Trends and Initiatives
In Immunizations

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NH Division of Public Health Services
New Hampshire Immunization Program (NHIP)

- Awardee for federal Vaccines For Children (VFC) program, which started in 1994
- “Universal” state - provides all vaccines up to age 19 (insurance funds, state funds, and federal VFC funds)

2014 Coverage rates in NH
- 19-35 months series: 80.4%
- Teens: 90.6% MCV4; 94.4% Tdap; 71% HPV1(F) and 56.1%(M)
Vaccines: A Public Health Success Story

Smallpox
- 1100s Variolation technique developed
- 1798 Publication on development of vaccine
- 1949 Last case of smallpox in US - eradicated globally 2 decades later

Polio
- 1952 Polio epidemic in US - 57,628 cases
- 1955 First polio vaccine licensed
- 1979 Last cases of wild poliovirus in US
- 1991 Last case indigenous polio in Western Hemisphere
Vaccines: A Public Health Success Story

Measles

- 2000 Measles declared no longer endemic in US following eradication campaigns started in 1967
- But - outbreaks have occurred
- Global society - although US immunization rates are high, not necessarily true for other areas
- Allows for importation of virus in possibly unvaccinated or under vaccinated persons and communities
Vaccines for Children
20 years of protecting America’s children

The Vaccines for Children program was established in 1994 to make vaccines available to uninsured children. VFC has helped prevent disease and save lives...big time!

CDC estimates that vaccination of children born between 1994 and 2013 will:

- prevent 322 million illnesses
- help avoid 732,000 deaths
- save nearly $1.4 trillion in total societal costs
  (that includes $295 billion in direct costs)

www.cdc.gov/features/vfcprogram
Routinely Recommended Vaccines Today

- Covers 16 diseases
- Many come in a variety of formulations and combinations
- Can be complex and confusing
- Requires appropriate storage, handling, accountability
Recent Updates and Additions to ACIP Recommendations

- Meningococcal Vaccines
- Pneumococcal Vaccines
- HPV9
Meningococcal Vaccines

Meningococcal ACWY - Meningococcal Conjugate Vaccine - MCV4 (Menactra®, Menveo®)

- All adolescents at age 11-12 years with booster at age 16

Meningococcal B Vaccine (Bexsero®, Trumenba®)

- June 2015 MMWR - ACIP recommended for certain high risk populations and in outbreak settings
- October 2015 MMWR - ACIP gave permissive (Category B) recommendation: provider MAY administer to any adolescent age 16-23
Men B Recommendations

Age 10 years and older:
- With persistent terminal complement component deficiency
- With asplenia (anatomic or functional)
- Who are taking medication eculizumab (Soliris®)
- Who are exposed during a community outbreak
- Who are microbiologists exposed to *N. Meningitides*

Based on individual clinical decision, persons 16-23 years (without a risk listed above), **may** also be vaccinated
- Series preferably given at ages 16-18 years
Why Category B for ages 16 - 23 years?

- Licensed under accelerated approval process
- Important data not yet available
  - Coverage against serogroup B strains in US
  - Effectiveness and duration of effectiveness
  - Impact on carriage and herd immunity
  - Post-licensure safety
- Current burden of disease is low

Meningococcal Vaccination for Adolescents: Questions and Answers
## Rates/Trends for MCV4 Vaccine

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2014 (≥ 1 dose)</th>
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<tbody>
<tr>
<td>HP 2020 Goal: 80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>US</td>
<td>63%</td>
<td>79%</td>
</tr>
<tr>
<td>NH</td>
<td>74%</td>
<td>91%</td>
</tr>
<tr>
<td>Maine</td>
<td>56%</td>
<td>74%</td>
</tr>
<tr>
<td>Vermont</td>
<td>54%</td>
<td>81%</td>
</tr>
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### Number of states in rate categories

<table>
<thead>
<tr>
<th>2010</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;29% (1)</td>
<td>&lt;54% (1)</td>
</tr>
<tr>
<td>30-44% (6)</td>
<td>55-69% (12)</td>
</tr>
<tr>
<td>45-59% (20)</td>
<td>70-84% (23)</td>
</tr>
<tr>
<td>&gt;60% (24)</td>
<td>&gt;85% (15)</td>
</tr>
</tbody>
</table>
Initiative to Increase MCV4 Rates

