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CDC Health Advisory encourages the 3-dose primary series of Hib vaccine

On March 18, 2009, CDC issued an official Health Advisory titled "Invasive Haemophilus influenzae Type b Disease in Young Children and Importance for All Young Children to Receive 3-Dose Primary Series with Available Hib-containing Vaccine." The information below is an excerpt from the CDC Health Advisory at: www2a.cdc.gov/HAN/ArchiveSys/ViewMsgV.asp?AlertNum=00281.

Healthcare providers must be vigilant about ensuring that all young children are appropriately vaccinated with the 3-dose primary series of Hib (Haemophilus influenzae type b) vaccine. Temporary deferral of the booster dose at 12 through 15 months of age for non-high risk children may have resulted in increased Hib carriage and transmission in non-symptomatic children in Minnesota and Pennsylvania, and there is potential to see increases in cases of Hib disease at the local level.

All children should complete the primary series by 7 months of age; the number of doses required depends on the child's age when they started the series.

If the child is 5 years old or older and hasn't received any Hib vaccine, no Hib doses are needed.

There is enough Hib-containing vaccine for all U.S. children to receive the primary series. High-risk children should continue to receive the full primary series and the booster dose. Completion of the primary series with currently available vaccine products (manufactured by Sanofi Pasteur) requires a total of 3 doses of Hib-containing vaccine given at 2, 4, and 6 months. If Hib vaccine is not available in the office at the time of a visit, children who are unable to receive one of the primary series doses should be tracked and recalled to schedule an appointment to receive their dose as soon as vaccine becomes available in the office. The Hib-containing vaccine prod-

ucts that are available may not be what providers used previously in their practice; however, the potential for increased transmission of Hib makes it more important than ever that every child is adequately protected.

VFC Provider Hib Survey Results

In October 2008, the Immunization Program at Public Health–Seattle & King County conducted a survey of all of our Vaccines For Children (VFC) providers to assess the implementation of the ACIP interim Hib recommendations. Specifically, we wanted to learn about 1) completion of the primary Hib vaccine series; 2) use of Pentacel® to complete the primary series; 3) willingness to defer the 4th (booster) dose; and 4) System of tracking children who were unable to get a dose of Hib vaccine due to the shortage.

Of 310 eligible VFC provider sites, 182 (59%) returned surveys, accounting for 35,725 doses (65%) of total Hib-containing vaccine distributed through the VFC program in 2008.

Of the providers who responded to the survey, 44% reported that they did not have enough Hib vaccine to finish the primary series. About half (56%) of those providers kept a recall list, and reported a total of 1,279 doses were needed to finish the primary series. Less than half (31%) of all respondents kept a recall list for the 4th (booster) dose, and reported a total of 4,044 doses of Hib vaccine needed to complete the series.

The majority of providers (65%) reported they would not use Pentacel® (DTaP-IPV-Hib combination vaccine) for children who needed a dose of Hib but not DTaP or IPV. The main reasons for not using Pentacel® include parental hesitancy and provider concerns. However, when all three components of Pentacel® are indicated, 86% of providers will give the combination vaccine.

In summary, VFC providers in King County have encountered challenges adhering to interim recommendations during the Hib vaccine shortage, including disruptions in clinic vaccine supply, maintaining recall lists, addressing vaccine hesitancy among parents, and provider and parent objections to administration of extra antigens. Also, the use of combination vaccine formulations complicates the response to the single antigen shortage. Additional strategies are needed to improve the response to vaccine shortages and adherence to interim recommendations to optimize use of limited vaccine supplies.

To receive a full report of the survey and findings, email your request to yolanda.stetson@kingcounty.gov.

2009 Immunization Schedule Laminated Cards Now Available

The **2009 pocket-sized laminated Recommended Childhood and Adolescent Immunization Schedules** are now available. The Immunization Action Coalition of Washington makes these schedules available free of charge to providers in Washington State each year. To order copies of the laminated card, contact Debbie Nakano at deb-bien@withinreachwa.org.

The intervals for IPV and MMR on the "Catch-up schedule for children 4 months to 6 years" were inadvertently switched on the final version. Some cards were distributed before this error was found—please make the change on your card. Cards distributed from now on have been corrected manually, thanks to volunteers at Seattle Children's Hospital.



