Immunization Barriers In A Family Practice Residency Clinic

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Background: Underimmunization was the primary cause of the 1990 measles outbreak in the United States. We examined the level and causes of underimmunization in a family practice residency clinic that received free vaccine supplies from the county health department.

Methods: The office computer selected 286 patients aged 2 to 3 years. From these 286 patients, 175 were sampled. Their charts were audited for immunization barriers, looking specifically for (1) valid reasons; (2) overly cautious interpretation of contraindications, especially minor illnesses; (3) missed opportunities (failure to address immunization status during acute care visits or lack of simultaneous vaccine administration); (4) parental refusal; and (5) delayed immunizations resulting from gaps in clinic attendance.

Results: There were 174 delayed doses; 90 were due to gaps in clinic attendance, 42 due to valid reasons, 33 due to invalid contraindications, and 25 due to missed opportunities. Some doses were delayed on more than one occasion and for more than one reason. Two parents refused initial immunizations, claiming that the children were too small.

Conclusion: Important causes of delayed immunizations in this residency clinic were gaps in attendance, overly cautious interpretations of contraindications, missed opportunities, and lack of simultaneous vaccine administration. (J Am Board Fam Pract 1994; 7:100-4.)

The United States experienced a major measles epidemic in 1990 involving 27,786 cases and 89 deaths, despite the ready availability of an effective vaccine for its prevention. Major outbreaks of other vaccine-preventable diseases, such as pertussis and mumps, have occurred as well.

According to the National Vaccine Advisory Committee (NVAC), inadequate immunization was the principal cause of the measles outbreak. Almost one-half (44 percent) of the measles cases reported in 1990 occurred in unimmunized children who were old enough for immunization. Childhood immunization rates at 2 years of age were low in many areas, as reflected by completion rates of 10 percent, 27 percent, 38 percent, and 38 percent for 2-year-olds in Houston, Miami, Washington, DC, and Oakland, respectively. NVAC viewed the measles epidemic as a sentinel measure of the efficacy of vaccine delivery and has predicted that outbreaks of other vaccine-preventable diseases will occur.

The major causes of inadequate immunization levels have included high cost, lack of insurance, the number of injections, lack of access to medical care, fear of litigation, safety concerns, immunization barriers within the health care system, missed opportunities by providers to administer vaccines, and inadequate public awareness. Surveys of parents have shown the importance of physician advice in patient acceptance of polio, measles, and pertussis vaccines. Physicians cannot directly change some barriers, such as vaccine cost, but there are areas in which physicians can make a difference. Three of these areas involve immunization barriers: overly cautious interpretation of vaccine contraindications, missed opportunities to address immunization status, and lack of simultaneous vaccine administration.

Many providers have been overly cautious in interpreting vaccine contraindications. For instance, in Minnesota many physicians (30 percent and 34 percent, respectively) would not administer measles-mumps-rubella (MMR) vaccine to a child with a minor illness, such as an upper respiratory tract infection with a temperature of
The computer has a patient status report for every patient at the FPRC. The status report contains on-line data about the patient's birth date, problem list, medications, immunizations, and health maintenance information. It is updated at each patient visit, based upon the physician's dictation regarding that visit.

Printed copies of the report for each (100 percent) of the 175 children were reviewed to assess the timeliness of DTP-1, DTP-2, DTP-3, DTP-4, and MMR-1. A dose was defined as "on time" if it was given within 1 month of recommendations.4,16 For DTP-4, 18 months was considered acceptable.17 If a child had one or more late immunizations, the principal investigator audited the patient's personal chart. Only one discrepancy in immunization dates was found between the patient charts and the status report. For that instance, chart data were used. For each late dose, the length of delay in administration and reason(s) for the delay were recorded by hand onto preprinted forms. Reasons for delays were categorized as (1) valid (e.g., valid contraindication or awaiting transfer of immunization records from another provider to FPRC), (2) invalid, (3) immunization administered by another clinic, (4) missing data about that immunization, and (5) parental refusal. Invalid reasons were subdivided as invalid contraindications, missed opportunities (e.g., immunization status not addressed during visit for a mild, acute illness or lack of simultaneous vaccine administration), and gaps in patient attendance at the clinic. Because more than one patient visit could occur after a child was eligible for a vaccine but before the child received it, more than one invalid reason could apply per dose. Invalid contraindications were defined from published references18,19 and typically involved a minor illness with a temperature less than 38.3°C (101.0°F) rectally or 37.8°C (100.0°F) axillary. Gaps in clinic attendance were defined as lack of attendance at the clinic during the recommended time for immunization,16,17 with a 1-month grace period. If no immunization data were available for a particular dose in the chart or status record, that dose was labeled as missing. Generally, missing doses indicated a child who either came to the FPRC at a later age and was fully immunized or a child who left the FPRC for another clinic. Five children had only one visit to the FPRC and did not have any immunization data on record; these children were excluded from further analyses, leaving 170 for the main analyses.
For children whose immunizations were late, their ages at immunization were calculated during chart audits. Because these age distributions were skewed \((P < 0.05)^20\), median values were reported instead of mean values. Data were analyzed using the Statistical Analysis System\(^21\) on a mainframe computer.

