Transcript School and Child Care Immunization Requirements for Health Care Providers Webinar
June 7, 2023

- Okay. Let some folks trickle in here real quick, and then maybe we can get started at 12:01 since we have a lot of stuff to cover today.

- Sounds good.

- Okay. Well, hello everybody. Gonna let some more people trickle in, but I think we'll get started. So welcome, hope everybody's having a great day today. Welcome to the school and childcare immunization requirements webinar, and we will be focusing more specifically today on healthcare providers. And as I mentioned, we do have a lot to cover today, so we're just gonna jump right into it. So before we start the presentation, I just want to cover a few ground rules. If you've attended any of our previous webinars, you should be familiar. We mute everybody for the webinar. If you have questions, please type them in the Q and A box, and we'll keep, and we'll answer questions at the end. And please keep the questions on topic to the webinar today. We are focusing more on healthcare providers today than school staff, so just be aware of that. But everybody's welcome, of course. We have a lot of continuing education credit options for folks including physicians, nurses, medical assistants, pharmacists, pharmacy techs, and, for the first time, health educators. Woo. So yeah. So we'll cover more of the requirements at the end of the webinar, but, basically, you'll want to attend either the webinar or the recording and then complete the evaluation, and you should be good to go. And you can find more information about the webinar including the slides on our webinar webpage, and the Zoom reminder email you should have received an hour ago also has a link to that webinar page. We're required to show some accreditation slides here that align with our continuing education credit that we offer. So this is our statement for continuing medical education through the Federation of State Medical Boards. This is our continuing education statement for nursing continuing education credit approved through the Montana Nurses Association. And last, this is our statement on CHES credit for health educators, and the Department of Health is an approved CE provider through NCHEC. Okay. And here's our disclosure statement. The planners and speakers of this activity have no relevant financial relationships with commercial interests pertaining to this activity. And we have two presenters today, Katherine Graff, who is our school and childcare immunization nurse consultant, and me, Phillip Wiltzius. I'm a school and childcare immunization and health educator. And obviously we're both from the Department of Health. Okay. So let's talk about our learning objectives, and then I will turn it over to Katherine. Okay. So we will identify updated school and childcare immunization requirements, including changes to DTaP, Tdap, polio, and requirements for four-year-old students, describe how to complete the certificate of immunization status and forms that healthcare providers give to families, discuss school and childcare exemption requirements in Washington state, and how clinicians should complete the certificate of exemption, identify clinic-based and external resources for vaccinating patients, learn different communication best practices for school and childcare immunization, and highlight some ways to support limited English proficiency families for in-clinic vaccinations. Okay, I'll turn it over to you, Katherine.

- Thanks Phil, I appreciate that. So today's webinar, will cover the 23,24 requirements, including updated guidance for four-year-old students and the Tdap roll-up. I'll share some resources for PC and Hib, and some information about the DTP family rules and catch-up schedules. We'll talk about information about the certificate of immunization status and certificate of exemption forms, an update to the school module rollout and resources, then I'll hand it back to Phil for some communication best practices. Like

he said, we'll have time for questions at the end. Let's start with the immunization laws and rules. The immunization law in the "Revised Code of Washington" gives the Washington State Board of Health the authority to determine the immunization rules in the Washington Administrative Code, including which diseases children must have documentation of full immunity against and what kind of documentation is needed. The Department of Health has webpages with links to the RCWs and all of the applicable WACs. You can access them from the main school and childcare webpage at www.doh.wa.gov/scci. This page really is a one-stop site for everything related to school and childcare immunization requirements. It's a good page to bookmarks so you'll always have access to the most up to date information and forms. Now, let's move on to the immunization requirements themselves. The child and adolescent CDC schedule recommended by the ACIP includes vaccines to protect against the diseases listed on the left. The Washington State Board of Health then determines which of these diseases children in school and childcare must have full immunity against. Those are listed on the right. The Washington immunization requirements follow the national recommended schedule, including the age when vaccine should be administered and the time intervals between doses. For children and adolescents attending preschool through 12th grade, the requirements are applied to specific grades. If providers vaccinate according to the CDC recommended schedule, their patients will be in compliance with the school and childcare immunization requirements. Washington State Department of Health is responsible for creating the vaccine requirements charts for the vaccines that are needed to document full immunity. This is the vaccine requirements chart for children in childcare. The requirements change based on the age of the child. There have been no changes to the childcare chart since December of 2021. If a child that is in childcare is also attending school, they need to meet the requirements on the school chart for the grade they're attending. And here's the school chart for the 23,24 school year. Again, it's based on the grade the student is in. Now let's go over the 23,24 requirement chart changes from this school year. A new footnote was added to the preschool transitional kindergarten row concerning students who are four years old on September 1st. The new footnote reads must have additional DTaP, IPV, MMR, varicella vaccine by the first day of school or within 30 days after the fourth birthday, whichever is later. This allows students 30 days from their fourth birthday to get the additional vaccine doses and turn in documentation to the school. This is consistent with the conditional status rules, which require documentation of the needed vaccine in a catch-up schedule to be turned in within 30 days of when the vaccine comes due. It is also equitable giving all students the same 30-day window if they have a birthday close to the start of school. For example, if a student turns four on August 15th, they will need, they will have until September 14th to get the extra doses and turn in documentation. If they have a September 1st birthday, they would have until September 30th. But if their birthday is more than 30 days before the first day of school, they must turn in documentation of the doses before starting school since it has been more than 30 days since they turned four. Now, I would like to emphasize that this should not be interpreted to mean that all students have a 30-day grace period for all vaccinations from the start of school. Additional guidance is in the immunization manual for schools, preschools and childcare facilities for students who are less than four years old on September 1st. It says that students who turn four after September 1st do not need to provide documentation of the additional doses until the next school year. Now, though the additional doses are not required until the following school year, we encourage providers to administer these doses after the child turns four to provide the added protection in the school setting, and have them up to date for the following school year. Now let's look at the Tdap requirements for students in 7th through 12th grade. The requirement for a Tdap at age 10 or older has rolled up to include 10th grade. In the 23,24 school year, students in 7th through 10th grade must have one dose of Tdap at age 10 or older. Students in 11th and 12th grades have been grandfathered, and are allowed to have a Tdap at age seven or older as allowed in the previous CDC ACIP recommended schedule. Though the Tdap booster is acceptable at age seven and older for those in 11th and 12th grades, we encourage providers to follow the current ACIP recommended schedule, and make sure all of

