



# CityLights

Promoting communication and collaboration to improve the health of urban children and families

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## U.S. Immunization Coverage: Urban Update

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U.S. metropolitan areas have and continue to be a major part of the recent national strategy to improve immunization coverage among young children. The 1989-1991 measles epidemics that stimulated the current national response

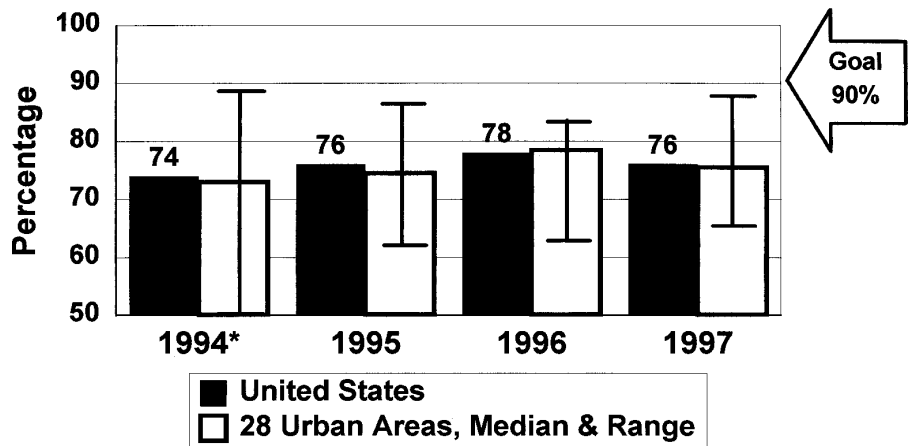
occurred in Houston, Chicago, New York and other major metropolitan areas. These epidemics occurred in highly populated areas because of

large pockets of low immunization coverage among predominantly poor and minority children.

**National Status.** Following these outbreaks, immunization levels rose precipitously due to heightened awareness and increase activities among public health, providers and the general public. The July 10, 1998 edition of the MMWR reports the highest ever recorded national coverage for recommended vaccines with four of the individual antigens at >90% levels (see Internet website-<ftp://ftp.cdc.gov/pub/Publications/mmwr/wk/mm4726.pdf>). Immunization coverage among children 19 to 35 months for new vaccines-Haemophilus, hepatitis B and varicella-also increased although the levels vary by geographic area. In recent years, however, the U.S. immunization coverage for the basic children's series of four DTP/DT, three poliovirus, and one measles

*Continued on pg.5*

### Estimated vaccination coverage among children aged 19-35 months with 4 DTP/DT, 3 Polio & 1 MCV, U.S. and 28 selected urban areas



\*1994 data is for the last three quarters only.  
Source: National Immunization Survey, CDC

Figure 1.

With coverage remaining at 76 to 78%, the nation is short of the 4:3:1 national goal of 90%

## Special CDC Immunization Insert

Welcome to the second in a series of special CityLights editions designed to increase access to the many urban MCH resources at the Centers for Disease Control and Prevention (CDC). CityMatCH has prepared a special insert, **Focus: Under-immunization of Urban Children**, to give readers an overview of how the CDC has addressed a leading MCH problem facing urban children and their families. In collaboration with the National Immunization Program (NIP), we have compiled an array of information about the current status of the problem, CDC's urban immunization strategy, selected urban initiatives designed to target 'pockets of need,' and immunization resources at CDC of use to urban health departments and their community partners who are working to improve coverage for children and adolescents in their communities.

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## Our 'Ideas Box'

by Magda G. Peck, ScD  
CityMatCH CEO/Executive Director

Immunizing kids reminds me of David's 'Ideas Box.' Last month, we were in the home stretch of Temple Israel's annual family retreat when the synagogue's religious school director shouted detailed instructions over a cacophony of voices for a family art activity. Each person was offered a plain cardboard box and told to make something that symbolized his or her "Jewish identity." Containers of colored paints, markers, glitter, mirrors, and glue covered the worktable.



Peck

Many hands went right to work this year. Now seven but with an old soul, David again was among the first with hand raised, eager to tell about his box. "It's an 'Ideas Box,'" he started. He had written his name in Hebrew on one corner; the Hebrew words for 'good' and 'bad' were written with some help on opposite corners. A circular yin-yang symbol covered the top, next to a palm-sized mirror. Inside, a smaller mirror had been pasted on the bottom. "I put all of my ideas in here." Peeking inside, he continued, "There are about ten thousand of them in there right now. Most of them are good."

When asked why mirrors of different sizes, he explained, "... just because you're small doesn't mean that you aren't special, and if you are big, you shouldn't brag about how big you are." And after a moment he added, "It takes lots of ideas to make things work."

Indeed, it has taken all kinds of ideas to successfully immunize urban children, some big, some small, many of them good. Urban health departments and their many partners have reached into a national "Ideas Box" of sorts for the essential pieces of a comprehensive local strategy for achieving and sustaining adequate childhood immunization levels. CDC has played a major role in fostering our collective box of ideas. In this special edition of *CityLights*, we are pleased to open it for you. Peek inside....there may be thousands... □

## CityMatCH Leadership Roundtable: Immunizing America's Urban Children

*Achieving and sustaining adequate levels of childhood immunization against vaccine preventable conditions was declared a national priority earlier this decade in the wake of predominantly urban outbreaks of measles. What do urban public health MCH colleagues think about the results so far? CityMatCH recently asked some of its leaders to give us their perspectives.*

### CityMatCH: What have been notable successes in increasing immunization levels among urban children, and to what do you attribute success?

