needed in border communities. Recently, in El Paso, over 14,000 families crossed the border to escape drug-cartel violence. Much of the influx occurred during the H1N1 pandemic, placing a heavy burden on immunization providers to vaccinate a large unexpected group of people.

The H1N1 pandemic also highlighted the need for more coordination and planning between the U.S. and Mexico. El Paso stakeholders voiced frustration that vaccine resources and supply did not take into account border families. Information dissemination was an issue as well. Stakeholders indicated that Mexico did not inform its residents as effectively as the U.S., contributing to vaccine-hesitant individuals.

Stakeholders cited lack of education about vaccinations or where to access them as a challenge. Stakeholders agreed that many families on the border do not understand the importance of vaccinations. Many mistakenly believe that they do not qualify for free or low-cost vaccines.

"Undocumented parents are afraid to use ImmTrac because of documentation status and privacy concerns. They often access multiple providers and receive multiple (duplicate) vaccinations."

- Stakeholder in Abilene

Lack of documentation or inclusion in ImmTrac was stated to be a primary barrier when vaccinating border families. According to stakeholders in the border region, most people have had the necessary vaccines and are up-to-date on immunizations. "The mom tells you they have all of their vaccines, but they do not have the records." Due to parents' fears about their family's information being stored in ImmTrac and the lack of proper documentation of immunization, providers are often forced to re-vaccinate.

Lack of coordination across the border also contributes to inaccurate immunization histories. Vaccine schedules differ between Mexico and the U.S., creating confusion over what vaccines are required. Some vaccination records are self-written, making it challenging for providers to determine the accuracy and legitimacy of vaccinations. Language and communication barriers also contribute to the confusion. And, there is no interface or data sharing between Mexico's IIS (PROVAC) and Texas' immunization registry, ImmTrac.

Recommendations

- 1. Improve coordination across the border with respect to emergency preparedness and planning.** Encourage public health partnerships across the border to ensure consistent messaging and timely dissemination of accurate information.
- 2. Increase outreach and education to border families on the importance of vaccinations, where to access free or low-cost immunizations, and eligibility requirements.** One stakeholder wrote, "I think getting the word out that immigration status should NEVER hinder someone from accessing vaccines is extremely important in Texas."
- 3. Encourage providers to better document immunization status of border families in ImmTrac.** At the same time, providers must educate border families on the benefits and safety of consenting to be included in ImmTrac.
- 4. Explore opportunities to share data between Mexico's IIS and ImmTrac.** Accurate documentation using IIS can help identify under-immunized individuals and ensure timely completion of immunization. IIS can also assist public health officials to identify pockets of need and design targeted interventions in the event of an outbreak.

VII. Improve Preparedness for Potential Pandemics

Background

When the first case of H1N1 hit the U.S. in April 2009, public health officials immediately put their preparedness plans into motion. Although the severity of H1N1 turned out to be less than feared, the disease was damaging. The CDC estimated that approximately 60 million cases, 270,000 hospitalizations, and 12,000 deaths resulted from H1N1 from April 2009 to March 2010.¹⁸ Texas reported approximately 2,400 hospitalizations and 240 deaths as a result of H1N1¹⁹. However, this only represents the cases that were reported. The actual number could be significantly higher.

What the Stakeholders Say

During the meetings, stakeholders reflected on their experiences and cited a variety of challenges with respect to H1N1, including: 1) vaccine shortages and delays, 2) confusion over the vaccine distribution process, 3) education about the disease itself, the vaccine, and the benefits of vaccination, and 4) vaccine availability.

When H1N1 emerged, production of seasonal flu vaccine was already in process, which made manufacturing a new vaccine untimely and difficult. The vaccine took months to develop and when it was finally distributed, albeit on a limited basis, the pandemic was already peaking. "People lined up to get it," voiced a stakeholder from Brownsville. However, only the high-risk populations were slated to receive the vaccine, which created confusion over who could get it. To complicate matters further, public health officials issued revised priority groups based upon morbidity and mortality rates, and disease trends. This created a new level of confusion for immunization providers implementing mass vaccination efforts. Several stakeholders expressed frustration over the lack of accurate and timely communication by public health officials. Due to the vaccine shortage and uncoordinated distribution, many people interested in getting vaccinated were turned away.