your patients have a Tdap booster at age 10 or older. In addition to the charts, I want to draw your attention to the individual vaccine requirement summary, or IVRS, which can be found on the school and childcare immunization website. It's an excellent resource that details the minimum ages and intervals for the different vaccines as well as the exceptions to the rules and catch-up schedules. We revise it every school year. I highly recommend that you refer to it if you have questions about the immunization schedule that must be followed for children to be in compliance with the Washington requirements. Now let's talk about Hib and PCV. As you probably know, Hib and PCV are not routinely given to children five years and older unless they have certain medical conditions, and, therefore, it's not required for school and childcare at age five and older. For children less than five, the number of doses needed depends on, for both Hib and PCV, the age of the child when the vaccine was administered. In some situations, only one dose is needed. For Hib, it also depends on which vaccine is used. The IVRS has two useful charts, one for Hib shown here and one for PCV. You can use this chart to determine how many vaccine doses are needed to complete the series depending on the child's current age, and the age they receive vaccine doses. In this example, a four-year-old child with only one dose of vaccine at 15 months old or older completed the series with just one dose. This is a similar chart for PCV. Okay, let's do a knowledge check. Here's the question. A child entering preschool or a transitional kindergarten who is four years old on August 15th must turn in documentation of the age four DTaP and IPV doses and dose two of MMR and varicella by, A, the first day of school, B, September 14th, or C, September 30th. And the answer is on September 14th, which is 30 days after the fourth birthday. Remember, they must turn in documentation of the additional DTaP, IPV, MMR and varicella vaccine by the first day of school or within 30 days after the fourth birthday, whichever is later. Now I wanna go over the diptheria, tetanus and pertussis vaccination rules and catch-up schedules. This is probably the most difficult of the vaccination schedules, and the one I get the most questions about. Here are some of the main rules that apply to the DTP family. DTaP vaccine is licensed for and given to children through age six years of age. Once a child turns seven DTaP is no longer used. We use Tdap instead. If they're in a catch-up schedule at age seven and older, they get a Tdap followed by additional doses of either Tdap or Td if needed. Though administering DTaP to a child aged seven and older is considered a vaccination error, the DTaP may count as a valid for the Tdap. DTaP contains more vaccine antigen than Tdap. Note, the capital letters mean a higher dose of vaccine antigen. And finally, there's a more obscure rule that we don't see very often that says because of the increased risk of larger localized reactions, no more than six doses of tetanus or diptheria vaccine should be administered before age seven. If a child has six or more DTaP, DT, Tdap or Td vaccines before age seven, and they need additional doses to complete the series because some of the doses are invalid due to not meeting the minimum age or interval, the IIS will forecast them for a Tdap at age seven. They can attend school and conditional status until the dose comes due at age seven. So this is the CDC ACIP recommended schedule for DTaP. Dose one, the first dose in the primary series at two months of age. Dose two at four months of age. It has a minimum interval between dose one and two of four weeks. Dose three at six months of age also has a minimum interval of four weeks from dose two. The next dose is the first booster dose given at 15 to 18 months. The minimum age for this dose is 12 months. It has a minimum interval from dose three of six months, though there is an exception to this rule saying that the dose can be considered valid if it was at least four months after dose three on retrospective record review. The final dose in the series is dose five, the second booster dose recommended at age four to six before school entry, including preschool. It has a minimum age of four years and a firm minimum interval from the previous dose of six months. The four-day grace period can be applied to all doses in the series. Now the DTP family catch-up rules. If a child gets behind on the DTaP schedule, fewer doses may be needed to complete the series. When determining the number of doses a child needs in a catch-up schedule, it's important to consider two things, the child's current age, and the age at which they received previous doses if any. If a child is 19 months to three years old, they need the full four doses in the routine schedule given before age four, they'll get the fifth and final dose