**Results**

Of the 170 children, 90 were boys and 80 were girls. Insurance coverage for the 170 children included Medicaid (75 percent), commercial insurance (17 percent), and self-pay/Hill Burton (8 percent).

The number of late immunizations for the 170 children ranged from 12 (7 percent) for DTP-1 to 56 (33 percent) for MMR-1 (Table 1). For children whose immunizations were late, the median age at DTP-3, DTP-4, and MMR-1 was 10, 24, and 18 months, respectively.

The principal causes of late immunizations, in descending order, were gaps in clinic attendance, valid reasons, invalid contraindications, and missed opportunities. Many doses were delayed more than once because of repeated invalid contraindications or lack of addressing immunization status at clinic visits (Table 2). Lack of simultaneous administration was considered a missed opportunity and occurred for 9 doses.

Immunizations for two children were delayed because of parent refusal. One parent refused DTP-1 on three occasions but later consented. Another parent did not bring in the child for the first well-child visit until 8 months of age because of concerns about vaccine safety in young infants.

**Discussion**

The principal cause of delayed immunizations was gaps in clinic attendance. Possible reasons for gaps in attendance include family dysfunction, lack of knowledge about the routine well-child care schedule, lack of awareness about immunizations, and transportation difficulties.

Recall or reminder systems are a solution to gaps in clinic attendance. Both mailed reminders\(^{22-24}\) similar to those used by dentists, and telephone reminders\(^25\) are effective. Comparative studies have shown that reminders which specifically list the individual and vaccine needed are more powerful than those which generally encourage up-to-date immunizations but do not list a patient's deficiencies\(^{26,27}\).

Overly cautious interpretation of contraindications was an important immunization barrier in this study and in others\(^9,12,13\). Minor illnesses are not valid contraindications according to the National Vaccine Advisory Committee and the Immunization Practices Advisory Committee, but they are important times to administer vaccines\(^{16,19,28}\). User-friendly lists of valid and invalid contraindications are available in the Standards

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**Table 1. Age-Appropriateness of Childhood Immunizations and Reasons for Delayed Immunizations for 170 Children.**

<table>
<thead>
<tr>
<th>Age-Appropriateness and Reasons for Delays</th>
<th>Number of Vaccine Doses</th>
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<tbody>
<tr>
<td>On time</td>
<td>131 DTP-1, 107 DTP-2, 98 DTP-3, 119 DTP-4, 87 MMR</td>
</tr>
<tr>
<td>Late</td>
<td>12 DTP-1, 34* DTP-2, 44* DTP-3, 28* DTP-4, 56* MMR</td>
</tr>
<tr>
<td>Valid reason</td>
<td>1 DTP-1, 9† DTP-2, 12‡ DTP-3, 9 DTP-4, 11 MMR</td>
</tr>
<tr>
<td>Invalid contraindication</td>
<td>2 DTP-1, 9 DTP-2, 9 DTP-3, 6 DTP-4, 7 MMR</td>
</tr>
<tr>
<td>Missed opportunity</td>
<td>1 DTP-1, 1 DTP-2, 4 DTP-3, 9 DTP-4, 10 MMR</td>
</tr>
<tr>
<td>Gap in clinic attendance</td>
<td>8 DTP-1, 16 DTP-2, 22 DTP-3, 10 DTP-4, 34 MMR</td>
</tr>
<tr>
<td>Immunization given elsewhere</td>
<td>26 DTP-1, 29 DTP-2, 27 DTP-3, 19 DTP-4, 22 MMR</td>
</tr>
<tr>
<td>(child transferred into or out of clinic)</td>
<td>Missing data on immunization(^\S)</td>
</tr>
</tbody>
</table>

DTP = diphtheria and tetanus toxoids and pertussis vaccine, MMR = measles, mumps, and rubella vaccines.