A prevailing challenge discussed during meetings was the lack of education about H1N1, the vaccine, and its implementation. When the pandemic peaked, the media reacted with vigor, creating conflicting responses. On one side of the spectrum, the hype encouraged the public to seek out vaccination. On the opposite side, the media spurred doubt and hesitancy in the vaccine and the disease. Several stakeholders were challenged with public concerns about vaccine safety, specifically the contents of the vaccine, how it was manufactured, and whether the development process incorporated appropriate safety and purity tests. Of stakeholders surveyed, 32% chose not to get vaccinated against H1N1 and of those, 45% indicated it was due to vaccine safety concerns.

Stakeholders said that the public was also uninformed about the disease itself, including how it was transmitted and its severity if contracted. Overall, there seemed to be a strong misunderstanding about the vaccine and mistrust in the vaccine's capacity to prevent H1N1. Communication on availability and where to access low-cost vaccines was also limited. Several providers in Texas had limited supply of the vaccine, forcing people to find alternative vaccination locations. Some providers chose not to stock the vaccine at all. Finally, there was limited education about the recommendation and dosage for adults and children. Documentation by providers in Houston showed adults getting two doses, when only one was required. In Texas, 80% of children who needed the second dose of H1N1 did not receive it. This was partly due to lack of awareness about the recommendations, vaccine skepticism, and apathy, as a result of decreased cases after the second wave of the pandemic.²⁰

Recommendations

- 1. Improve communication and coordination between federal, state, and local government.** Ensure providers have clear, accurate, and timely information regarding changes to vaccine supply, distribution processes, and response plans.
- 2. Enable providers to carry out on-the-ground response and manage influx of patients with resources and funding.** Specifically, ensure that border communities are equipped to vaccinate unexpected cohorts of individuals.
- 3. Collaborate with other community and social entities to pool resources, disseminate information, and vaccinate individuals.** Stakeholders in McAllen successfully collaborated with fire fighters to implement H1N1 mass immunization efforts. The county health department also worked with community clinics and schools to conduct health fairs and administer free vaccinations.
- 4. Optimize use of Immunization Information Systems.** Utilize IIS to chart the distribution of interventions, including the administration of vaccines and anti-viral medication, and to report doses administered to CDC's Countermeasure and Response Administration (CRA) system.
- 5. Encourage clear and straightforward information to dispel myths and misperceptions.** Ensure consistent messages are relayed in a timely manner about the nature of the threat and vaccine prevention measures.

VIII. Reduce Costs and Increase Reimbursement for Vaccines

Background

With the advent of new, expensive vaccines and the push by managed care to reduce cost, there is a strong concern that immunization providers will stop providing vaccinations due to financial constraints.²¹ Recent studies show a wide differential in the prices paid by immunization providers and the reimbursements received for vaccination services.

Depending on the size and location of the practice and whether or not the practice is part of a purchasing cooperative, prices paid for identical vaccines can range from \$4 to \$30. Similarly, the reimbursements for a single vaccine can vary from \$8 to \$80.²²

In addition to covering the cost of the vaccine, providers must also pay for storage (refrigerators) and administration (syringes, needles, etc.). In many cases, insurance company reimbursements are insufficient to cover the cost and administration of vaccines. As a result, providers have chosen to terminate services or refer their patients to alternative locations.

Vaccine financing issues hinder access. A survey by the California Academy of Family Physicians reported that as a consequence of insufficient payment, some providers refer their patients to public health departments or community clinics, which pushes costs back onto the state and decreases local access to vaccines. Furthermore, many of these referred patients may not follow through with vaccination referrals, leaving them susceptible to disease.

"We want to vaccinate. We just can't afford to pay for it with such minimal payments from the insurance companies."

