

# The BUZZ



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## Vaccine Preventable Disease-Varicella then and now

### ELIZABETH CHAPMAN-LAWRENCE

When Elizabeth Chapman-Lawrence decided to vaccinate her children, she based her decision on a harrowing experience from her adolescence.

At 14, Elizabeth came down with chickenpox. After missing 3 weeks of school, she recovered and went back to class. However, months later, while at summer camp, Elizabeth’s left eye began to hurt and became so irritated that she couldn’t keep it open. When she went to the camp clinic she was diagnosed with pink eye. But her mother knew something was amiss when she picked her up, and she took her straight to a doctor.



The doctor couldn’t determine the cause of Elizabeth’s illness. Elizabeth spent almost 2 years on antibiotics and steroid drops, while her eye continued to deteriorate. She lost almost all vision in the eye. Still she did not have a diagnoses.

After two years, Dr. Jeff Lanier at Houston Eye Associates realized that Elizabeth’s condition was caused by a repeat chickenpox infection that had attacked her eye. When Elizabeth was 17, she had a cornea transplant that resulted in 64 stitches in her eye, 32 of which are permanent. As a result of the surgery, she was home schooled for three months, forcing her to give up extracurricular activities and leaving her feeling socially isolated.

Although it wasn’t available when Elizabeth was a child, the varicella, or chickenpox vaccine is now available and recommended for infants 12 to 15 months old, with a booster dose at age 4 to 6 years of age.

When it comes to her children, Elizabeth says she knows all too well the dangers of not vaccinating. She isn’t willing to take that chance with her children’s health.

“There’s no reason to have a vaccine-preventable disease,” she says. “It’s on thing you can eliminate from your list of worries.”

Elizabeth carries daily reminders of the perils of vaccine-preventable disease. Due to the uneven scar tissue in her eye, she had to wear glasses until last spring when she was finally able to be fitted for contacts. She continues to be sensitive to sunlight, and her eye often reddens and droops.

“Talk to your doctor,” Elizabeth urges. “Don’t just listen to media and news hype; really think about the consequences of not vaccinating. Why subject your child to dangers that can be avoided?”

*Complications from varicella are much more frequent among persons older than 15 and infants younger than 1. Courtesy Texas Children’s Hospital Center For Vaccine Awareness & Research*

**WELCOME NEW PROVIDERS!**

**KSWEBIZ PROVIDERS**

- Highland Med Clinic- Highland
- Downtown Clinic- Frankfort
- E.C. Tyree Clinic- Wichita
- Wesley Peds Clinic-Wichita
- Centralia Med Clinic-Centralia

**HEP B HOSPITALS**

- Gove County Medical
- Providence Medical Center

**KSWEBIZ SCHOOL MODULE**

USD 234 - Fort Scott
USD 235 - Uniontown
USD 246 - Northeast
USD 247 - Cherokee
USD 250 - Pittsburg
USD 252 - South Lyon
USD 253 - Emporia
USD 257 - Iola
USD 330 - Mission Valley
USD 404 - Riverton
USD 417 - Morris County
USD 436 - Caney Valley
USD 445 - Coffeyville
USD 446 - Independence
USD 447 - Cherryvale
USD 484 - Fredonia
USD 493 - Columbus
USD 499 - Galena
USD 503 - Parsons
USD 504 - Oswego
USD 506 - Labette Co.
USD 508 - Baxter Springs

## School's Out and In in 3 short months



With summer vacation for students just around the corner, we would like to remind everyone of the changes in immunization requirements for the upcoming 2009-2010 school year.

Immunization requirements and recommendations for the 2009-2010 school year are based on the Advisory Committee on Immunization Practices (ACIP) recommendations.

K.A.R. 28-1-20 defines immunizations required for any individual who attends school or early childhood programs operated by a school.