after they turn four. If the child is four to six years old, they can complete the series with a total of four doses. Must be at least four weeks between doses one, two and three, and the fourth and final dose must be on or after age four with at least six months from the previous dose. When a child is seven or older, we move to the catch-up schedule with Tdap. One of the doses must be a tdap, preferably the first one if more than one dose is needed. Just like with the DTaP, the final dose must be given at least six months after the previous dose. The total number of doses for a child this age depends on their age when they got the first dose. If it was before age 12 months, then they need four doses. If it was after they turned one year old, then only three doses in total are needed. Now, that's a lot to remember or you can reference the IVRS. It has all of these rules on pages six and seven. Now another question, true or false. DTaP should only be administered to children through age six. And the answer is true. DTaP is only licensed, and should only be administered to children through age six. If more doses are needed at age seven plus, we change to Tdap. Now let's talk about the certificate of immunization status form, the CIS. Before a child may attend school or childcare center, a parent must provide proof of the required immunizations, or immunity using a department-approved certificate of immunizations, or CIS form. The CIS is an official state form created by the Department at Health. It should not be recreated in an electronic health record. There are three acceptable versions of the CIS, the validated CIS printed from the immunization information system, or IIS, the CIS printed from MyIR, which is a place where parents can sign up to see their children's immunizations documented in the IIS, and a hard copy, CIS was handwritten immunization dates. If the hard copy CIS is used, it must be verified for accuracy by a healthcare provider or must have medical vaccination records attached so school or childcare staff can verify the accuracy of the vaccination dates. This is the validated CIS. The validation says complete, conditional or not complete for the series selected. It's very important to select the correct series so the validation is accurate for the child's age or grade. The CIS shows the date when it was printed and validated by the IIS. No provider or parent validation signature is needed. There are two places where a parent or guardian can sign the CIS. The one on the left is for schools using the school module. The one on the right is a place for a parent or guardian to acknowledge their child will be attending school or childcare with a temporary conditional status. This signature is required if the child will be attending in conditional status. Children who have not completed the vaccinations required for school or childcare can attend as long as certain conditions and timelines are met. For a child catching up on their vaccinations to attend school or childcare, they must have all of the vaccine doses they're eligible to receive, and not be currently due for any of the additional required doses. While waiting for the next dose to come due, they can attend school or be in childcare in that temporary conditional status. Once the dose comes due, they must turn in documentation of the dose within 30 days. More detailed information including a catch-up schedule, an overview video, FAQs, and sample parent letter is available on the school and childcare immunization page. Now, back to the validated CIS. If a provider has entered laboratory evidence of immunity by blood antibody titer into the IIS, the CIS will print the word immune in the positive titer column. This is considered provider verification of immunity, and no other documentation is required. If history of chickenpox disease has been entered in the IIS, the box on the varicella line will be checked. This is considered provider verification of history of disease, and no other documentation is required. The validated CIS has a page two action report. There are three boxes on the report, required vaccines, recommended vaccines and invalid vaccines. Of note is if something is in the invalid vaccines box, it may not need another dose depending on subsequent doses that were administered. Now let's talk about the hard copy CIS. Parents may fill out a hard copy CIS with their child's vaccination dates. It can be used for any child, but children coming from out of state have this version of the CIS most often since their vaccination records are not in the IIS. This is the hard copy CIS, what it looks like. It's the older version. Because this hard copy CIS does not use records from the IIS, it needs to be medically verified for accuracy. This is done by certification that the information is accurate at the bottom of the page. Well, this verification can be by a healthcare provider who is licensed,