You’re Not Done If You Give Just One

- 2014 NIS Teen - most teens inadequately protected from Meningococcal (A,C,W,Y) disease
- Only 28% of teens by age 17 had received 2nd dose
- Sponsored by Immunization Action Coalition (IAC) in collaboration with Sanofi Pasteur
  - Fact Sheets, Talking Points, Recommendations
Pneumococcal Vaccine Confusion

Two different Pneumococcal vaccines
- Pneumococcal Polysaccharide vaccine (PPSV): Pneumovax®
- Pneumococcal Conjugate vaccine (PCV): Prevnar®

Children vs. adults immunization schedules

Normal vs. high-risk individuals
- High risk: chronic diseases (immunocompetent)
- High risk: immuno-compromising conditions

Differences in intervals between vaccination depend on all of the above
Pneumococcal Conjugate (PCV13)
for Persons > 19 Years

- Routinely administer 1 dose to all persons > 65 years with no previous dose of PCV13.
- Administer 1 dose to persons 19-64 years with a high risk indication and no previous dose:
  - CSF leaks, cochlear implants
  - Immunosuppression caused by disease or medications, HIV, functional or anatomic asplenia, sickle cell, general malignancy

Use of 13 valent PCV and 23 valent PPSV among Adults Aged 65 Years:
Recommendations of the ACIP. MMWR 63(37) Sept. 19, 2014
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm
Pneumococcal Polysaccharide (PPSV23)

Routinely administer 1 dose to all persons age ≥ 65 final recommended dose, regardless of risk factor

For persons with a high risk indication:
- Administer 1 dose to persons aged 19-64 years who smoke cigarettes or have asthma
- Administer 1 dose to persons aged 2-64 years with chronic pulmonary, kidney or heart disease, diabetes, alcoholism, CSF leaks, or cochlear implants
- Administer 2 doses to persons aged 2-64 years with immunosuppression caused by disease or medications, HIV, functional or anatomic asplenia, malignancy

Minimum interval between 2 doses is 5 years
Additional Health Benefits for ≥ 65

- PPSV is effective at preventing invasive Pneumococcal disease
- PPSV has unclear/questionable efficacy at preventing pneumonia
- PCV is effective at preventing both invasive Pneumococcal disease and pneumonia in adults

Use of 13 valent PCV and 23 valent PPSV among Adults Aged 65 Years: Recommendations of the ACIP, MMWR 63(37) Sept. 19, 2014
Recommendations for PCV13 and PPSV23

- Give PCV13 first (if not previously received)
- Give PPSV23 12 months after PCV13 (at least 8 weeks)
- If PPSV23 given first, give PCV13 12 months after PPSV23 (at least 8 weeks)
- Only those with immunosuppressive conditions, including functional/anatomic asplenia, get a 2nd dose of PPSV23 (not the immunocompetent with a chronic medical condition)
- No more than 2 doses of PPSV23 before age 65
## Pneumococcal Vaccination Recommendations for Children and Adults by Age and/or Risk Factor

### Routine Recommendations

For Pneumococcal Conjugate Vaccine (PCV13) and Pneumococcal Polysaccharide Vaccine (PPSV23)

- **For children age 2 months and older:** Administer PCV13 series to all children beginning at age 2 months, followed by doses at 4 months, 6 months, and 12–15 months (booster dose).
- **For adults age 65 years and older:** Administer 1-time dose to PCV13-naïve adults at age 65 years, followed by a dose of PPSV23 6–12 months later.