In Syracuse, NY, Llamara Padro Milano, Director of Nursing, Onondaga Health Department, says physicians are adhering to Standards of Pediatric Practice, boosting levels for children there. In St. Petersburg, FL, improved immunization levels are attributed to the Vaccines for Children (VFC) program, HMO Medicaid, and a federal outreach team project, according to Claude Dharamraj, Assistant Director of the Pinellas County Public Health Department. In Milwaukee, WI, Public Health Nursing Director Elizabeth Zelazek describes success as increased collaboration across systems, including the formation of an Outreach Committee comprised of representatives of managed care, service agencies, and local health departments. But has "success" truly been realized? There is some doubt at the local level about sustained improvements and variable measures of progress. "Although we are locally aware of the federal pronouncements of success in increasing the rates of immunization for children across the country, particularly in urban areas, we have not been able to document this improvement," observes Len Foster, Deputy Director of Public Health, Orange County (CA) Health Care Agency. "We have no local evidence to support the sense of victory over ignorance and limited access to immunizations."

### CityMatCH: Has increasing immunization levels lead to greater access to primary care for children in your community?

Immunization is a result, not a cause of primary care access improvement, according to Portland, OR Health Officer Gary Oxman. While the focus on immunizations has contributed to improved collaboration among organizations and

individuals in Orange County, CA, it has not lead to greater access to primary care. "I would suspect that the reverse is true," says Foster, "As children gain access to primary care through such vehicles as CHIP, immunization levels will increase." "The driving factor has and continues to be the availability of a payer source for care," says Maggie Gier, Manager of Women's Health Programs at the Tri-County Health Department, Englewood, CO.

### CityMatCH: Have better data been critical to immunization success? How have registries helped?

Because registries are still in the early stages of development in many urban communities, it is too soon to tell. Reliable county-wide assessments must await the expansion of the current registry to include private sector providers, a year or more off for Orange County CA, which continues to rely on sampling techniques. In Portland OR, early registry data is proving more accurate. "I believe that rates of immunization are better than routine data collection has reflected," says Oxman. "Poor immunization rates are as much an issue of data as one of reality." For some like Milwaukee's Zelazek, they hold great promise: "Registries will be the single most effective strategy to improve immunization levels over the next years."

*"Registries will be the single most effective strategy to improve immunization levels over the next years."  
- Zelazek*

### CityMatCH: What are key next steps in sustaining immunizing coverage in urban children?

Portland's Oxman calls for better data and administration/delivery systems individualized to each community. In Orange County CA, Foster hopes for the establishment of a county-wide immunization registry which is consistently utilized by providers. Milano in Syracuse agrees: centralized registries with the full cooperation of pediatricians and family practice physicians are an important next step

Meeting the dual challenges of full implementation of the state's immunization registry and full implementation of Title XXI- child health insurance legislation is highest on the list for Dharamraj in St. Petersburg. In Englewood, Colorado, convincing the community that immunizations are still important is the challenge. "We still hear more groaning and complaining about having to get immunizations than we hear thank you for providing the service," notes Gier. □

# Under-immunization of Urban Children

## Leading MCH Problems Facing Urban Families

- Adverse perinatal outcomes
- Violence
- Adolescent pregnancy & adolescent parenting
- Under-immunization of children
- Substance abuse

Source: CityMatCH Member Survey, 1995.

## CDC Leadership Roundtable: Children, Immunization, and Cities

Several CDC leaders with the National Immunization Program were recently interviewed by CityMatCH CEO/Executive Director Magda Peck about immunization and urban MCH. Excerpts below provide insight into CDC's approaches to protecting urban children from vaccine-preventable diseases. Dr. Walt A. Orenstein is Assistant Surgeon General and NIP Director. Dr. Jose Cordero is NIP Deputy Director. Dr. Joel Kuritsky directs the NIP Division of Immunization services, and Dr. John Livengood heads the NIP Division of Epidemiology and Surveillance. Dr. Edwin M. Kilbourne heads the Division of Data Management.

**PECK: What is CDC's national leadership role in improving immunization coverage for children and adolescents in the U.S.?**

**ORENSTEIN:** The National Immunization Program is key to disease prevention in that it seeks to control, eliminate and eradicate diseases preventable by vaccines. There are at least six things CDC does to raise and sustain immunization levels in the United States and globally. We (1) work in tandem with health and immunization experts to develop national immunization policy; (2) work with public and private sector providers to ensure access to high quality immunization services; (3) remove cost as a barrier and promote immunization in a child's medical home; (4) work in partnerships with national organizations and local coalitions to ensure community involvement and to raise public aware-

In a 1995 CityMatCH national survey, local health departments serving cities over 100,000 in population were asked to rank in order of importance the leading maternal and child health problems faced by the families and children in their jurisdiction. Under-immunization of children ranked among the most important. CDC has developed multiple "tools for prevention" to address this concern. Selected health statistics, prevention strategies, and leadership perspectives are featured in this insert

ness; (5) ensure adequate vaccine preventable disease surveillance and monitoring of immunization coverage to tell how we are doing; and (6) work with researchers and manufacturers to provide new and improved vaccines and vaccine use.

**PECK: What have been major barriers to immunization facing urban children and adolescents?**

**ORENSTEIN:** There are some major universal problems. The 1994 National Health Interview Survey showed that 80% of parents of children who were not up to date for their shots thought their children were completely vaccinated. Schedules have changed and become more complicated. Providers don't necessarily know the immunization status of children in their practices, and often perceive coverage to be higher than it may be. And with 25% of children having two or more providers, records are scattered.

**CORDERO:** Although coverage for preschool immunization is high in almost all States, "pockets of need", i.e., areas within each State and major city where substantial numbers of underimmunized children reside, continue to exist. These areas are of great

which provides as entry points into CDC's many resources and initiatives aimed at protecting children and adolescents from vaccine-preventable diseases.

The National Immunization Program's array of activities to address childhood immunizations is too numerous to include in full. Readers are encouraged to follow up with CDC through its website at <http://www.cdc.gov> to identify additional contacts and resources. □

concern because, particularly in large urban areas with traditionally underserved populations, there is a potential for outbreaks of vaccine-preventable diseases. Cities have higher population, crowding, and greater in and out migration, which yield more opportunities for exposure to vaccine preventable diseases. Factors associated with under-immunization are greater in cities, for example there are more large families. We know that the greater the family size, the less likely it is that younger children will be immunized. Getting urban children to the public clinics, immunizing adolescents born after Hepatitis B and a second MMR became routine, and catching kids who fall through the cracks because of no insurance or missed opportunities also are barriers.