certified or registered in a profession listed in the RCW if administering vaccinations is within the profession scope of practice. If signed by a healthcare practitioner, no medical immunization records need to be attached to the CIS, or a school nurse administrator, childcare health consultant or their designee. Before signing, they must determine the information on the CIS is accurate after comparing it with attached medical vaccination records. If not signed by a healthcare provider, the CIS must have medical vaccination records attached. Now, healthcare providers can use the gray section on the right to verify history of varicella disease. Again, this is considered provider verification of disease. Healthcare providers can also use this section to document laboratory evidence of immunity by blood antibody titer. This is considered provider verification of immunity. Note, immunity by antibody titer is not acceptable for pneumococcal disease or pertussis. And polio can only be documented as immune by antibody titer if they are immune to all three polio viruses. Testing for immunity to poliovirus type 2 has not been readily available since 2016, when type 2 was removed from the oral polio vaccine, or OPV still used in other countries. OPV doses administered on or after April 1st, 2016 do not contain vaccine against poliovirus type 2, so they cannot be used in series completion in the US schedule and in the school and childcare immunization requirements. Now let's talk about exemptions to the immunization requirements and their certificate of exemption form known as the COE. A child can be exempted from one or more of the immunization requirements. To do this, a properly completed and signed COE must be turned into the school or childcare. The COE is an official state form, just like the CIS, that's created by the Department of Health. It should not be recreated in an electronic health record. And of note is that exemption forms or letters from other states are not acceptable. Now, a personal or philosophical exemption is used when the parent or guardian has a personal or philosophical objection to the immunization of the child. This exemption cannot be used for the measles, mumps and rubella immunization requirements. There's also a religious exemption, used when the parent or guardian has a religious belief that's contrary to the required immunization. And it's important to note that there is no requirement for a parent to validate or prove their personal or religious beliefs. This is a screenshot of two sides of the COE form. Personal, philosophical and religious are on one side and medical exemptions are on the other. Now, philosophical and religious exemptions must have the signature of a healthcare practitioner, which is defined as a medical doctor, a doctor of osteopathy, a doctor of naturopathic medicine, a physician assistant or advanced registered nurse practitioner licensed in Washington state. The signature affirms that they have provided the signature with information about the benefits and risks of immunization to the child. A healthcare practitioner, who, in good faith, signs the statement about the education is immune from civil liability for providing the signature. Clinicians and school staff have no role in assessing the validity of parent or guardian's personal or religious beliefs. Signing the COE does not mean that the healthcare practitioner agrees with the parent's beliefs. Healthcare practitioners can also choose to give the parent a letter to be attached to the parent-signed COE. The letter must include the child's name, state that they have provided the information to the parents about the benefits and risks of vaccination and be signed, including credentials, and dated by the healthcare practitioner. Now, this is the section to be completed for personal, philosophical or religious exemptions. It should be used for parent-requested exemptions or alternate schedules. It needs both parent or guardian and healthcare practitioner's signature. Now, another kind of religious exemption is the religious membership exemption. It's used when the parent or guardian affirms membership in a church or religious body that does not allow the child to receive medical treatment by a healthcare practitioner. Because it would be against their religious beliefs to go to a healthcare practitioner to get information about the benefits and risks of immunizations, no healthcare practitioner's signature is required for this kind of an exemption. Now, if the parent or guardian has a religious objection to vaccination but the child does receive other care from healthcare practitioner, then they need to use the personal, philosophical, religious exemption section of the COE, which does require healthcare practitioner's signature. This is the section of the COE where the parent affirms they belong to a church or religion that doesn't allow any medical treatment by a healthcare

practitioner. The last type of exemption is a medical exemption. They're granted when there is a medical reason that the child cannot be vaccinated. This is based on the judgment of the healthcare practitioner. Guidance about considerations to contraindications of vaccinations can be found in the recommendations of the ACIP on the CDC website and the vaccine package insert. Now, medical exemptions can be permanent or temporary depending on the student's medical condition. Both require healthcare practitioner and parent or guardian's signatures. When the temporary exemption ends, the child has 30 days to get the missing immunization or another exemption. Now, this is the section to be completed for medical exemption. It should not be used for parent-requested exemptions or alternate schedules. If the exemption is temporary, it must have an expiration date. Some considerations of the COE include a completed COE can be used for the student's K-12 school attendance. Only temporary medical exemptions expire. Now, the most recent version of the form should be used for all new exemptions. And if a COE is incomplete or improperly filled out, it should be returned to the parent or healthcare practitioner to complete correctly. One thing we see a lot is where students have more than one type of exemption for an immunization requirement. They can only have one. So for example, both a medical and personal exemption for polio is not allowed. Now, different exemption types are allowed for different requirements. For example, a student can have a medical exemption for varicella and a personal exemption for pertussis. Additional exemption information including a fact sheet and FAQs is in the exemption section of the school and childcare immunization page. Now another question, which statement is true? A, the religious membership exemption can be used for children who go to a doctor for medical treatment, B, exemption forms from other states are okay to use, C, new exemption forms must be turned in annually, or D, the Washington certificate of exemption form must be completed for all exemptions. And the answer is D, the Washington COE must be used. Exemptions from other states are not acceptable. Now I wanna give you an update on the IIS school module rollout. This graphic helps to explain the relationship of the IIS and school module. Schools with view only access can view immunization records and print a CIS. The school module provides view add access like providers have. In addition to viewing records and printing a CIS, school module users can add records and run school-specific reports and letters. Now, where are we at with the rollout? Well, as of May, we have 210 public school districts, 88 private schools, 8 charters and 15 childcares or Head Start ECAPS using the school module. In all, we serve around 806,000 students in the school module, which is about 74% of OSPI's total K-12 enrollment for the 22,23 school year. Here's a map of school districts using the school module. As you see, it's starting to fill in. Now, healthcare providers play an important role in school module, and are critical to its success. The data in the IIS is used by schools to accurately determine immunization compliance for their students, and to quickly identify vulnerable students during a disease outbreak and results in fewer requests for immunization records from parents. The immunization data provided to the IIS impacts compliance status in the school module and the certificate of immunization status form. Missing immunization data in the IIS causes functionality issues. Healthcare providers can support parents and schools by entering missing historical immunizations, entering immunity and disease information, and providing medical vaccination records to schools and parents. I always like to leave you with some resources. For more information about this immunization requirements including forms and resources, please go to the website, the school website. If you've got questions, any questions about immunization requirements, please send them to oischools@doh.wa.gov. I'm really excited to share our new immunization page for families. This page is designed to help parents understand the rules around school and childcare immunization. It has all the forms needed to meet the requirements, and it is also translated into Spanish. Also wanna let you know about the new brief-on-demand video series. There's a video giving an overview of the requirements in Washington. There's one on the CIS and one for the COE and another for conditional status. They're available in the corresponding section of the school and childcare page. For example, the CIS video is linked in the CIS section of the page, and they're also on the