- Survey Respondent

What the Stakeholders Say

Seventy-nine percent (79%) of survey respondents believe that "issues related to vaccine cost or reimbursement" are a "somewhat" or "very important" barrier to increasing immunization rates in Texas. Several providers commented on the low insurance reimbursements and the high cost to store and administer vaccines. One Houston physician expressed frustration over the significant cost differential between the previous and new pneumococcal conjugate vaccine (PCV7: \$85; PCV13: \$108). Furthermore, because the new vaccine became available quickly, she was unable to renegotiate insurance reimbursement to accommodate higher costs. An Abilene provider dropped vaccination services because demand in his rural community was low, and the cost of purchasing vaccine stock and storage was inefficient.

Of survey respondents, 82% believed that "lack of provider participation in the Vaccines for Children (VFC) program" is a "somewhat" or "very important" barrier to increasing immunization rates. Because the VFC program provides vaccines to program-enrolled providers at no cost, several stakeholders believed this program should be leveraged to reduce costs associated with vaccines.

Recommendations

1. **Institute local advocacy efforts with insurance companies.** Efforts could include negotiating reimbursements for both vaccine purchase and storage, standardizing reimbursement rates, or adding profits for providers who conduct immunization services.
2. **Share best practice strategies with respect to billing, third-party payer negotiation, and purchasing powers.** Encourage providers to work with professional medical organizations to identify and incorporate efficient business practices. Enable providers with the tools to contract and bill appropriately, using correct Current Procedural Terminology (CPT) codes.
3. **Increase participation in the Vaccines for Children (VFC) program.** Promote the program to both providers and parents. Conduct outreach to providers who serve VFC-eligible children and encourage them to participate in the program. Outreach towards non-traditional providers, like obstetrician/gynecologists, is critical. Market VFC to parents as a “gold standard.”

IX. Increase Efforts to Control Pertussis

Background

Despite extensive immunization, pertussis remains one of the world's leading causes of vaccine-preventable deaths.²³ After the pertussis vaccine was introduced in the 1940s, Texas saw a dramatic decline in the disease. However, within the last five years, pertussis in Texas reached an incidence rate that had not been seen in approximately 40 years.²⁴ In 2009, approximately 3,358 cases were reported, an increase of over 1,300 cases since 2008.²⁵

This increase is partly due to an increasing number of cases in adolescents and adults who have lost their immunity from their childhood vaccines and need booster vaccines. In 2006, the Centers for Disease Control and Prevention recommended a “cocoon” vaccination strategy to reduce the incidence of pertussis. The cocooning strategy focuses on protecting newborns against the disease by vaccinating adult caregivers and others who come into contact with infants.

What the Stakeholders Say

Stakeholders were somewhat familiar with the concept of cocooning—efforts were cited at some clinics in the Rio Grande Valley and at a large birthing hospital in Houston. A stakeholder from a private pediatrics office indicated that management used the cocooning effort to vaccinate all office staff with the Tdap (tetanus, diphtheria, and pertussis) booster.

“VFC providers have safety measures and standards in place typical providers may not. They receive specialized training and technical assistance to ensure vaccines are safe and effective. Consumers need to know VFC is a ‘gold standard.’ If the parents start asking their pediatricians if they are a VFC provider, providers may be motivated to sign up.”

- Kurt S. Becker,
Immunization Program
Manager, City of
Austin HHSD

A physician in San Antonio also wrote to us about how he is attempting to partner with the city health department to promote postpartum Tdap vaccination in the University Hospital. Funds have already been allocated for a program targeting pre-partum women.

Although efforts are underway in some areas of Texas, because the tactic is generally new, there was a general impression that cocooning is not widely used. Some stakeholders expressed interest in the strategy, but questioned the implementation process.