**KURITSKY:** The overlay of poverty for children in cities is a factor. There has been a persistent 10% difference in immunization levels between kids still living in poverty and those living above the poverty line. There may be other issues of higher priority than immunization facing urban families living in poverty. Parents and providers alike have been shown to want their children immunized, they just don't always know they aren't.

**CORDERO:** Adolescents are the  
*continued on page 6*

# How is the CDC Organized to Address Immunization?

## CDC - The Centers for Disease Control and Prevention

National Center for Environmental Health

National Center for Health Statistics

National Institute for Occupational Safety & Health

National Center for Chronic Disease Prevention & Health Promotion

National Center for HIV, STD, & TB Prevention

National Center for Infectious Diseases

National Center for Injury Prevention & Control

### NATIONAL IMMUNIZATION PROGRAM

Epidemiology Program Office

International Health Program Office

Public Health Practice Program Office

## What Does The NIP Do?

The National Immunization Program (NIP) is a part of the Centers for Disease Control and Prevention, located in Atlanta, Georgia.

As a disease-prevention program, NIP provides leadership for the planning, coordination, and conduct of immunization activities nationwide.

In carrying out its mission, NIP--

✕ Provides consultation, training, statistical, promotional, educational, epidemiological, and technical services to assist health departments in planning, developing, and implementing immunization programs.

✕ Supports the establishment of vaccine supply contacts for vaccine distribution to state and local immunization programs.

✕ Assists health departments in developing vaccine information management

systems to:

- facilitate identification of children who need vaccinations

- help parents and providers ensure that all children are immunized at the appropriate age

- assess vaccination levels in state and local areas

- monitor the safety and efficacy of vaccines by linking vaccine administration information with adverse event reporting and disease outbreak patterns

- ✕ Administers research and operational programs for the prevention and control of vaccine-preventable diseases.

- ✕ Supports a nationwide framework for effective surveillance of designated diseases for which effective immunizing agents are available.

- ✕ Supervises state and local assignees working on immunization activities. □

## CDC's Prevention Tools

The CDC uses eight essential "tools" for prevention to achieve its mission and address its top priorities. These eight tools reflect the range of activities, resources and opportunities at the CDC which can assist local and state health departments and other partners improve the health and well-being of women, infants, children and adolescents in communities. Symbols corresponding to prevention tools are shown below. Look for the symbols throughout the descriptions of selected CDC initiatives, programs and resources which address under-immunization of children in America's urban communities. □

laboratory

health communication & social marketing

behavioral risk reduction

epidemiology

prevention strategies & programs

health statistics

technology transfer

surveillance

## *“Pockets of Need”: One Key to CDC’s Urban Immunization Strategy*

*A "pocket of need" is an area with low immunization coverage, a large number of under-vaccinated children and high-potential for vaccine-preventable disease outbreaks.*



Although immunization coverage levels among preschool children are at record high rates, the risk of outbreaks of vaccine-preventable is not uniformly low, due to variation in immunization coverage levels among different groups and increased exposure risk in some populations.

Variations in coverage can be seen among States as well as urban areas. The NIS data for calendar year 1995 reveal a 30% difference between the highest and lowest coverage among major urban areas.

Studies have shown that low socioeconomic status is associated strongly with under-immunization.

The association of low socioeconomic status with crowded living conditions, low parental educational level, large family size, young parental age, and late start for immunizations indicates that a significant portion of urban populations exist that are at increased risk of vaccine-preventable diseases.

Reducing the risk of disease in these pockets of need through improved immunization coverage has been an important part of NIP's disease prevention strategy for many years. In the next few years, NIP will focus activities on these populations.

□



### *Urban Update (continued)*

containing vaccine has remained stable, according to the National Immunization Survey (NIS) (see page 7, Figure 2). With the percentage coverage remaining stable at 76 to 78%, the nation is short of reaching the national goal of 90% for the combined series.

**Urban Status.** 28 selected U.S. urban areas are included in the NIS and represent a combination of cities, urban counties and metropolitan areas. The recent 4:3:1 immunization coverage levels for these urban areas mirror that of the nation with the median of the 28 selected urban areas usually running 1, to 2% less than the nation as a whole (see page 1, Figure 1). Of note, the range of coverage levels across the 28 urban areas from the minimum to the maximum estimated level has narrowed substantially since 1994. The individual 1994 and 1997 coverage levels for these urban areas are provided on page 7.

While nationally there was modest improvements in the 4:3:1 series coverage from 1994 to 1997, the coverage changed

substantially within some urban areas. For example, the immunization level in Bexar County, Texas (San Antonio) increased from 66% in 1994 to 81% in 1997, while the immunization level in El Paso County, Texas (El Paso) decreased from 85% in 1994 to 67% in 1997. In fact, recent trends in coverage levels for 4:3:1 series in the selected 28 urban areas varied based on their 1994 levels. Those urban areas with the lowest immunization coverage levels in 1994 made progress toward

improving their levels while those urban areas with the highest coverage levels made little progress or actually declined. The average coverage level for the seven urban areas with the lowest levels in 1994 (fourth or bottom quartile) increased from 61% in 1994 to 72% in 1995 and remained stable at that level through 1997. The average coverage level for the next lowest seven urban areas (third quartile) increased from 72% in 1994 to 78% in 1996 and

remained stable at that level. Trends for the urban areas with higher coverage in 1994 were different. The coverage levels for highest seven urban areas (first or top quartile) actually decreased from 83% in 1994 to 77% in 1997. This trend was predominantly due to the decline in three urban areas: El Paso Co. (El Paso), Cuyahoga Co. (Cleveland) and Santa Clara Co. (San Jose). The coverage levels for next highest seven urban areas (second quartile) remained relatively stable near 78%.