\(*^{Number \ of \ reasons \ exceeds \ total \ number \ late \ because \ immunizations \ can \ be \ delayed \ on \ more \ than \ one \ occasion \ for \ different \ reasons \ (e.g., \ not \ seen \ until \ late, \ then \ invalid \ contraindication \ when \ seen).}

\(†^{Includes \ children \ who \ received \ DTP-2 \ after \ 5 \ months \ of \ age \ because \ DTP-1 \ was \ late \ (DTP-2 \ was \ given \ within \ 2 \ months \ of \ DTP-1).}

\(‡^{Includes \ children \ who \ received \ DTP-3 \ after \ 7 \ months \ of \ age \ because \ DTP-2 \ was \ late \ (DTP-3 \ was \ given \ within \ 2 \ months \ of \ DTP-2).}

\(\S^{Missing \ data \ most \ likely \ occurred \ when \ a \ child \ transferred \ into \ or \ out \ of \ the \ clinic.}

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Table 2. Frequency of Various Immunization Barriers in a Family Practice Residency Clinic.

<table>
<thead>
<tr>
<th>Immunization Barrier</th>
<th>Number of Doses Late</th>
<th>Number of Visits in Which Immunization Delayed</th>
</tr>
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<tbody>
<tr>
<td>Mild, acute illness with temperature &lt; 38.3°C (101°F)</td>
<td>33</td>
<td>48</td>
</tr>
<tr>
<td>Immunization status not addressed although visited clinic and eligible for immunization</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>Lack of simultaneous vaccine administration</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

for Pediatric Immunization Practices\(^\text{19}\) and a review article.\(^\text{18}\)

Missed opportunities were important barriers to immunization in this study as in others.\(^\text{12,14}\)

Appointments for acute care visits are important opportunities to address immunization status and to administer vaccines, unless there is a contraindication.\(^\text{19}\) Office staff can routinely evaluate the immunization status of patients prior to the physician seeing the patient.\(^\text{29-32}\) This evaluation can be done at the time of registration or by nursing personnel when they obtain temperature, blood pressure, and pulse and respiratory rates. Colored stickers, checklists, computer-generated prompts, or inked rubber stamps are practical approaches to communicate the need for immunization.

Lack of simultaneous vaccine administration was only a minor problem in this study, but it has been an important barrier in other studies.\(^\text{3,15}\)

Simultaneous administration of vaccines is safe and efficacious\(^\text{31}\) and is encouraged by the National Vaccine Advisory Committee.\(^\text{19}\)

Parental refusal to accept immunization was a minor problem in this study. Media reports on alleged reactions to vaccines increased greatly in the late 1980s, leading a number of parents to fear certain immunizations, particularly pertussis vaccine. For instance, in Massachusetts, there has been a selective increase in the philosophical exemption from pertussis immunization (although DT has been acceptable).\(^\text{34}\)

Vaccine cost and reimbursement have been major barriers to immunization, but they were not factors in this study because the county provided free vaccines. Surveys of Texas, Minnesota, and Washington physicians\(^\text{13,35,36}\) found that many made referrals to public clinics because their patients were unable to afford immunizations.

A limitation of this study was our inability as a result of cost constraints to interview parents about gaps in clinic attendance and to interview physicians about immunization barriers. Because our study was conducted in a residency clinic, its generalizability could be limited. We did not include in the analyses 5 children who attended the clinic only once and who did not provide immunization histories; if these children were included, the immunization rates might be lower.

We found three important immunization barriers in a family practice residency clinic: gaps in clinic attendance, overly cautious interpretation of vaccine contraindications, and missed immunization opportunities. A concerted effort by all segments of the health care system is needed to avoid needless outbreaks of vaccine-preventable diseases.

Data analysis was conducted at the Department of Family Medicine and Clinical Epidemiology at the University of Pittsburgh.

References


