



Overcoming Immunization Barriers

Reaching CMS' goal of immunization for all nursing facility patients against flu and pneumonia requires proactive steps.

AT PRESS TIME, THE CENTERS for Medicare & Medicaid Services (CMS) was edging toward a mandatory requirement that all nursing facility patients be immunized against influenza and pneumonia. Yet many facilities have been unable to reach an immunization rate of greater than 90 percent—the goal set forth by the U.S. Public Health Service in its Healthy People 2010 initiative.

There are a number of barriers that nursing facilities commonly encounter in their efforts to boost immunization rates, including problems with obtaining physician orders for vaccine and patient or family refusal based on the notion that vaccines make people sick.

What Providers Can Do

Overcoming such barriers could be critical to meeting the CMS immunization mandate as well as to boosting the overall health of a facility's patient base. Based on the medical literature and experience acquired from nursing facilities with high immunization rates, following are some approaches for overcoming these common barriers.

■ Obtaining a signed consent.

Despite the common belief that patients must sign a consent form prior to receiving either the influenza vaccine or pneumococcal vaccine (PPV), there are no federal or state laws or regulations requiring such consent except in the state of Maryland.

Nevertheless, there are strong recommendations that providers inform patients, prior to vaccine administra-

tion, of the benefits and possible side effects. Vaccine Information Statements are available from the Centers of Disease Control (CDC) for distribution prior to administration of the vaccine and may help nursing facilities educate patients about the risks and benefits of the vaccinations.

■ Obtaining physician order for vaccine.

When preparing for mass immunization of patients, some nursing facilities mail physician orders to each patient's primary care physician in order to obtain a physician order for the vaccination. Although this may be an effective mechanism for some physicians, orders may not be returned to the facility in a timely manner.

A successful strategy for overcoming such delays is to adopt institutional processes related to immunization, including policies for annual influenza immunization, routine evaluation and assessment, ordering vaccination upon admission, or institution of a standing orders program (if available). Research indicates that adopting processes such as these can ease the burden on staff and improve overall vaccination rates.

■ Regulations prohibiting standard orders.

In some states, there are regulations prohibiting standing orders. Orders signed by nursing facility medical directors that permit licensed personnel such as nurses to administer vaccines can eliminate the need to obtain a written physician order for each patient. While such standing orders are prohibited in some states, it is the exception rather than

the rule. Yet informal conversations with nursing facility staff and state employees indicate that misconceptions concerning the prohibition of standing orders continue to persist, even in states where the rules have been changed.

Studies have shown improved flu and pneumococcal vaccine rates through standing orders programs, specifically in nursing facilities. The Conditions of Participation for Medicare and Medicaid (42 CFR Parts 482, 483, and 484) were recently changed to reflect the following for nursing facilities: "The physician must sign and date all orders with the exception of orders for the administration of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

Facilities should conduct a review of state rules and regulations for explicit statements prohibiting standing orders. If state surveyors claim that regulations prohibit standing orders, facilities should ask them for copies of the regulation. If, in fact, a state prohibition does exist, a policy can be adopted that every admission include an order for "Influenza Vaccine 0.5 cc IM yearly" and "Pneumococcal Vaccine 0.5 cc IM if patient has not received vaccine or is

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unsure if they have received the vaccine previously.” This approach, while not as effective as a standing order, is still far more effective than sending reminders yearly to physicians for influenza vaccine orders.

■ **Unsure if patient has already received either influenza vaccine or PPV.**

Patients and their families often don’t know if the patient has been vaccinated, particularly for pneumonia, since this vaccine is administered only once in a lifetime.

In order to combat this barrier, nursing facilities should be proactive in trying to obtain this information from the patient’s attending physician or transferring agency. If there is no documentation available, however, current recommendations from the Advisory Committee on Immunization Practices say that practitioners should assume that the vaccinations have not been given and vaccinate the patient—provided there are no contraindications. CDC concurs. According to current CDC recommendations, providers “should not withhold vaccination in the absence of an immunization record or complete medical record. The patient’s (or family’s) verbal history should be used to determine prior vaccination status. When indicated, the vaccine should be administered to patients who are uncertain about their vaccination history.”

To further ensure that a patient’s vaccination history follows him or her throughout the continuum of care, providers should communicate a patient’s immunization status and history during any interfacility transfers. This can be accomplished by adding vaccination information to facility or interagency transfer forms.

■ **Staff concern about duplicate/concurrent immunization.**

Despite the recommendations cited above, nursing facility staff may still be concerned that patients who are re-immunized or who are given influenza

and PPV vaccines concurrently will experience increased side effects or complications.

One way to overcome this barrier is to educate staff. Several studies have examined and found little data to support any significant increase in complications for persons re-immunized with either the influenza or pneumococcal vaccines.

■ **Patient or family refusal due to concern that vaccines cause illness.**

Refusal usually occurs because the patient or family member is concerned about side effects or complications from the vaccines. Or, they may fear that the vaccine itself causes infection and illness. It is not uncommon for a patient to say, “Last time I got the vaccine, I got sick shortly afterwards.” Another common reason for refusal is that a patient or family member reports that the influenza vaccine may not cover current flu strains.

Exploring the reasons for a refusal can help facilities to better educate their patients about the vaccines. It can also help to specifically address concerns and correct any misconceptions about the virus and the vaccines. When educating people about the vaccines, it is important to remember the following:

—Both the influenza and pneumococcal vaccines are standardized to contain hemagglutinins of strains that are purified and do not contain live or full viruses or bacteria; rather they only contain parts of the influenza virus and pneumococcal bacteria needed to trigger the human body to develop antibodies. These antibodies then protect the individual when exposed to either the influenza virus or pneumococcal bacteria by eliciting antigen-specific antibody responses that usually develop within two to three weeks of immunization. Therefore, an individual cannot become infected as a result of receiving either vaccine.

—People who become sick after receiving the vaccines have most likely

contracted a different virus that causes respiratory illness (such as a cold). Since most people, on average, develop between three and four colds each year, the development of a cold or other virus is likely coincidental; it is likely unrelated to vaccine administration.

—Even though the antigenic match may not be perfect for the predominant circulating virus strains each year, the vaccine does provide some cross-reactive protection. Patients who get vaccinated and are subsequently exposed to the predominant circulating virus are less likely to have severe complications (including hospitalization and death) if they contract influenza. Receiving the influenza vaccine is still recommended, even in years where there is not a perfect match of vaccine and virus.

■ **Immunization programs do not continue throughout the influenza season.**

Many nursing facilities have mass immunization programs in place for all current patients. For example, flu vaccinations are often scheduled for one or two days at the beginning of the flu season. Since flu season extends from October to March, many patients are admitted after the completion of that season’s mass immunization program; these patients risk failing to receive their flu shots until the following fall. To ensure that all patients receive the vaccine, it is recommended that the nursing facility adopt a policy stating that patients admitted between October and March be vaccinated at the time of admission, assuming they have not already received the inoculation. ■

For More Information

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