To break through the 78% plateau and reach the goal of 90% for the 4:3:1 series, urban areas will need to strengthen and enhance current strategies and/or develop new ones. The challenges will be to more timely and consistently provide the fourth dose of DPT, and to better incorporate immunization initiatives into the overall initiative to find and provide primary care or a medical/health home for all urban children. In addition, newer vaccines—Hepatitis B and varicella—will also need to be provided in a more timely and consistent fashion. □

*To break through the 78% plateau and reach the goal of 90% ... urban areas will need to strengthen and enhance current strategies and/or develop new ones.*

## Focus: Under-Immunization of Urban Children

### CDC Leadership Roundtable

(continued)

most challenging. Currently less than 20% of adolescents under 21 years old have received Hepatitis B vaccine. This is the first vaccine that can actually prevent a form of liver cancer! Few teens have a regular health care provider, so somehow we need to reach out to these kids during school time.

**KURITSKY:** In eight or nine years, Hepatitis B universally vaccinated infants will reach their adolescence, but right now, if we don't get current teens vaccinated, we will be in trouble. Although one year ago, adolescents through age 18 became entitled to be vaccinated through the VFC program for Hepatitis B, successive cohorts of teens are escaping into adulthood unvaccinated. As adults, some will develop liver disease, resulting in preventable deaths. We have to figure out how to take advantage of this entitlement and do it fast enough that we don't lose too many of these children.

**PECK:** What has been CDC's "urban strategy" in its efforts to improve and sustain childhood immunization levels?

**ORENSTEIN:** Using National Immunization Survey data, we identified eleven cities with the highest number of two year olds that are behind in immunization. We worked in each of these cities to reach out to these populations by bringing together providers, academia and other sectors to increase coverage levels. We developed contracts with academic health centers (AHCs) in selected urban areas for demonstration projects on increasing networks between AHCs and health departments, and reaching out to children in need of immunization. The issue is to concentrate efforts on strategies where we all work together. We have to focus on strategies that work.

**KURITSKY:** Our initial work in cities had several key strategies. First, we targeted WIC, the largest single access point akin to school entry, and developed a system for reviewing the immunization records of every child at WIC sites. Second, we borrowed from what dentists and mechanics and hairdressers do well: recall and reminder systems. And third, we formulated a "pockets of need" approach based on coverage data that showed high concentrations of underimmunized children in a few cities. We focused our attention on selected cities and gave them resources and the responsibility to further identify the issues.

**KILBOURNE:** One part of CDC's urban strategy involved data. We launched the National Immunization Survey (the NIS), the largest ongoing telephone survey in the

federal government. It includes 28 urban areas, as well as all 50 states. Other data collection activities on immunization status such as CASA audits of providers' practices help pinpoint gaps in childhood immunization (and the reasons they are occurring) and allow providers to follow up the specific kids who are behind.

**PECK:** What must urban health departments know about NIP's efforts to be a successful local partner in increasing and sustaining childhood immunization coverage?

**CORDERO:** Immunization and MCH are natural and essential partners. We are seeing the same children. One of my nightmares is that a child will leave the physician's office immunized but will drive home without the protection of a carseat and seatbelt. We must work together more—not necessarily harder but smarter—to ensure that these kids get all preventive services available to them so that they have their best chance at growing up healthier. Children that are fully immunized are more likely to get all the services they need and have medical homes.

**KILBOURNE:** Never underestimate the power of assessment. Assessment is itself an intervention. Just as CASA audits motivate providers to immunize more completely, data and information from the NIS help make the case for what needs to be done to policy makers and those with resources.

**KURITSKY:** The end game is to have high coverage, but the real end game is to have healthy children and adolescents. We encourage the integration of immunization into comprehensive primary care. That is what the VFC program is all about. Children not fully immunized are less likely to be screened for tuberculosis and lead.

**PECK:** How can urban health department MCH leaders best help CDC fulfill its role as the nation's prevention agency in the area of childhood immunization?

**CORDERO:** Know what is the coverage in your area, in your practice; it may be lower than you think. Know and work with the local and state immunization program; partnering is key. Know what is working around the country. Take a look at what Boston is doing that has caused them to have one of the highest immunization rates in the country.

**LIVENGOOD:** There will always be new concerns raised about vaccine safety. Urban health departments should be prepared to provide honest information which is science based and well communicated. Our topical Questions and Answers series and our articles on vaccine safety are for immunization providers like MCH professionals to use in speaking with parents.

**KURITSKY:** Local health department roles in immunization are changing. In 1990, 50% of childhood immunizations were given in health department clinics. The Vaccines for Children Program, mandatory Medicaid managed care and private sector insurance reform have changed the delivery of primary and preventive care, shifting children into the private sector. An estimated 20% of immunizations currently are administered through public clinics. Health departments can continue to support and promote the immunization partnerships we have invested in for assuring immunization and other preventive services. Immunization has to be a community issue. As new products come on line, like chicken pox vaccine, we will never get coverage up to where it must be without community-based coalitions who can maintain success in future years by keeping awareness high and mobilizing resources.

**KILBOURNE:** Registries are the way to sustain and further enhance the high coverage we already have. From surveys and studies we can identify risk factors that point

out, in only a general way, which children are the most likely to be under immunized. But immunization registries let us get real-time data to target the specific children at risk with recalls and reminders.

**LIVENGOOD:** Disease burden is at historic low levels. We worry that people will lose their frame of reference that measles and other increasingly rare vaccine-preventable diseases are a bad thing. Vaccine safety may become a more threatening issue than the diseases they are designed to prevent because people do not see these diseases around them anymore. When the balance between risk and benefit of vaccines is upset, coverage may decline, especially in our cities. Urban health departments must help sustain community awareness and trust.