[http://www.kdheks.gov/immunize/download/KS\\_Imm\\_Regs\\_for\\_School\\_and\\_Childcare.pdf](http://www.kdheks.gov/immunize/download/KS_Imm_Regs_for_School_and_Childcare.pdf)

- **Diphtheria, Tetanus, Pertussis (DTaP):** five doses required. Four doses acceptable if dose 4 given on or after the 4<sup>th</sup> birthday. Booster dose of Tdap required at age 11. Students who will be 12 years of age on September 1, 2009 should have documentation of Tdap if more than 2 years since previous dose of Td.
- **Poliomyelitis (IPV/OPV):** four doses required. Three doses acceptable if dose 3 given on or after the 4<sup>th</sup> birthday.
- **Measles, Mumps, Rubella:** two doses required.
- **Hepatitis B:** three doses required through grade 9.
- **Varicella (chickenpox):** two doses required for Kindergarten; one dose required grades 1-9 unless history of varicella disease documented by a licensed physician. Two doses are currently *recommended* by the ACIP for all ages.
- **Haemophilus influenzae type b (Hib):** three doses required for children less than 5 yrs of age in early childhood programs. Total doses needed dependent on the age of the child when doses given.
- **Pneumococcal conjugate (PCV7):** four doses required for children less than 5 yrs of age in early childhood programs. Total doses needed dependent on the age of the child when doses given.
- **Hepatitis A:** two doses required for children less than 5 yrs of age in early childhood programs.



Debbie Baker



Erica Hutton



Shelly Pfeffer

Debbie, Erica and Shelly have over 33.5 years of combined experience with the KIP program, helping to keep the program running from day to day!

**HEP B INFO FROM CDC-** Since February, there have been intermittent pediatric hepatitis B vaccine supply constraints in the United States, with some local areas experiencing delays in shipments. **Despite these supply constraints, current analysis indicates that during the remainder of 2009, sufficient pediatric hepatitis B vaccine will be available to meet demand, if providers continue to order vaccine judiciously.** CDC has worked closely with the two US manufacturers of pediatric hepatitis B vaccines to understand their projections for how much vaccine will be available for the remainder of 2009. Merck expects vaccine to be limited during the remainder of 2009.

## The ABC's of VFC

GSK has planned to bring additional vaccine into the US in September or October to meet the US demand for pediatric hepatitis B vaccine in the fall and is currently working closely with CDC, sharing information about how much vaccine is planned for delivery to the US on a month-by-month basis until that time. Vaccine supply is anticipated to be tightest during the summer months. CDC will continue to monitor the supply situation carefully, in collaboration with the vaccine manufacturers. One strategy employed by CDC earlier in the year was to release some of both pediatric hepatitis B vaccines from the vaccine stockpiles. If the supply outlook changes and additional strategies are needed, such as a change in the vaccination recommendations, CDC will communicate any new strategy immediately and support its implementation. At this time, however, providers should continue to administer pediatric hepatitis B vaccine according to ACIP/AAP/AAFP 2009 immunization schedule. We are most likely to be successful in maintaining the ability to provide 3 doses of hepatitis B vaccine to all infants and toddlers on schedule if immunization providers continue routine ordering practices for hepatitis B vaccine.

## BeeWise takes flight around Kansas

National Infant Immunization week was held April 25<sup>th</sup> through May 2<sup>nd</sup> with several events being held across the state. BeeWise logged over 750 miles during this week at the following events:



Bee and Edgar the Elephant were present to entertain the children.

**Reno CHD- Kathy Winger-** Reno County Health Department participated in "Week of the Young Child" activities April 19 through the 25<sup>th</sup>. On Friday, April 24<sup>th</sup>, the Family Children's Theatre presented "The Cat In The Hat" movie at Memorial Hall in Hutchinson. The Health Department provided information on Lead, Safety, Dental Health and Immunizations. The BeeWise Immunize



**Mitchell CHD- Pat Dowlin-** We had about 250 adults and 125 kids through our Health Fair April 25<sup>th</sup>. All kind of vendors and organizations set up tables and we were offering "No out of pocket Td, Tdap" we gave 92 total shots while BeeWise handed out fruit treats to kids.



**Montgomery CHD-Ruth Bardwell-**

Montgomery Co. Health Dept. staff participated in the OK Kids Fest hosted by Coffeyville Regional Medical Center. The theme this year was "Blasting Off for Health and Safety". Four hundred kids plus their parents came to enjoy the activities Saturday, May 2<sup>nd</sup>. Most activities

were indoors and the rain didn't keep them away from this annual safety and health fair event. Seventy-four organizations provided fun educational activities and prizes for the children. The health department hosted the BeeWise Bee, who gave away balloons, Frisbees and stickers which the kids always enjoy, and educational information on the 6 P's of swimming safety was provided. We also provided the parents with information about services available at the health department and the current topic "H1N1 influenza prevention". The day was a great success and we are looking forward to next year's event.