immunization training web page. One more pitch for the IVRS. It really is a go-to document regarding the different required vaccine series. And now I'm gonna hand it back over to Phil.

- Thanks, Katherine. That was awesome presentation. I was listening to you, so. Lot of stuff. So I wanted to cover some communication best practices clinics can do to help with school and childcare immunization. So my goal today is to share some observational trends we've noticed this year and previous years around school and childcare immunization. And then use that to talk about communication best practices to support immunizations. Additionally, I'd like to talk about families with limited English proficiency, and how they can support, how they can be supported around school and childcare immunization. And then please note, I'll abbreviate limited English proficiency to its acronym, LEP, moving forward. So broadly speaking, we've seen a variety of clinic and school trends from interactions with our community partners. We're hearing from healthcare providers, they're continuing to see high numbers of patients coming in, and, additionally, some providers are continuing to face staffing shortages. And luckily now we're entering the summer months. I've seen that a lot of the respiratory virus cases have started to decline. So hopefully that's providing everybody with a little bit of relief. On the school side of things, many schools face issues with limited access to nursing staff. I know, at least in my community, some schools are also facing budget cuts, which may or may not make this situation worse. And school nurses wear many hats, and immunizations are just one specific topic. Looking at the school immunization data from the 2022, 2023 school year, we're still seeing student immunization rates below pre-pandemic levels. We're also seeing a slight rise in out of compliance numbers. We've seen more requests for immunization forms and materials in different languages as well. And just a brief example, we have recently expanded our certificate of immunization status form to 16 different languages to support different communities in the state. I think when I first started working with Katherine, I think we might have been at five. So it's really been, it's been picking up a lot. When we look at the summer between school seasons, there are a few things that apply additional pressure on healthcare providers. Childcare numbers increase with school out, and families trying to find another place for their kids. Most families behind on school immunization requirements will schedule appointments before the new school year, and this can create a rush for appointments towards the end of summer. As Katherine covered, students need to show that they meet immunization requirements before the start of the school year, which is, we generally say around September 1st. Additionally, families who forget or don't know about the immunization requirements face the possibility of having their child excluded from school at the start of the year. And, of course, if clinics are already booked up with visits, those families are gonna have a hard time trying to get their kids in. So there are definitely a variety of factors that impact families getting in for immunizations. So let's talk about ways providers can continue to support school and childcare immunization. As many of you are aware, reminder recall messaging is one of the best practices we have at improving immunization rates. Reminder recall is simply the practice of determining which of your patients are due for immunizations, and then sending them a message letting them know they need to schedule an appointment. If you haven't already, I recommend reading through the CDCs page on reminder recall, which list of variety of studies that you can read. And broadly speaking, reminder recall is strong at improving immunization rates. It can reduce children who are behind schedule on vaccinations. And one of the best reasons, it's relatively cheap. You can break reminder recall into a two-step process, running a report to pull patients behind on immunizations, and then communicating out to them to get them to schedule an appointment. And there's a variety of ways you can do this messaging. Depending on your practice, you could do hard copy letters, cell phone texts, emails, patient portal reminders. Those are all great examples. And I suggest finding what works best for your organization. As a brief aside, I just wanted to show this comic panel, which I think highlights the need for reminder recall messaging. In my personal life, reminder recall messaging has been seared into my brain by dentists, and I don't know if you all have the same