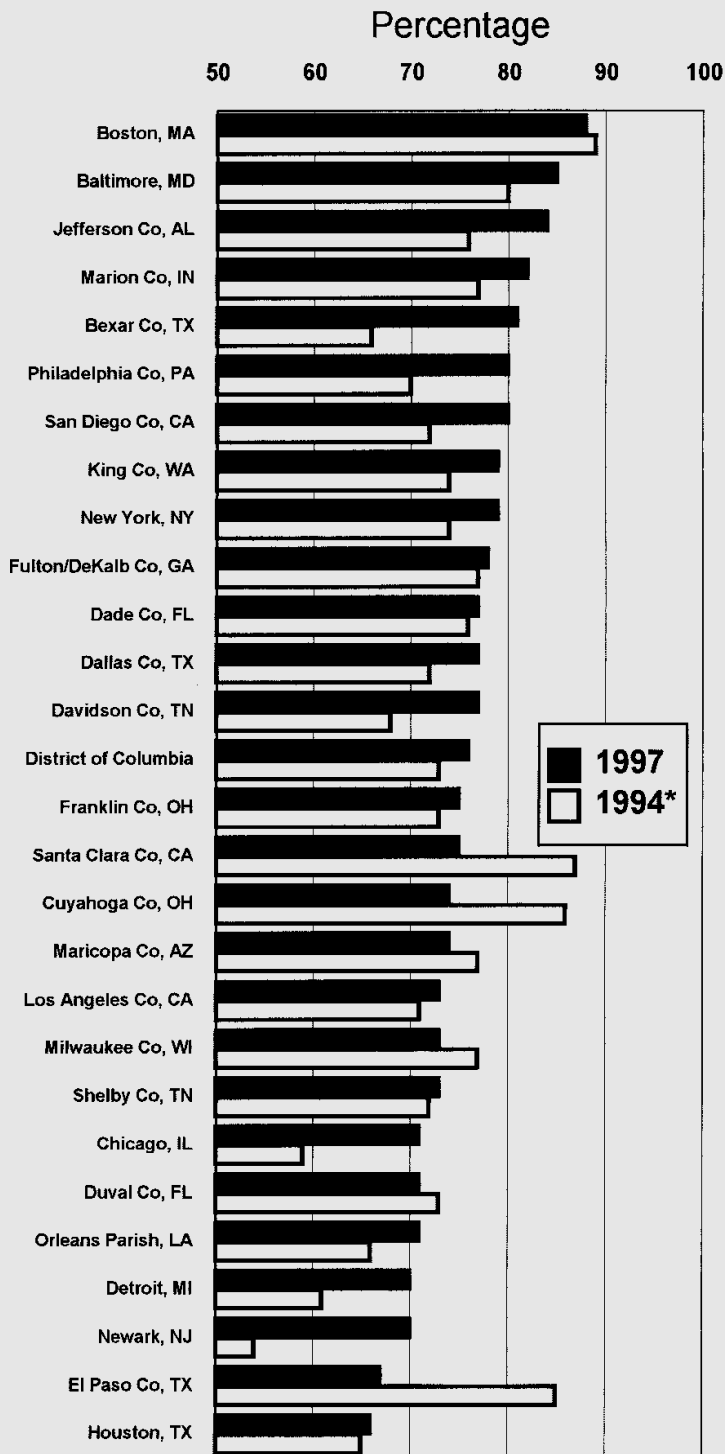
**ORENSTEIN:** We have common goals: we are all striving to improve the health of the same children who need help and prevention. The more closely we work together, the better we are able to sustain success and sustain healthy kids.

*...we are all striving to improve the health of the same children who need help and prevention. The more closely we work together, the better we are able to sustain success and sustain healthy kids.*

— Orenstein

# National Immunization Survey (NIS) Yields Urban Data

**Estimated vaccination coverage among children aged 19-35 months with 4 DTP/DT, 3 Polio & 1 MCV, in 28 selected U.S. urban areas**



\*1994 data is for the last three quarters only  
Source: National Immunization Survey, CDC

Figure 2.



The National Immunization Survey (NIS) is an ongoing survey that provides national estimates of vaccination coverage among children aged 19-35 months based on the data for the most recent 12 months for each of the 50 states and for 28 selected urban areas, including the District of Columbia. NIS was implemented in April 1994 to monitor vaccination coverage levels as one element of the Childhood Immunization Initiative (CII), a national strategy to ensure high immunization coverage of children during the first 2 years of life.

The NIS uses a quarterly random-digit-dialing sample of telephone numbers for each of the 50 states and for each of the 28 selected urban areas (i.e., survey areas) to collect vaccination information for all eligible children. Information at the mother level (e.g., age, marital status, level of education, race/ethnicity) is also collected during the telephone interview. For completeness and verification, vaccination data are requested from the immunization providers. Survey responses are weighted to represent the entire group of children surveyed and to account for household nonresponse, natality data, and the lower vaccination coverage among children in households without telephones.

The NIS findings for July 1996 - June 1997 indicate that all the national coverage goals established by CII for 1996 have been met or exceeded for the vaccines routinely recommended for children.

Vaccination levels among US children aged 19-35 months remain the highest ever recorded. Also, during this period, for the first time ever, the NIS has produced annualized estimates of varicella vaccination coverage for the nation, states, and urban areas. Nationally, varicella coverage was 19%, at the state level, the coverage ranged from 3% to 33%; and at the urban area level, from 7% to 33%. During the last quarter of this reporting period (April - June 1997), national coverage was even higher, at 25%. It is expected that the upward trend for varicella vaccine coverage will continue.

The achievement of the 1996 goals merely demonstrates the feasibility of reaching high coverage levels, it does not ensure that high coverage will be maintained in the future. More work needs to be done.

For additional information on the National Immunization Survey, contact: Victor G. Coronado, MD, MPH, (404) 639-8892, Fax (404) 639-8613, or E-mail at vgc1@cdc.gov. □



# Vaccines For Children Keeps Kids "Home"

Vaccines For Children (VFC) has become a critical element of President Clinton's Childhood Immunization Initiative (CII). Since its inception in August of 1993, VCF has grown rapidly and now annually funds 61 immunization projects, ninety percent of these funds directly used for vaccine purchase. The VFC program marks the first time private providers in all states have been able to receive publicly purchased vaccine.

Supporting efforts to increase childhood immunization levels, federally purchased vaccines are made available to children 0 - 18 years of age who are either Medicaid enrolled, without health insurance, or are American Indian or Alaskan Native. Children with health insurance which does not cover immunization also may receive VFC vaccines at a federally qualified health center or a rural health clinic.