[http://www.kdheks.gov/immunize/vfc\\_program.html](http://www.kdheks.gov/immunize/vfc_program.html)

Placing larger-than-normal orders to build a stock of vaccine is discouraged. As you know, changes in vaccine purchase patterns based on concerns about vaccine supply can worsen the nationwide supply situation. The continued judicious purchase of pediatric hepatitis B vaccine during the remainder of 2009 will help manage through the tight supply anticipated in the summer months and assure that US providers can continue to protect all children by following the routine 3-dose schedule.



**Governor's Birth Card Project-** The current Birth card Project Partnership between the Kansas Immunization Program, Hallmark and the Governor's Office will discontinue for approximately 6-8 weeks while we update, print and receive the new cards. Each year this project sends out nearly 44,000 cards to the parents of new babies congratulating them on the birth of their child and promoting the importance of getting their new baby immunized.



## Utilizing best practice tools helps provider raise rates 31%



*Submitted by Mollie Shriver, RN– Immunization Clinic Coordinator, Salina Family Healthcare Center*

In evaluating our immunization program, the first thing we really identified is that we didn't have a true immunization program with a single leader to oversee the process. Our process was reactive and provider-driven, relying on the physicians and physicians assistants to remember to check immunizations at acute care and well child examinations, identify those in need and relay that information to the nurses. As such, the first thing we did was to create an immunization nurse position and put that person in charge of leading the development of a true immunization program and then maintaining it. Responsibilities include establishing a process to proactively identify children in need of immunizations, working with parents to create catch-up schedules for children who are behind, managing the vaccine inventory, entering patients/immunizations into our electronic immunization registry, and doing most of the day-to-day immunization administration and patient/parent teaching. Although all of our nurses, and now most of our medical assistants, are capable of and often help administer immunizations, this established a single "go-to" person to clarify lines of communication and organize the program. The immunization nurse also maintains contact with the Kansas Department of Health and Environment (KDHE), the Saline County Health Department, and other local clinics to share immunization records, best practices and updates.

One of the initial and perhaps biggest barriers to improving our immunization rates that we identified is the transient nature of a significant portion of our patient populations. As a community health center, many of our patients are transient, subsequently limiting the opportunities we have to address their children's immunization status. We felt in order to overcome this barrier we had to develop a proactive system that addresses immunization status at every visit a child makes to the clinic, whether for an acute care problem or ongoing wellness and prevention visits. Our process begins with our immunization nurse pulling the shot records, whether from our old paper charts or from our immunization registry, for every child being seen in our office everyday at least a half-day prior to their visit. She then identifies the children that are in need of immunizations and communicates that need to both the medical assistants and the providers and schedules immunizations for those patients. The needed immunizations are then given on that day at that visit. At that time, she also works with the parents of all children who are behind by more than one series of immunizations to develop a written plan for bringing them up to date. Appointments are then made for specific dates according to the plan. A copy of this catch-up schedule and appointments is then given to the parent and a copy is scanned into our electronic medical record (EMR). Our operator then calls all patients with a courtesy reminder the day before the appointment.

The above process has made our clinic more proactive about administering immunizations at the time of office visits, but does not identify the children who are seldom seen in our office and who are behind on their immunizations. We were relying on parents to remember to bring their children in at the appropriate times for their immunizations. To address this barrier, our immunization nurse attended training with the Kansas Web IZ immunization registry personnel to learn how to use the Co Casa data reporting system to actively use the information contained in the immunization registry. This has allowed our immunization nurse to export data from our on-line immunization registry and import it into the Co Casa system; allowing her to run multiple helpful reports including one that identifies patients that are behind on their immunizations. This report is generated and reviewed monthly by our immunization nurse and the patients identified as behind are contacted to make appointments to get caught-up. These appointments and charts are flagged within our EMR to ensure follow-up should the children not be brought in for their immunizations.

As we made the above changes, we felt it important to ensure that all nursing staff and providers were well versed in the most recent immunization practice knowledge. We had the nursing staff and providers attend a training offered through the Maximizing Office Based Immunizations (MOBI) program. Education included indications and true contraindications to immunizations, updated schedules, catch up schedules, information on how many immunizations can be administered at one visit, process to streamline immunization administration within the office and strategies for engaging parents to bring their children in for immunizations.