experience, but we used to get postcards when I was a, when I was a kid that remind me about appointments, and then we upgraded to voicemail messaging. And now I get phone texts that say, "Hey, you're due for your appointment." And do I go to my appointments? Yes. But do I want to go? That's probably a different conversation we could have at a later date. So over the next couple of slides, I'm going to share some reminder recall tips. So when you use reminder recall, it's best to message out when you have the space for new appointments. And based on research, expect about 20 to 40% of your patients to schedule appointments from reminder recall. So use that number to inform the amount of patients you message. And if you're already practicing reminder recall, I just want to mention it's good to evaluate your messaging, and see how effective you are with that. Perhaps there's a communication method that's more effective about pulling patients or families back in for routine immunization visits. Now, looking specifically at school and childcare requirements, you might wanna focus your reminder recall efforts on school-aged children, perhaps at specific ages or grade levels, depending on the size of your practice. So for example, you might wanna pull a report on children four to six years of age as this is when they first enter the school system. Or perhaps during age 10, when children need their DTaP booster and HPV shots. One of the main goals for doing reminder recall for school immunizations is to reduce the appointment rush that happens close to September. So to me it feels like... We talk about reminder recall messaging as really awesome, but then I feel like sometimes folks are left alone to figure out what their messaging to patients should actually say. So I just wanted to briefly talk about writing a reminder recall message. And so it's important to pay attention to the actual wording of your reminder recall messaging. I wanna stress the importance of following what we call plain language standards. So using short, simple sentences and avoiding any kind of jargon. So the question is why is that important? And there's some research that suggests that the average person in the US has a reading level of seventh to eighth grade, and almost 20% of working adults are functionally illiterate. And that means they have a difficulty performing tasks that require reading skills beyond a basic level. An interesting point with this is that the white population in the United States is the largest portion of this illiteracy rate, but obviously it affects many different groups. So writing in simple terms will have the broadest reach. And if you're in a community with lower illiteracy rates, you might want to use multiple communication methods such as voicemail messaging, which may be more effective at getting people in the door. Another important reason for simplicity is if you need to translate your reminder recall message into a different language. So Spanish for example. I'm gonna skip over this for time, but I have two contrasting examples of reminder recall messaging here. The first one I just made to break all the rules I've shared. And then the second example is a good example of being clear and concise. I wanted to plug one of our reminder recall resources here, which we just created. It's a multi-language reminder recall letter for immunizations and well-child visits, which you all can use. It's found on our immunization quality improvement for providers webpage. And the document contains a simple reminder recall message for immunizations in well-child visits. It's written in English, Spanish, Vietnamese, Somali, Russian, Chinese, Korean, Amharic, Arabic, Ukrainian and Marshallese. And I had a great time trying to get all those languages on one page, but we did it. The goal of this letter is to make it easier for providers to message a variety of families in the language they prefer while reducing the workload of the provider having to print different language messaging for different families. So definitely check it out, and as well, if you want additional reminder recall support, that IQIP page is great. We have Crystal, a nurse consultant who specifically works in this who's a great resource. Okay, moving on from reminder recall. Let's talk briefly about external communication. I read some interesting research recently around social media and healthcare. 54% of millennials and 42% of adults would like to follow or friend their healthcare provider. Almost everyone, including parents, are on the internet and use social media with a vast majority using it for health information as well. So what does this mean? To me this means your practice has a value online, be it social media, blogs, emails, etc. As a millennial, myself, an elder millennial, I guess you'd say, I can tell you the one thing that I hate is when I search for a provider, and they don't have a webpage or even a

Facebook page. So it's just something to think about. You all are trusted members of the community, and your messaging carries weight, so utilize this communication to support school and childcare immunization work. So do you have extra space for vaccine appointments? You could write a quick blurb on Facebook. Want to share a community vaccination clinic? Share it out. Want to remind people that school is approaching soon, and it's a great time to check on your child's vaccinations? Excellent. And if you wanna talk about other health stuff as well, it's a great place to do so. Now, I understand we all don't have access to every form of communication at work, but utilize what you can. If you don't have time for social media posting or maybe it's against your organization's policy, look at utilizing the resources you have. For example, newsletter emails or giving reminders in your patient portal. And if you feel like you have a great grasp on this, I recommend looking at expanding your content to more than one language, especially if you have staff who already support another language. So for example, also posting in Spanish, Somali, whatever your community is made of. So if you're looking to get your feet wet with social media or perhaps want some content that's prepped for you, we have a variety of DOH toolkits with graphics and social media messages you can use for immunization-related content. And I believe all of our toolkits here have English and Spanish. Okay. And if you're just plain busy, and don't have much time for some of the stuff that I've talked about, here are a few things to consider. Use every appointment to check for immunizations. Many teens, teen boys specifically, are less likely to attend wellness checkups. So if they're in for a sports physical or another reason, it's a great time to check. You might want to consider vaccine appointment blocks that are shorter and allow you to handle more families. Some pediatricians have practiced this to great effect, we've heard. We also have the DOH caravan, which can now support communities with routine immunization. So check out that page if you want to request help. And, of course, consider referring families to other places if you don't have capacity. Some suggestions might be pharmacies, the local health department, if they vaccinate, mass vaccine clinics, etc. And, of course, these options will depend on your community and probably your patient's insurance status. And then last, I just wanted to plug local health jurisdictions. They're always a great resource, especially if you want to connect to a local school or consult about a mass vaccination clinic or get additional support. Okay. Let's see the time. We're doing pretty good for time. So I just wanted to talk briefly about supporting limited English proficiency families. So to give a little bit of background, I wanted to mention migration briefly, and this is really interesting. I've seen that Washington state continues to grow each year. They've never had a decline in the amount of people coming in. One in seven residents are foreign born, and they play an important role in our economy. We have also seen the refugee population grown in the last few years, with Ukrainian and Afghan refugees making the bulk of this group. This underscores the importance of providing translation services where needed. Of course, one of our goals in healthcare is to provide services in an equitable manner. So there's a variety of research showing LEP patients face worse medical outcomes compared to the general population, which is caused by a lack of language and culture support. So addressing these areas can improve quality of care. Okay. So in-clinic best practices around LEP should follow national, culturally and linguistically appropriate services standards, or CLAS standards. CLAS standards were originally created by the Office of Minority Health underneath the US Department of Health and Human Services to improve health equity and access to care. I have some broad examples up on this slide, but I'm gonna go, I'm going to go to the next slide to specifically talk about immunization work. Okay. So applying some CLAS standards. Share some examples of how you can support LEP families. Prepare immunization materials in the appropriate language before the visit. Just like the CDC has VIS statements in different languages, the Department of Health has required immunization forms and charts, as I mentioned, in 16 different languages. So it'd be good to have those on hand. Understand there may be cultural differences around immunization. So trying to approach this situation with curiosity and ask questions to learn their standpoint. Use simple and straightforward language to explain the vaccine requirements. And I did wanna mention, if they request an exemption, go ahead, provide the exemption, provide the education,