Private providers may enroll in the VFC program and administer vaccines to eligible children. Prior to the VFC program, many private providers - as many as 50% were increasingly referring children to public clinics for immunizations because of the increasing costs of new vaccines. This practice splintered health care delivery, resulting in missed opportunities for vaccination and inadequate immunization for many children. The VFC program addresses this problem by removing vaccine cost as a barrier for eligible children. Children may now be vaccinated in their medical homes (allowing comprehensive health care from their primary providers), reducing the burden on public health clinics.

The VFC program is operational in all 50 States and other U.S. territories. As of April 1998, public purchased vaccine is being delivered to enrolled public and private providers in all States, except New Jersey. New Jersey will have a vaccine delivery contract for private providers in place by the end of 1998.

The program covers recommended vaccines, including new vaccines, new vaccine combinations, and revised

guidelines for vaccine use; saves parents and enrolled providers about \$370 per child in out-of-pocket expenses for vaccine; and saves monies by negotiating federal vaccine contracts at lower prices.

Participating providers have responsibilities both in provision and data collection. They must screen the parent or guardian of a child to determine VFC eligibility. Providers maintain records on all children immunized with VFC vaccine, documenting VFC eligibility, which is available to public health officials upon request. Vaccine information materials must be offered and proper records maintained in accordance with the National Vaccine Injury Compensation Act, and providers must comply with recommended immunization schedules.

Providers may not charge fees for administering the vaccine beyond the fee cap established by the HCFA, or deny services if the administration fee cannot be paid.

The National Immunization Program (NIP) at CDC is responsible for the operation of the VFC program. State health department immunization programs provide leadership at State and local levels. Close collaboration and participation by a variety of programs and agencies ensures program success.

For more information about the Vaccines For Children Program, please contact Alison Johnson, Kimberly Lane or Brock Lamont of the National Immunization Program at (404) 639-8222. □

## Community/Migrant Health Center Project



Since 1995 the National Immunization Program (NIP) has been involved in a partnership with the Health Resources and Service Administration's (HRSA) Bureau of Primary Health Care (BPHC) to improve immunization levels in Community/Migrant Health Centers (CHCs) through a continuous quality improvement approach using the AFIX model (Assessment, Feedback, Incentives, Exchange of information) in 10 participating states: Arizona, Colorado, Connecticut, Maine, Missouri, North Carolina, New Jersey, New York, Ohio and Utah.

Nationally, CHCs provide comprehensive primary care services to approximately 8 million high-risk, medically underserved patients through a network of 700 agencies with 2000 primary care sites. Over 600,000 patients are children under the age of two.

The immunization project is being implemented by staff at the Primary Care Association level--the centers' professional membership organization. Their main activities

involve assessing immunization levels and provider practices semiannually using a standard methodology at all participating sites; providing data feedback to interdisciplinary quality teams established at the centers; assisting centers to diagnose service problems and improve pediatric standards of practice; providing ongoing technical assistance and support to center staff; and developing partnerships with State and local health departments, WIC and MCH programs.

Accomplishments made since the inception of the program include development of standardized measurement approaches and improvement in health center immunization systems.

Quality improvement approaches have been introduced, a training strategy and curriculum have been established through the National Association of Community Health Centers, and sustainable improvements in clinical practices are being instituted through the CQI process. For more information about the Community Health Center Project, contact Rita Goodman, BPHC, 301-594-4297, or Ken Anderson, CDC, 404-639-8222.





## *Demonstration Projects in Public Housing Authorities Boost Immunizations*

A three-year Federal Partnership was formed in late 1996 among Health and Human Services (HHS)/Centers for Disease Control and Prevention (CDC), Housing and Urban Development (HUD), and the Corporation for National Service (CNS) to address the problem of under-immunization among children in public housing developments. Together they agreed to: form Public-Private Partnerships to solve local problems; establish Welfare-to-Work linkages; attain Healthy People 2000 goals; and engage Volunteers in Community Service.

This unique Federal partnership established the basis for initiating local demonstration projects to develop, implement, and evaluate key strategies to increase and sustain immunization coverage among public housing residents 19-35 months of age.

The four Public Housing Immunization Demonstration Projects selected in 1997 (Chicago, IL; Kansas

City, MO; Little Rock, AK; and Philadelphia, PA.) will yield lessons learned for applicability on a national basis.

Each local partner is expected to have a role in and share responsibilities for planning and implementing local immunization initiatives and interventions appropriate to their community. Each local partner must also commit the resources to assure the success and sustainability of the local plan and infrastructure.

The demonstration projects are designing and implementing interventions unique to their communities, including activities to raise parental and health care provider awareness of immunization; linking the families to permanent medical homes that are both accessible to and accepted by public housing residents; creating health care employment opportunities for the target population; and ultimately building local infrastructure which will

sustain acceptable immunization levels.

Now in the second year, the local demonstration projects will be implementing those strategies and leveraging existing funds/resources to assure sustainability of the demonstrations.

Public housing residents are enthusiastic about being empowered to assist in the design and implementation of strategies designed to increase immunization coverage levels among their population. HMO and primary care providers see the potential benefits of hiring and training public housing residents to do outreach and education on such topics as managed care in order to reduce rate of turnover and costs associated with switching among HMOs by the target population. For additional information, contact Bill Broom, Health Education Specialist, (404) 639-8443, Fax: (404) 639-8555 or E-mail: wfb4@cdc.gov □

## *COPB Reaches Out To Raise Immunization Rates*



**The Community Outreach and Planning Branch (COPB)** is at the helm of public and private partnership activities for the National Immunization Program, Centers for Disease Control and Prevention. By developing broad-based support on the national, State, and local levels; heightening awareness of parents, providers, individuals, and the general public; promoting national and community-based initiatives; and evaluating and promoting innovative interventions, the COPB has found great success in partnering efforts to improve immunization rates over the last three years. Outreach and planning efforts involve overlapping activities in health education, health communications, research and evaluation, and field operations.