The MOBI program has been an important part of our efforts to improve our immunization rates. Some of the things we learned in that training have been beneficial in helping us to overcome the barrier of getting parents and children to come back for their immunizations. First and foremost, we recognized the need to develop an efficient and systematic approach to make the immunization visit as short as possible and as positive an experience as possible. If the process takes too long, children begin to develop an escalating anxiety about their immunizations. This anxiety increases exponentially if the immunizations are set up in the room in front of the child. As such, we prepare everything prior to the visit outside of the room and go into the room with everything ready to quickly and efficiently administer the immunizations to not allow time for negative anticipation to build. We also use multiple nurses or a nurse and medical assistant team when giving multiple immunizations to ensure quick administration of the immunizations. Shots are divided equally and the nurses or nurse and medical assistant each administer immunizations at the same time. All children then receive a prize after their immunizations as a reward for coming in and to make the visit less frightening. The prizes are provided to us free of charge through the Immunize to Win a Prize program offered through the KDHE. This program includes an incentive for the parents to get their child immunized. Any family whose child completes their 1 year immunization series by age 2 is entered in to a drawing for \$400 of their utility bills to be paid for them.

By developing a proactive system that has open lines of communication among all of the health care team and that utilizes available technology in the EMR and patient registry to provide an efficient, positive immunization experience with some extrinsic incentives for children and parents alike, we have made significant improvements in our immunization process. The result of this process improvement has been remarkable improvement in immunization rates for our practice as a whole, and a healthier patient population.

*During this time period of March 2008 through March 2009 Salina Family Healthcare's 4-3-1-3-3-1 compliance rate has increased 31%.*

## Adhering to vaccine schedule is best way to protect children from disease



by Margaret C. Fisher, M.D., FAAP,



and Joseph A. Bocchini Jr., M.D., FAAP

**Vaccination rates** are at a record high level, and rates of almost every vaccine-preventable disease continue to drop. Now that we are seeing fewer infections, however, we are beginning to encounter more hesitancy in vaccine acceptance. Parents are asking: Why is the vaccine schedule one size fits all, why so many vaccines, why start so early, why not spread out the schedule? Following is information regarding the development of the vaccine schedule and the rationale behind it. The vaccine schedule is published yearly in January; on occasion, the schedule has been updated during the year. These schedules are developed by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with input from the AAP Committee on Infectious Diseases and the American Academy of Family Physicians (see sidebar). The vaccine schedule undergoes vigorous scientific and evidence-based review each year. The schedule is designed to protect children from vaccine-preventable diseases as soon as possible and is appropriate for the majority of children.

### Why is the schedule one size fits all?

Decisions regarding an individual child's immunizations are not one size fits all. Exceptions to the schedule are made when there is a reason to delay or omit a vaccine. Contraindications and precautions are taken into account for each vaccine in the series and at the time of each dose. Additional vaccine strategies are utilized in patients with special clinical circumstances, such as immunocompromised children and those with chronic diseases. Furthermore, the schedule is adjusted for situations such as planned international travel and for catch-up.

### Why so many vaccines?

To us, this is part of the good news. Now, we can prevent 16 serious illnesses and their consequences in girls and 15 in boys through routinely recommended immunizations. Making it possible for their children to receive vaccines is one of the important ways parents can keep their children healthy. In fact, we look forward to when we will have vaccines to prevent or modify infections due to respiratory syncytial virus, *Staphylococcus aureus*, *Streptococcus pyogenes* and other agents.

### Why do some vaccines require multiple doses?

Immunity following a single dose of some vaccines is either incomplete or short-lived. Using a series of doses improves the percentage of patients who develop immunity and the duration of such immunity. These vaccines also require booster doses to maintain long-term protection. Some people are concerned that giving a number of vaccines at the same time may not be safe. However, prior to vaccine licensure, the Food and Drug Administration requires studies to evaluate the safety and response to the new vaccine when the other vaccines recommended for that age are given at the same visit. The studies also must evaluate whether the new vaccine alters the response to the other vaccines. This information is reviewed carefully before decisions are made about adding a vaccine to the schedule.