Recommendations

- 1. Increase access to free or low-cost adult vaccines.** Collaborate with alternative providers to provide free or low-cost adult vaccines (including Tdap) in locations that are convenient for family members and household contacts of newborns.
- 2. Institute policies to administer Tdap vaccination to postpartum women in birthing hospitals.** The California Department of Public Health conducted a study to determine the impact on pertussis incidence in birthing hospitals that instituted Tdap policies. Overall incidence in all facilities with a Tdap policy declined significantly after policy implementation. Results also showed a significant decline in pertussis incidence over time, from 2006 (when no postpartum Tdap policies existed) to 2009.²⁶
- 3. Share best practice strategies for designing and implementing cocooning efforts.** Several hospitals across Texas have successful cocooning efforts in place, including LBJ in Houston and Parkland Health and Hospital System in Dallas. Encourage agencies interested in implementing cocooning efforts to work collaboratively with those that have effective systems in place.
- 4. Educate women to seek vaccination before getting pregnant or immediately after giving birth.** Work collaboratively with maternal and child health programs to educate women of child-bearing age about the importance of the pertussis booster.

"From my limited research, this important 'cocooning' effort does not exist anywhere around town, despite recommendations from the CDC and more recent support from American Society of Obstetrics and Gynecology."

- Physician from
San Antonio

X. Increase Access to Adult Immunizations

Background

The need for immunizations does not end at adulthood. About 95% of the 50,000 Americans who die every year from vaccine-preventable diseases are adults.²⁷ Several adults require vaccinations due to factors such as age, gender, lifestyle, type and locations of travel, overall health, and previous immunization.²⁸ While Medicare covers influenza and pneumococcal vaccines for adults age 65 or older, no federal programs comparable to the children's VFC Program exist to help adults who may not have access to good medical care or cannot afford recommended vaccines.²⁹

What the Stakeholders Say

According to our stakeholders, adults often do not get vaccinated due to lack of awareness about what vaccines are recommended, high costs associated with vaccination, and limited access to adult vaccines. These barriers make it challenging for adults to get necessary vaccinations for employment and college. Stakeholders in Houston said that not all physicians supply the newer vaccines like H1N1 or HPV (human papillomavirus vaccine). In Brownsville, stakeholders explained that some clinics stock adult vaccines but require adults to be established patients in order to receive vaccines. Documentation continues to be an issue, especially when adults are immunized in alternative settings.

Recommendations

- 1. Provide referral sources on where adults can access free or low-cost immunizations.** DSHS recently expanded their adult immunization safety net program, whereby uninsured and underinsured adults can receive routine vaccinations at local or regional health departments, STD or HIV centers, family planning clinics, federally qualified health centers, jails, or substance abuse centers.
- 2. Reinforce to patients the need for adult immunizations.** Encourage adults to incorporate vaccination into comprehensive preventive care plans.
- 3. Encourage continuous education among providers.** Ensure that providers are knowledgeable about new and existing recommendations and can adequately educate their patients.
- 4. Broaden the pool of providers who can administer vaccines.** To expand vaccine availability, encourage alternative providers such as obstetrician/gynecologists and pharmacies to administer vaccines. Also, identify opportunities to collaborate with agencies that serve high-risk adult patients, including STD clinics, drug treatment centers, domestic abuse shelters, and violence prevention programs.

APPENDICES & ENDNOTES

APPENDIX I: METHODOLOGY FOR WEB-BASED SURVEY

The 2010 Web-based survey sought to gather information and perspectives from immunization stakeholders familiar with immunization issues and Immunization Information Systems in Texas. It was the third of its kind and again it was sponsored by the St. David's Foundation.

Staff from The Immunization Partnership, with assistance from Texas Department of State Health Services, the Public Health Informatics Institute, and Nybeck Analytics, constructed the 2010 survey. They used questions from the surveys administered in 2006 and 2008 and chose topics deemed important at the 2010 stakeholder meetings. Five experts in immunization, immunization registries, or survey research piloted the survey and offered valuable feedback that was incorporated. The online survey was administered using SurveyMonkey.

On June 29, 2010, staff from The Immunization Partnership sent emails to immunization stakeholders on its mailing list, inviting them to complete the survey. Over 1,800 people are on this list. Many on the mailing list are people who actively use Immunization Information Systems. They include people who work for city and county health departments, school district health departments, private non-profit clinics, private for-profit doctors' offices, clinics, and hospitals. Other invitees include foundation staff members and representatives of the Texas Pediatric Society, Texas Academy of Family Physicians, Texas Medical Association, Gateway to Care, and Center for Health Training. The email invitation encouraged people to forward the link to their colleagues. The Immunization Partnership staff sent email reminders to complete the survey on July 6 and July 13.