The Branch staff help to give creative direction to factual and necessary information through the development of new advertising campaigns in conjunction with the Ad Council and HMA Associates.

Field activities conducted by COPB continue to help build community-based infrastructures and strengthen relationships between public- and private-sector groups. In addition to in-house staff's work in the field, 10 regional outreach consultants, positioned in the 10 Public Health Service regions, are dedicated to mobilizing community coalitions, sharing information and ideas, promoting programs, and providing programmatic technical assistance. COPB's behavioral scientists have embarked on a number of evaluation projects to measure the effectiveness of education, communication, and outreach strategies. Evaluation also helps to determine barriers to immunizations and identify strategies for improving communication messages to parents, caregivers, and providers across the country. For additional information, contact Shaunette Crawford, at (404)-639-8375 or Fax (404)-639-8555. □

## Focus: Under-immunization of Urban Children

*The National Immunization Program (NIP)* for the CDC provides information of immunizations, including adult and child immunization schedules, a summary of misconceptions about vaccinations, and links to the Registry Clearinghouse. The NIP web site can be accessed at <http://www.cdc.gov/nip/>.

*The Immunization Action Coalition* provides numerous resources on immunization, including free informational materials for both the population and clinic staff in web and .pdf format in English, Spanish, and other languages. Their website can be accessed at <http://www.immunize.org/>.

*"The Immunization Gateway"* provides extensive links to information on vaccine research, free handouts, state vaccination programs, and corporate and organizational partners. Their website can be accessed at <http://www.immunofacts.com/>

Information about vaccine

## Dr. Seuss to Help Urban Kids

On October 30, 1997, some of the late Theodor Seuss Geisel's (*That's Dr. Seuss to you and me*) most well-known characters came to life again through the release of three posters proclaiming, in a classic Seuss-like rhyme, the importance of childhood immunizations. Through the generosity of Mrs. Audrey Geisel (widow of Dr. Seuss) and Dr. Seuss Enterprises, L.P., the Centers for Disease Control and Prevention (CDC) was granted the right to develop and use characters from such memorable stories as *The Cat in the Hat*, *The Sneetches*, and *The King Stilts*. The National Immunization Program (NIP) provided guidance in the creation of the posters and



schedules, safety, and alternate delivery technologies can be found at the *Sabin Vaccine Institute at Georgetown University*.

### Immunization CityResources



Included is a general description of the history of vaccines, vaccines under development, and their impact on childhood disease. Their website can be accessed at <http://www.sabin.georgetown.edu>.

*"A Vaccine Risk Communication"* is an article in the April 1998 edition of the *American Journal of Preventive Medicine*. It summarizes some of the points of discussion at the Institute of Medicine's Vaccine Safety Forum. Included is information of informative materials, informed consent, and the reporting of adverse effects. A more complete report of the forum is available on the Internet at <http://www2.nas.edu/hpdp/>.



their distribution to doctor's offices, clinics, schools, and other groups and organizations throughout the country.

In its second printing and still in high demand, close to 50,000 poster sets have been mailed. The poster campaign teaches the fundamentals of childhood immunization in a fun, new way that is enjoyable to all. A combination of color and characters and catchy wording adds whimsy to the seriousness of vaccine-preventable diseases — *What's going on here?/What's wrong with this fella?/Why isn't he protected against/ measles, mumps and rubella?* (King Stilts). The posters target parents, caregivers, and health care providers with three central messages: 1) Keep track of your child's vaccinations, 2) Be aware of schedule changes and new vaccines, and 3) Immunize on time, every time. Dr. Seuss' stories and characters are universally recognizable and appealing — crossing cultural, socioeconomic, and demographic boundaries. To achieve full immunization for all children, immunization programs and

## The National Immunization Information Hotline

The National Immunization Information Hotline provides information to both English- and Spanish-speaking populations 15 hours a day, from 8:00 a.m. to 11:00 p.m.

Eastern Time. Parents, caregivers, health care providers, and the general public, throughout the United States, its Territories, Puerto Rico, and the U.S. Virgin Islands make an average 130 calls per day for immunization information.

The Hotline is staffed by trained professionals who answer questions and provide information on immunization programs or recommendations, refer callers to local clinics and public and private providers in their regions, and accept requests for vaccine information statements and other publications and materials.

After hours, Hotline voice information and messaging systems continue to relay information to callers. Special services are available for the deaf or hearing impaired, persons who speak English as a second language, and persons with physical challenges. □

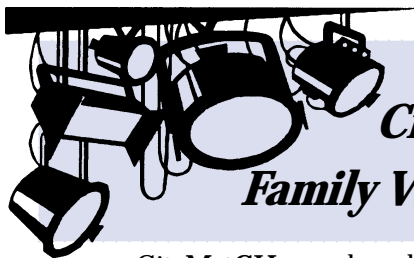
English: 1-800-232-2522

Spanish: 1-800-232-0233

.....

plans must also cross cultural, socioeconomic, and demographic boundaries. These Dr. Seuss posters are helping to make that happen.

All in all, Mrs. Geisel, donated six pieces of original artwork from her late husband's private collection. The second set of three posters will be released in September 1998 in Los Angeles at the Immunization Education and Action Committee Meeting. These posters include characters from *Yertle the Turtle and Other Stories*, *If I Ran the Zoo*, and *The Sneetches and Other Stories*. For more information about the posters and to request an order form, contact Joy Dorsey at 404-639-8698. □



## CitySpotlight 1997: Lincoln's Family Violence Prevention Council

CityMatCH was pleased to recognize the Family Violence Prevention Council in Lincoln, Nebraska with a 1997 SpotLight Award for the following MCH initiative:

The Family Violence Prevention Council was established with funding from a prevention block grant. It has sought out and established broad-based involvement and collaboration among schools, health care organizations, health care advocates, clergy, law enforcement and community advocates. The need for such a group became evident during a Community Health Partners conference, where violence and affordability of health care were cited as top health concerns.

