

## Vaccines and Immunization Performance Measures

I read with interest the articles by Berman<sup>1</sup> and Mehl<sup>2</sup> regarding performance measures and new vaccines. Their comments are very thought-provoking and raise two questions:

First, when do “new” vaccines become “established” vaccines? Berman<sup>1</sup> suggests that “new” and “established” vaccines should be considered separately when immunization rates are being measured. But what are the criteria for new and established? Among the important factors to consider are state laws requiring specific immunizations for school entry or middle school attendance. For example, as of August 1999, 41 states and the District of Columbia require childhood hepatitis B vaccination (38 of these states require immunization before school entry, and 22 require immunization for middle school attendance).<sup>3</sup> Hence, it is reasonable to consider hepatitis B vaccine and other vaccines that are widely mandated by legislative action to be “established” vaccines when immunization rates are tracked. It is also worthwhile to determine how broadly an immunization recommendation has been implemented when deciding whether a vaccine should be considered new or established. This can easily be done by referencing national vaccine coverage levels (regularly published by the Centers for Disease Control and Prevention) and published data on physician immunization practices. Certainly, any vaccine that is widely administered and achieves high coverage rates should also be considered an established vaccine.

Second, should physicians’ immunization recommendations be measured? Mehl<sup>2</sup> proposed that physicians’ efforts to recommend specific immunizations be measured and recognized to give physicians credit, whether or not parents agree to have their children immunized. Although this approach may be worthwhile, it is difficult to implement because it would require extensive chart reviews that are likely to be inconclusive. Furthermore, such efforts generally cannot measure the strength of physicians’ immunization recommendations, further limiting their usefulness.

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### References

1. Berman HS. Performance measures: the destination or the journey? *Eff Clin Pract.* 2000;2:284-8.
2. Mehl AL. Physician autonomy, patient choice, and immunization performance measures. *Eff Clin Pract.* 2000;2:289-93.
3. Immunization Action Coalition. What’s your state doing? *Needle Tips.* 1999 Fall-Winter:11.

### DR. BERMAN RESPONDS

*I appreciate Dr. Schaffer’s constructive comments.*

*Let me start by discussing his first suggestion, that is, to define an “established” vaccine as one that is required by many states for school entry or one that is widely administered. For the purposes of Health Plan Employer Data and Information Set (HEDIS) scoring, it would make sense to choose one of these two definitions; I strongly prefer the latter, for several reasons. State laws presumably should follow good clinical practices, not define them; in addition, with the “new politics” surrounding immunizations, it may become riskier for politicians to require them than it was in the past. Finally, state legislatures can deal only with requirements for school attendance. This inevitably means that the immunizations are required by age 5 or 6, when clinically we generally want them administered by age 2.*

*Concerning the second point—the difficulty inherent in trying to give physicians credit whether or not parents agree to have their children immunized—I plead guilty. Plans and physicians already do too much paper pushing, and the benefits of this recommendation are not worth the extra chart reviews. However, I disagree with Dr. Schaffer’s statement that chart reviews “cannot measure the strength of physicians’ immunization recommendations.” In my experience, physicians as a group are guilty of underdocumenting advice and counsel. I would be pleased to assume that any physician who took the time to make a chart entry indicating that an immunization was offered and refused is also a physician who took the time to have a thorough discussion with the parent.*

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### DR. MEHL RESPONDS

*Dr. Schaffer articulates two important ideas. First, when should a “new” vaccine be considered no longer “new” but instead “established”? With his suggestions, one could propose a scheme that includes the number of years since introduction, the penetration thresholds as measured by national organizations, and school requirements established by individual states. An interim measure of immunizations deemed as “new” could then be tabulated separately from measures of “established” vaccinations, providing a better cross-section of the overall performance of a health care delivery system.*

*Second, Dr. Schaffer is also reasonable in suggesting that the measurement of a physician’s recommendations rather than actual completion of immunizations would be problematic. Nevertheless, in settling for a less ambiguous measure, the sacredness of the physician–patient bond will gradually but predictably be eroded, and informed consent will inevitably evolve into imposed consent.*

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