### Risk-based Recommendations

People with Underlying Medical Conditions or Other Risk Factors

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Underlying medical condition or other risk factor</th>
<th>PCV13</th>
<th>PPSV23</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunocompetent</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Chronic heart disease</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Chronic lung disease</td>
<td>X</td>
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<td></td>
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<tr>
<td>Diabetes mellitus</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Cerebrospinal fluid leak</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Cochlear implant</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Alcoholism</td>
<td>X</td>
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<tr>
<td>Chronic liver disease, cirrhosis</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>Cigarette smoking (≥19 yrs)</td>
<td>X</td>
<td></td>
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<tr>
<td><strong>Functional or anatomic asplenia</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sickle cell disease/other hemoglobinopathy</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Congenital or acquired asplenia</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Immunocompromised</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Congenital or acquired immunodeficiency</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>HIV</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Chronic renal failure</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Nephrotic syndrome</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Leukemia</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Lymphoma</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Hodgkin disease</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Generalized malignancy</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Iatrogenic immunosuppression</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Solid organ transplant</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Multiple myeloma</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</table>

3. Including asthmatics if treated with high-dose oral corticosteroid therapy, including asthmatics in adults.
4. Includes B- (humoral) or T lymphocyte deficiency, complement deficiencies (particularly C1, C2, C4, and C8 deficiencies), and hypogammaglobulinemia (excluding chronic granulomatous disease).
5. Diseases requiring treatment with immuno-suppressive drugs, including long-term systemic corticosteroids and radiation therapy.

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<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Underlying Medical Condition</th>
<th>PCV13 Recommended</th>
<th>PPSV23 Recommended</th>
<th>Revaccination 5 years After First Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunocompromised persons*</td>
<td>Congenital or acquired immunodeficiency*</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>HIV</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
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<td></td>
<td>Multiple myeloma</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Persons with functional or anatomic asplenia*</td>
<td>Sickle cell disease/other hemoglobinopathy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td></td>
<td>Congenital or acquired asplenia</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Immunocompetent persons*</td>
<td>Cerebrospinal fluid leak</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
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<td>Cochlear implant</td>
<td>✓</td>
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Use of 13 valent PCV and 23 valent PPSV among Adults Aged 65 Years: Recommendations of the ACIP. MMWR 63(37) Sept. 19, 2014
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm

Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of the ACIP. MMWR, Sept.4, 2015;64(34):944-7
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6434a4.htm
Pneumococcal Tools & Resources for HCPs (continued)

- CDC: Q & A’s and Scenarios for Healthcare Professionals

- Pneumococcal Vaccine Timing for Adults

- Adult pneumococcal guide for HCPs (NFID)
  [http://www.adultvaccination.org/professional-resources/pneumo/adult-pneumo-guide-hcp.pdf](http://www.adultvaccination.org/professional-resources/pneumo/adult-pneumo-guide-hcp.pdf)
9-valent Human Papilloma Virus Vaccine - HPV9 (Gardasil 9®)

Covers additional 5 strains of HPV - about 14% of HPV cancers in females (2800 cases annually) and 4% of HPV cancers in males (550 cases annually) are caused by the 5 additional types.

HPV4 expected to be discontinued in near future.

Current recommendation is same as for HPV4.

Can start/complete series with either product.

No recommendation to repeat series with HPV9 if completed HPV4.
HPV Rates (HP2020 goal 80%)

Improving but room for improvement

<table>
<thead>
<tr>
<th>Rates for 1 dose</th>
<th>2010</th>
<th>2014 F / M</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>49%</td>
<td>60% 42%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>50%</td>
<td>71% 56%</td>
</tr>
<tr>
<td>Maine</td>
<td>55%</td>
<td>67% 53%</td>
</tr>
<tr>
<td>Vermont</td>
<td>50%</td>
<td>63% 51%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Rates for 3 doses</th>
<th>2010</th>
<th>2014 F / M</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>32%</td>
<td>40% 22%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>42%</td>
<td>50% 33%</td>
</tr>
<tr>
<td>Maine</td>
<td>33%</td>
<td>43% 28%</td>
</tr>
<tr>
<td>Vermont</td>
<td>39%</td>
<td>50% 31%</td>
</tr>
</tbody>
</table>
FIGURE 1. Estimated vaccination coverage with selected vaccines and doses among adolescents aged 13–17 years, by survey year — National Immunization Survey–Teen, United States, 2006–2014

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6429a3.htm
Initiatives to Increase HPV Rates

Collaborations

- CDC’s Division of Cancer Prevention and Control journal supplement: *Assessing the Burden of Human Papillomavirus (HPV) Associated Cancers ABHACUS*