but remember that you can continue to recommend vaccination at the next visit. I want people to remember it's a longer-term discussion with your patients, and you might need to build that rapport before they might be willing to vaccinate. So just take that in mind. And I did have a note here just to be careful about refusing exemption requests as it may restrict access to care depending on the patient's insurance status. So as Katherine mentioned, signing an exemption form does not mean that you agree, but just that you've provided the education to that patient. And it's not always possible, but if you're supporting an LEP family with a vaccine appointment, it can be, it can help to get any immunization records ahead of the visit. You may need to do some interpretation or get the document translated. And if you do not, add those medical records into your IIS or EHR. Having posters, materials or other materials in appropriate languages in patient rooms can go a long way. Dr. Gretchen LaSalle, one of the pediatricians we regularly present with, she recently has been talking about the importance of having relevant immunization charts and posters in patient rooms, which I thought was really interesting. And so if you think about it, while a patient is in the room, they're looking around, reading stuff. If they see the official vaccination chart in their specific language, they can say, "Oh, yes. I can see that this is the vaccine schedule, and my child is due for vaccination." So it actually primes them to be more receptive to your recommendation when you enter the room, which, of course, is interesting because we want them to believe you as the community leader expert. But just having that additional resource helps a lot. Okay. So I listed a lot of resources and references here. Some things to note, the AAP has some example reminder recall messaging on their site. That's number six on this slide. There's some great resources for clinicians here. Number 12. DHS has a cool flip book which helps staff identify a patient's language. And we didn't cover this in the presentation, but it's important to make sure that your new patient intake process screens for language preference. Number 16, HSQA actually has an older guide which talks about similar things as the CLAS standards, but it has a really nice primer on how to use interpreters during a patient visit. For example, talking to the patient and not their interpreter. So there's some really cool tips in there if you're not used to using an interpreter. And something that I'd like to provide as a resource, the healthcare authority offers interpreter service support for patients with Apple Health or Medicaid, which can be helpful for providers looking for more interpreter support. I'm not the expert in that though, so you'll wanna check out that website if you want to enroll. And then last on this slide, I've linked some of our existing resources. I think Katherine listed them as well, the CIS, the COE, the parent charts in 16 different languages. Great for patient rooms. And then our new family-friendly immunization page, which Katherine also mentioned. And then this last thing, down on the bottom here, while resources are still limited around interpreting non-English immunization records, Spokane Health District has a great guide for interpreting Russian and Ukrainian immunization records for school. And Katherine and I recently discovered an immunization record interpretation guide for Mexico specifically. So we have those listed as well. And as a note, schools often struggle with non-English immunization records, and so if you have the abilities to support them as much as you can, I promise you they'll be very appreciative. And I think it was a new area, where we need to see additional resources, but, hopefully, we'll see more support for this in the future. I just wanted to mention too, I'd love to hear from all of you, what practices you're doing to support LEP families and school immunizations. And if there's any support or resources you need, we'd love to hear from you. For example, we did, I think, a survey earlier in the year where we got a lot of feedback from healthcare providers saying that they would love to see more immunization posters. So feel free to shoot us an email if you're interested, and let us know how things are going. Okay. I'm gonna slide through this real quick 'cause I wanna get to questions. Okay. As I mentioned before, continuing education credit, watch the webinar or the recording, complete the evaluation, and then it takes a couple of weeks, but we will send you a certificate in the mail. And if you have any questions about those, please email Trang Kuss at trang.kuss@doh.wa.gov. And just something specifically for health educators only, please make sure to watch the webinar or the recording, and complete the evaluation no later than June 19th, this month. And as part of the evaluation, you'll need