Some 536 respondents completed the survey from June 29, 2010 to July 16, 2010. The survey took about 5 to 10 minutes to complete. Fifty-seven (57%) percent of respondents reported they were healthcare providers; 42% said they were in administrative or managerial positions. Among providers, 35% said they were registered nurses, and 21% were physicians. Some 38% of people who completed the survey participated in at least one of the ten stakeholder meetings hosted by The Immunization Partnership throughout Texas in 2010.

The purpose of the survey was to collect information from immunization stakeholders familiar with immunization issues in Texas and The Immunization Partnership. Each response represents an important view that any number of people may share. The percentages shown in the tables can act as a guide to interpreting the salience of the issues. Findings in this report represent individual responses, and some of the respondents may work in the same clinic or office.

APPENDIX II: HOW STAKEHOLDER MEETINGS WERE CONDUCTED

During the spring and summer of 2010, The Immunization Partnership and Frontera Strategy conducted a series of stakeholder meetings across Texas. Ten meetings were held in Abilene, Austin, Brownsville, Houston, El Paso, San Antonio, Dallas, Fort Worth, Galveston, and McAllen.

The goals of the stakeholder meetings were to make people aware of current events in immunization on the state and national front, determine local concerns, share advocacy strategies and techniques, and identify policy priorities for 2011. The stakeholder meetings also promoted the 3rd Texas Immunization Summit and continued to build the statewide network of Texans interested in improving immunization policies and practices.

The Immunization Partnership collaborated with local immunization coalitions, government entities, and statewide medical/pediatric associations to assist in the planning, coordination, and implementation of the stakeholder meetings. Participants were recruited by local champions in the communities where the meetings were held. Recruitment included: 1) flyers strategically distributed by local constituents, 2) outreach during special events, including the Texas Medical Association (TMA), Texas Pediatric Society (TPS), and Texas Immunization Stakeholder Working Group (TISWG) meetings, 3) promotion in TMA and TPS newsletters, 4) compilation of lists from existing client databases, and 4) word-of-mouth promotion.

Stakeholder meetings in 2010 addressed these topics: implementation of electronic medical records, improvements to ImmTrac, evaluation of local and state responses to H1N1, HPV, vaccine preparedness, vaccine hesitancy, vaccine reimbursement, and concerns specific to the border region. Participants had the opportunity to raise additional concerns and ideas. Careful notes were taken at each session to ensure that emerging trends and themes could be included in the proceedings of the summit. All participants gave their contact information, received invitations to the summit, and helped to disseminate information about the summit and the related Web-based survey.

More than 412 Texans participated in the meetings including parents, healthcare providers, state agency personnel, and representatives from hospitals, foundations, medical associations, local public health authorities, and pharmaceutical companies. Events were scheduled at times and places convenient to the broadest range of participants possible.

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RESOURCES

For more information on immunization, please visit the following Websites:

American Academy of Pediatrics

<http://www.aap.org/immunization/>

Centers for Disease Control and Prevention

<http://www.cdc.gov/vaccines/>

Center for Vaccine Awareness and Research, Texas Children's Hospital

<http://www.texaschildrens.org/carecenters/vaccine/default.aspx>

Every Child By Two

<http://www.ecbt.org/>

Immunization Action Coalition: Vaccination Information for Healthcare Professionals

<http://www.immunize.org/>

Immunization Branch, Texas Department of State Health Services

<http://www.dshs.state.tx.us/immunize/>

Immunize Texas

<http://www.immunizetexas.org/>

National Network for Immunization Information (NNii)

<http://www.immunicationinfo.org/>

The Immunization Partnership

<http://www.immunizeUSA.org/>

PKIDs (Parents of Kids with Infectious Diseases)

<http://www.pkids.org/>

Vaccine Education Center, Children's Hospital of Philadelphia

<http://www.chop.edu/service/vaccine-education-center/home.html>

For online copies of this report, visit The Immunization Partnership's Website at www.immunizeUSA.org.



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