- CDC developed the national gynecologic cancer awareness campaign *Inside Knowledge: Get The Facts About Gynecologic Cancer*
  

Resources - You Are the Key To Cancer Prevention

- [http://www.cdc.gov/hpv/hcp/index.html](http://www.cdc.gov/hpv/hcp/index.html)
Missed Opportunities

- Studies show 9.3% to 83.7% (depending on date of birth) girls had a healthcare visit and received vaccines such as Tdap without receiving HPV.
- If HPV had been given at these visits the rate could have been 91% instead of 57%.
- 2013 Survey showed lack of Health Care Provider’s recommendation was one of the five reasons given by parents for not having the HPV vaccine.

Barriers to Increasing Rates

Knowledge
- Internet
- Politicians
- Celebrities

Fear
- Side Effects
- Adverse effects
- Safety

Access
- Demographics
- Transportation
- Insurance
Barriers – Parent Refusals

Recent American Academy of Pediatrics article - within a 12 month period, 74% of pediatricians report dealing with a parent refusal of vaccines

In a 2011 survey (families of children 6 months to six years), 13% used alternative schedule - of those, 53% refused certain vaccines and 55% delayed some vaccines
Alternate Schedules Overview

Dr. Donald Miller - starts later, eliminates some vaccines

Dr. Stephanie Cave - starts at 4 months and slows rate of vaccinations

Dr. Robert Sears - 2 options starting at 2 months

The Problem With Dr. Bob’s Alternative Vaccine Schedule (Pediatrics, 2009, Dr. Paul Offit, Charlotte Moser

Discussion with Reluctant Parents

- Listen to objections
- Correct misinformation, dispel myths
- Be strong advocate
- Use personal references if comfortable
- Discuss preservatives and adjuvants
- Continue to work with family
  - AAP does not recommend turning away families who will not immunize
Advisory Committee on Immunization Practices (ACIP) Schedule

- Science and Evidence Based System
- Monitored and Reviewed
- Most effective preventive health program in US
- NHIP recommends and follows

Panel 15 National Experts, meet 3 times per year, annual schedules, recommendations in MMWR (Morbidity and Mortality Weekly Report). VEARS, Vaccine Court, VICP (National Vaccine Injury Compensation Program), Ask the Experts, FDA, CDC.
If We Stop Vaccinating

Diseases Return: Outbreaks & Epidemics

Pertussis:

2010  >9000 cases, 10 deaths (California)
2012  2520 cases (Washington)
2014  9935 cases, 3 deaths (California)

Measles:

2013  11 outbreaks, 3 with >20 cases, 1 with 58 cases
2014  667 cases, most since 2000
2015  89 cases, 24 states

California passed Senate Bill 277: Personal Beliefs Exemptions Ending - no distinction between religious and personal belief
Initiatives to Raise Immunization Rates

Strong Health Care Provider Recommendations
- Encourage HPV as cancer prevention
- Use every opportunity to update vaccines

Reminder/Recall
- System to schedule next immunization
- Procedure to get patients rescheduled if missed appointment
More Initiatives

Standing Orders
- Authorizes appropriate personnel to administer vaccines according to approved protocol
- Enables assessment and vaccination without clinical exam or direct order from attending provider
- Has been shown to increase immunization rates
- Templates: [www.immune.org/standing-orders](http://www.immune.org/standing-orders)

Take a Stand Workshops (IAC & Pfizer)
- Raise your adult immunization rates while streamlining your practice
- No cost, one time opportunity, full year support
  - [http://www.standingorders.org/workshop-schedules/](http://www.standingorders.org/workshop-schedules/)
State Initiatives

Immunization Information System - IIS (Registry)

2012 National Center for Immunization and Respiratory Disease (NCIRD) launched the creation of the IIS Strategic Plan so real time consolidated immunization data and services could be available

NH only State without active IIS

Vaccine Ordering Management System (VOMS) is part of the NH-IIS (VaxNH) that is currently utilized statewide

Process to have a fully functioning system in place is ongoing (held up in rule making process)
Strategies to Improve Adult Immunization Practices

- **Strongly Recommend** vaccines
  - **understand** recommended vaccines, based on age, risk condition, occupation and/or lifestyle
- **Assess** immunization status at every visit
- **Offer** all recommended vaccines at every visit
  - be prepared to make referrals for vaccines not available
- **Document** administered vaccines

“Standards for Adult Immunization Practice” 2013
Immunizing Adult Patients:
New Standards for Practice

Your patients trust you to give them the best advice on how to protect their health. Vaccine-preventable diseases can result in serious illness, hospitalization, and even death. Make adult vaccination a standard of care in your practice.