Achievements have been recorded in several areas. The Council has been able to establish Safe Nights at two schools and a Friday night gathering site for the Mad DADS, a men's advocacy group working to prevent youth violence and drug abuse. The council has also

been able to develop and distribute a resource guide for local clergy. The Violence Prevention Council also has assisted in the creation of "Men Against Domestic Violence," a community action group.

Local hospitals and the Health Department are currently working together to create a standardized emergency room reporting form to address the problem of inconsistent reporting of data. The Lancaster County Health Department has been involved in the Council's work by helping to assemble the coalition, providing expertise in analyzing hospital data and crime reports, and by developing the resource guide for the clergy.

For more information on the Violence Prevention Council, contact:  
Steve Beal  
Lincoln-Lancaster County  
Health Department  
3140 N Street  
Lincoln, NE 68150-1514  
(402) 441-8045

□

### Calling All Profiles

In order to be included in the conference materials, Urban MCH profiles need to be returned by participating members CityMatCH by August 7, 1998. Profiles provide current information about MCH efforts throughout the United States, which may be useful to your health department in planning new efforts and modifying and comparing current efforts.

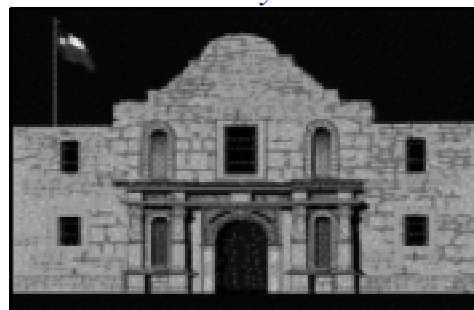
Health departments that return the profile on time also become eligible for SpotLights recognition. Member profiles also will be published in Lessons Learned 1998. Profiles are required for member participation in the 1998 CityMatCH Conference, "Remember the Mission: Improving the Health of Urban Children and Families," in San Antonio. □

### Members Elect 98-99 Board

CityMatCH members elected five representatives to serve on the Board of Directors for three-year terms beginning September 1998:

- Region II: Llamara Padro Milano  
Syracuse, NY
- Region IV: Betty Thompson  
Nashville, TN
- Region VII: Carole Douglas  
Lincoln, NE
- At-Large: Gary Oxman  
Portland, OR
- At Large: Zenobia Harris  
Little Rock, AK

The slate of candidates was among the largest ever. Over 50% of the membership cast ballots. Congratulations to our newest CityMatCH leaders, and kudos to all nominees for offering their service. □



### 1998 CityMatCH Leadership Conference At-A-Glance San Antonio, Texas September 12-15, 1998

**Friday, Sept. 11**  
'98-'99 Data Use Institute  
Orientation

**Saturday, Sept. 12**  
'97-'98 DUI Teams Meeting  
Pre-Conference Workshops  
CityMatCH Board of Directors  
Meeting

**Sunday, Sept. 13**  
Exhibit Set-up  
"CityMatCH 101" Breakfast  
Data Use Institute Symposium  
Regional Kickoff Luncheon:  
"It Starts with Community"  
Skills for Making A Difference I  
Opening Night Reception  
-SpotLights Recognition  
-Data Use Institute Poster Session  
-Children of Children Exhibit

**Monday, Sept. 14**  
"Hot Topics!" Breakfast Roundtables  
Skills for Making A Difference II  
Plenary 1: *What Will It Take?: Eliminating Racial Disparities in Urban MCH Outcomes*  
CityMatCH Annual Business Meeting  
San Antonio Area MCH Site Visits  
Urban-State MCH Task Force Meeting  
Friends of CityMatCH Dinner

**Tuesday, Sept. 15**  
CityMatCH Action Groups Breakfast  
Action Workshops  
Plenary 2: *"Our Cities. Our Future?"*  
Closing Luncheon: *"Stories for Heading Home"*

**Advance Registration  
Deadline:  
August 7, 1998**

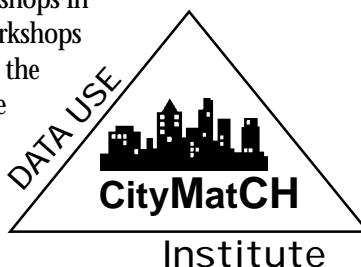
## Data Use Institute Announces 1998-1999 Teams

CityMatCH has selected its teams for the second Urban MCH Data Use Institute (DUI). The eight teams selected from Phoenix, Arizona; Orange County, California; Hartford, Connecticut; St. Petersburg, Florida; Shreveport, Louisiana; St. Paul, Minnesota; Greensboro, North Carolina; and Columbus, Ohio will be funded in part by CDC. Many qualified teams proposed interesting and creative projects; a few additional teams have been invited to participate upon securing independent funding for DUI activities.

Teams were selected on the basis of team composition (members had to have experience in one or more of the following areas: data analysis, policy/politics/presentation, and/or program planning); demonstrated agency leadership; data use capacity; project feasibility and creativity; a clear potential to improve the health of women, children, and families in their community; and overall health department commitment to support the team in their DUI participation and project completion.

Team projects proposed range from implementing an urban PRAMS project, to developing an integrated birth outcomes data system. Another will develop and test a neighborhood pediatric injury risk assessment tool.

The new teams will join first year DUI alumni at the Urban MCH Leadership Pre-Conference Workshops in San Antonio, Texas, September 11-13. The workshops will give this year's teams the opportunity to set the agenda for the upcoming year, network with the 1997-98 teams, and learn more about data use through workshops on economic analysis, small area analysis, and data outcomes and accountability for urban MCH. For more information Contact Donadea Rasmussen at CityMatCH.



### *Leadership into Action Through Effective MCH Data Use*

*This special edition was produced with the additional assistance of UNMC's Printing Services Department. Special thanks to Lori Fuller for newsletter production, and to Michael Fullenkamp for project coordination. Thanks also to Ken Anderson, Bill Broom, Shaunette Crawford, Dean Mason, Pam Protzel-Berman, Karen Resha and Diana Woods at CDC/NIP for their help and input. Alison Johnson was instrumental in coordinating communication at CDC.*



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