Vaccines For Children

Program News and Alerts

WHAT IS A SITE VISIT?:

Everything You Wanted to Know But Were Too Busy to Ask – Part II

(Read Part I in the March VacScene)

Following the site visit, Public Health sends you a complete document of the visit—including areas of strength as well as areas needing improvement. During the visit, we also seek information from clinic staff regarding the management of the VFC Program: what works well, where more help is needed, what systems the clinic has in place to assure program compliance. The visit is not a test, but is a conversation about the increasingly complex world of immunization practice. Public Health is there to listen, and to answer *your* questions.

We also collect patient chart information, and use CDC software to analyze it (Comprehensive Clinic Assessment Software Application or “CoCASA”). The software assesses immunization history data and can point out areas needing attention. We produce a diagnostic report listing the up-to-date (UTD) rate, missing immunizations, invalid doses and more. Of those reports, only the UTD rate is shared with the CDC. However, this is an important piece of data, because it demonstrates the effectiveness of the VFC Program in increasing immunization rates, which in turn supports continued funding. The CoCASA software is available online free to providers who wish to do their own assessments, at www.cdc.gov/vaccines/programs/cocasa/default.htm.

The follow-up documentation is likely to contain a number of recommended or required changes in practice for each provider we visit. These recommendations are offered in the spirit of cooperation and support, and do not necessarily reflect badly on the clinic; nearly every site visit results in some recommended changes. Only on extremely rare occasions have we encountered serious practice issues that require more stringent handling. When a site visit is scheduled for your clinic, please feel encouraged to call Public Health with questions beforehand; we aim to make the visit a helpful and informative experience for everyone involved.

PLEASE NOTE! STATUS SCREENING REMINDER

As of April 1, 2009, all providers enrolled in the VFC Program should have begun to screen children for “VFC status” and to document it in the patient chart. Watch for a broadcast fax/email with answers to Frequently Asked Questions regarding this new CDC requirement.

Did you know...

...about minimum intervals between doses?

- Doses administered 5 or more days earlier than the minimum interval or age of any vaccine should not be counted as valid doses and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For example, if *Haemophilus influenzae* type b (Hib) doses one and two were administered only 2 weeks apart, because the minimum interval from dose one to dose two is 4 weeks, dose two is invalid and should be repeated. The repeat dose should be administered 4 or more weeks after the invalid (second) dose. The repeat dose would be counted as the second valid dose.
- Doses administered 5 or more days before the minimum age should be repeated on or after the child reaches the minimum age and 4 or more weeks after the invalid dose. For example, if the first dose of varicella vaccine were administered at age 10 months, the repeat dose would be administered no earlier than the child's first birthday.

ERRATA from the March VacScene

- One training opportunity, for “Immunization Update—Emerging Issues” was detailed in the March *VacScene*, but two were listed under “In this issue” on the first page. The second training opportunity is detailed in this month's edition.
- The NOTE at the bottom of page 1 stated that, beginning July 1, 2009, the *VacScene* would be available only in an electronic format and a paper copy of the *VacScene* would be mailed only on request. We do encourage you to take advantage of the *VacScene* online and for some providers, this may replace the paper copy. However, we strive to get current immunization information to our health care providers in whatever format is most helpful. If you would like to subscribe to email updates and be alerted when a new issue is online, go to the link on the right side of the *VacScene* homepage at www.kingcounty.gov/health/vacscene. Your mailing address will stay on our mailing list for a paper copy until you tell us to remove it.

We apologize for any confusion caused by these errors.

Training Opportunity for Nurses: Overcoming Obstacles to Vaccination

More parents are refusing vaccinations for their children, an article published in *Nursing World* can help providers break down the barriers that are putting these children at risk. The article describes the transmission and incidence of vaccine-preventable diseases, identifies ways to overcome barriers to vaccination, and provides specific information about several vaccines. The article is available online at <http://nursingworld.org/mods/mod467/vaccinefull.htm>.

This continuing education (CE) activity is supported by an unrestricted educational grant from Sanofi Pasteur. The grant includes funding for 1.6 contact hours of free CE credit, including 1.0 pharmacology contact hours through 12/10/10.

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