Your patients have probably not received all the vaccines they need.
Even though most insurance plans cover the cost of recommended vaccines, adult vaccination rates in the U.S. are unacceptably low. Each year, tens of thousands of adults needlessly suffer, are hospitalized, and even die as a result of diseases that could be prevented by vaccines.

Your patients may not even realize that they need vaccines.
A recent national survey showed that most adults are not aware that they need vaccines throughout their lives to protect against diseases like shingles, pertussis, and hepatitis. Many also report not receiving vaccine recommendations from their healthcare professional.

You can make a difference.
Healthcare professionals are the most valued and trusted source of health information for adults. Research shows that most adults believe vaccines are important and that a recommendation from their healthcare professional is a key predictor of patients getting needed vaccines.

Make Immunization a Standard of Patient Care In Your Practice:
1. ASSESS the immunization status of all your patients at every clinical encounter.
   - Stay informed about the latest CDC recommendations for immunization of adults.
   - Implement protocols in your office to ensure that patients’ vaccine needs are routinely assessed and patients get reminders about vaccines they need.
2. SHARE a strong recommendation with your patients for vaccines they need.
   - Address patient questions and concerns in clear and understandable language.
   - Highlight your positive experiences with vaccination (personal or in your practice).
3. ADMINISTER needed vaccines or REFER your patients to a vaccination provider.
   - For vaccines that you stock, make vaccination services as convenient as possible for your patients.
   - For vaccines that you don’t stock, refer patients to providers in the area that offer vaccination services.
4. DOCUMENT vaccines received by your patients.
   - Participate in your state’s immunization registry to help improve your office, your patients, and your patients’ other providers know which vaccines your patients have had.
   - Follow-up to confirm that patients received recommended vaccines as you referred them to get from other immunization providers.

DON’T WAIT. VACCINATE!


1. Assess Status
2. Share Your Strong Recommendation
3. Administer or Refer
4. Document
NHIP Adult Immunization Program

Began in 2006 with education; since 2008, provides vaccines to practices serving uninsured adults (317 funds)

“Start the Conversation” Campaign in 2013

2015 Adult Immunization Grant

- develop programs to increase rates and reduce coverage disparities; strategies from the Community Guide to Preventive Services and the Adult Immunization Standards
- strengthen partnerships - pharmacists, hospital systems, health centers
- increase use of 317 funds for uninsured
Conclusion

- Immunizations are single most effective way to prevent numerous contagious diseases
- ACIP schedules for Immunizations are the best scientifically proven, evidence-based schedules
- Healthcare providers have a tremendous influence in promoting vaccines and in diminishing missed opportunities
- Systems that promote reminder/recall increase rates
Thank you

The NHIP understands the time and effort it takes to promote, educate, prepare, and administer vaccines.

We sincerely thank all health care providers for their tremendous contribution in this endeavor.
Questions??
References/Resources

Centers for Disease Control and Prevention
http://www.cdc.gov/vaccines/

Current Immunization Schedules
http://www.cdc.gov/vaccines/schedules/hcp/index.html

Immunization Action Coalition
http://www.immunize.org/

“Start The Conversation” - NH Adult Immunization Initiative
http://www.dhhs.nh.gov/dphs/immunization/campaign.htm
Other References/Resources

Immunization Of Health Care Personnel

Responding to Parental Refusals of Immunizations
http://pediatrics.aappublications.org/content/115/5/1428

Effective Messages in Vaccine Promotion: A Randomized Trial
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For More Information

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http://www.dhhs.nh.gov/dphs/immunization/

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