### Why start so early?

The decision as to when to give a vaccine is based on the epidemiology of the vaccine preventable disease. Often, these diseases are more severe in younger children. Therefore, we start early to ensure that the youngest and often most fragile are protected as soon as possible. For example, most deaths due to pertussis occur in infants younger than 6 months of age. The peak incidence of meningitis due to *Haemophilus influenzae* type b before the introduction of conjugate vaccine was approximately 9 months of age. Prior to birth, a baby receives antibodies from the mother. These maternal antibodies provide protection against many of the previously "usual childhood infections" such as measles, mumps and chickenpox, and bacteria such as *H. influenzae* and *Streptococcus pneumoniae*. The levels of these antibodies decrease with each month of age so that by 6 months, protection is minimal. The vaccine schedule ensures that while the levels of maternal antibody are falling, infants are developing their own antibodies due to immunizations. The goal is to protect the infant as soon as possible; the current schedule has essentially eliminated *Haemophilus* and greatly decreased the incidence of invasive pneumococcal disease. For measles, mumps, rubella and varicella, we wait until all maternal antibody is gone so that these live vaccines are not inactivated by residual maternal antibody. Because of the success of vaccines, the incidence of these viral infections is quite low so there is little risk of infection in the first year of life. However, if vaccination rates fall and measles outbreaks increase as they have this past year in the United States, we will begin to see more cases of measles not only in children whose parents refuse vaccination but also in children too young to receive the vaccine.

### Why not spread out the schedule?

Spreading out the schedule would leave a child unprotected. Furthermore, there is no reason to expect that spreading out the schedule would decrease adverse events. Spreading out the schedule also would increase the number of visits to a physician and would increase the number of visits that require an immunization. Such a schedule would increase the number of unprotected children in the population, which would decrease the benefits of herd immunity. Since there is no advantage but several disadvantages, there is no logic to spreading out the schedule. Parents who are considering delaying their child's immunizations need to be made aware that they are putting their child at risk. Although the incidence of most vaccine-preventable diseases in the United States is very low, they are low because the majority of U.S. children are immunized. As a result, the circulation of many of these organisms has been interrupted. However, these pathogens can be reintroduced easily into a population as a result of today's mobile society. If enough children are not immunized, we will see outbreaks of these vaccine-preventable diseases. In areas of Great Britain where measles immunization rates have decreased, outbreaks are occurring, prompting mass immunization campaigns. Similarly, pertussis outbreaks occurred within a few years in countries where pertussis immunization was discontinued. Immunizations have been a major public health success story. The vaccine schedule has evolved over the past 50 years based on scientific evidence. Following this schedule is the best way to protect your patients from these diseases. Please continue to encourage your families to have their children immunized on time; children are our future, and it is our job to protect them.

*Dr. Fisher is chair of the AAP Section on Infectious Diseases executive committee. Dr. Bocchini is chair of the AAP Committee on Infectious Diseases. Article from 2009 AAP News*





# Just Lookin' Around!



The Mid America Immunization Coalition (MAIC) will be hosting their 2009 Immunization Symposium on Friday June 19th! There are several great speakers scheduled featuring Dr. William Atkinson from CDC. Please click here to register and for more information: [www.mchc.net](http://www.mchc.net)



## SAVE THE DATES



**"Communicating The Facts"**  
**Kansas Imm Program State Conf.**  
 October 14-16, 2009  
 Hyatt, Wichita KS

**2009 School Nurse Conference**  
 July 20-23, 2009  
 Hyatt, Wichita

★ **MAIC** ★  
 2009 Symposium  
 Friday June 19th,  
 Ritz Charles Conf. Fac  
 Overland Park, KS

**KAFP Conference**  
 June 18-19, 2009  
 Marriott, Wichita KS

**KPHA Conference**  
 September 22-24, 2009



**Kansas Family Planning Conference**  
 June 10-11, 2009  
 Marriott, Wichita

**KAAP Fall Conference**  
 September 10-11, 2009  
 Marriott, Wichita



Stats as of May 5th, 2009

Number of Providers Live = 217

Private = 132

Public = 85 (52 direct entry, 33 interface)

Number of Patients = 1,421,839

**Number of Vaccinations = 10,233,538**

Save the Date  
 October 14-16, 2009  
 KANSAS IMMUNIZATION PROGRAM  
 ANNUAL CONFERENCE  
 "Communicating the Facts"  
 Hyatt Regency, Wichita, KS  
Sponsored by Kansas Department of Health & Environment  
 and The University of Kansas Medical Center Area Health Education Centers

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