Title  Physician and Staff Knowledge and Attitudes about Childhood Immunizations Before and After a Clinic-wide Educational Intervention and Use of a Parental Vaccine Refusal Form

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Abstract

Objective or Hypothesis  The purpose of the study was to implement and evaluate two strategies to improve immunization rates for the underserved, racially diverse children at a clinic in Minneapolis, MN. The project included the following interventions:

1. The patient care staff (PCS) were included in the process of counseling about vaccinations by providing them with “talking points” to give in response to common parent concerns.
2. Physicians were provided with “Decision to not vaccinate my child” forms for parents to sign who refused immunizations. These forms were used as a source of standardized counseling information and as a demonstration of the importance placed on immunization

Population  PCS and physicians working at a family medicine residency clinic

Methods  Providers and PCS completed online surveys to evaluate their views and beliefs regarding routine childhood immunizations. The surveys were reviewed to determine the knowledge gaps regarding the vaccines. Educational sessions were given to address these gaps, to give “talking points”, and to introduce the vaccine refusal form. Nine months after implementation, the providers and PCS were surveyed again.

Main Results  The most common reason reported by providers and PCS that parents give for refusing a vaccine was fear that the vaccines can cause autism. 87% of respondents reported that the MMR vaccine generates the most questions from parents. 53% of respondents felt they had enough time to discuss parents’ concerns; 74% felt they had enough information to discuss their concerns; and 86% felt confident about answering their concerns. 26% of respondents felt uncomfortable giving more than 2 injections at one time. 20% of the respondents who were parents had refused a vaccination for their own child. After the intervention, 78% of the respondents reporting using the “talking points”, and that the parent changed his or her mind and agreed to the shots usually or occasionally. 92% of providers reported receiving the vaccine refusal form usually or occasionally. 50% of providers reported that the parent then changed his or her mind about the shot after reviewing the form usually or occasionally. After the intervention the percentage of respondents agreeing that parents are open to hearing information about childhood vaccinations increased from 58% to 78%. The respondents who felt they had enough information to discuss parental concerns about immunizations increased from 74% to 89%. After the intervention, only 15% of respondents reported being uncomfortable giving more than two injections at a time. 14% of respondents worried that additives in vaccines might be harmful initially, while no respondents agreed with this statement after the intervention.

Conclusions  The interventions of education for providers and PCS, “talking points”, and use of a vaccine refusal form were associated with improvements in some aspects of their views and beliefs about childhood immunizations. They also appear to be associated with influencing some parents to change their minds and allow their children to receive immunizations.

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