to enter your NCHEC credential number as well. Okay. And one last thing, we've recently created a new email subscription list for folks interested in immunization training. If you're interested, you can directly subscribe at the link above, otherwise you can edit your dev delivery subscription preferences on the DOH website. And the immunization training list will be found under the immunizations topic. Okay. Let's get to questions. So Katherine and I know, I believe, earlier we had some questions specifically around vaccination. This first question is on Hib. So if all doses of Hib are not received by 15 months then the patient needs additional doses at under five years old. Is this correct?

- Yes, they're going to need the number of doses. Take a look at the schedule in the IVRS that I pointed out 'cause it'll show that they might need fewer doses, but they will need doses, depending on when they had the doses and how old they are now.

- Somebody else asked, does the grace period rule mean that doses may be administered up to four days early?

- Yes. That's the general four-day-grace-period rule in the CDC schedule and their clinical guidance. Of note, though, is that four day grace period does not apply for two different live vaccines, that 28-day rule. So if you have an MMR and a varicella, the varicella has to be at least 28 days after. So you can't apply the four day grace period in that situation.

- Let's see here. How can we help providers, MAs, school nurses feel more confident in handling it when families only want the required vaccines?

- That's a good question. I think making sure we understand the value of each of those different vaccinations and the diseases that they protect against, and help parents understand that even though they're not required in Washington state, they're still really important for children to have so they can have the maximum protection.

- Yeah. Yeah, especially HPV focusing on the cancer prevention, meningitis, obviously, great for kids that are going to college. So, yeah. Being aware of those different things. Let's see. A significant number of my students are immunized in Oregon. Is there any progress being made in making those records available to Washington schools?

- So I know that our IIS folks here at DOH that manage the system are actively working on trying to get interoperability between Oregon's IIS and Idahos, too, for the other side of the state because we do understand that there are children that go back and forth to the doctors, and they're not always vaccinated here in Washington. So it is actively being worked on. It has to do with laws and rules around privacy and things, and so sometimes it can take a little while, but we're not giving up.

- Great. Let's see. We have a question around the four-year-old rule here. So the WAC states that doses a child is eligible to receive must be given when the immunizations are part of a series, and must be given within 30 days after recommended date. I'm confused by this for kids turning four after September 1st if they don't need the dose till the next school year. Can you please elaborate?

- So, actually, the part of the WAC that talks about that is actually talking about students who are in conditional status specifically. So, basically, if a child is not four years old yet on September 1st, then they're gonna have the preschool requirements that are on the chart for children who are less than four years old, which does not include those additional doses. That's why they're not required until the next

school year. But like I said, we encourage providers to give the doses when they come in after they have their fourth birthday so that we can make sure they're ready for next school year. And we encourage preschool staff to let parents know, "Hey, your kid's due for some more vaccines. They're not required, but would be really great to get them done so you're ready for next year." So yeah.

- Are you planning on any more virtual vaccine promotions or social media promotional materials? And if so, will they be in multiple languages? I'd say we're always looking to create more social media and promotional materials. It usually depends on what campaigns we're trying to do statewide, but we will usually create toolkits to support providers with that. We will always have them in at least English and Spanish, but I agree, we should probably expand that out to other languages as well. That's something that we're continuing to work on. And we'll try to share those as well when we create more. Let's see. For those who have a licensed health practitioner in Oregon due to living on the border, can their provider sign the COE?

- The law is pretty specific, saying that the healthcare practitioner who signs the COE must be licensed in Washington state. That's the way the law was written. So really the answer is no.

- Right. Well, it could be a possibility that they're licensed in both states, right?

- If they're licensed in, Yeah, if they're licensed in both states, then definitely they can sign it, but it does say licensed in Washington.

- You see the COVID vaccine being required for school-aged children. So that's more of a State Board of Health question. The State Board of Health is the one who determines school immunization requirements. As of now, that's been a no, but that could be revisited. But I've not heard of anything like that, so I wouldn't count on it. Let's see. Are we allowed to translate the vaccine records? So I guess this depends if you're school staff or clinic staff or... So if you are, let's say, a clinic staff that is trained... Let's say you're native Spanish, yeah, I mean, you're totally fine to translate those records. Again, like I said, if you need help, it's probably best to get those translated or interpreted, but we do, obviously, have some guides to support school staff and clinicians to interpret those records to be able to enter them. So the answer is yes, you do have the ability to do so. Question about polio. You talked about OPV not qualifying for polio requirements. Do we revaccinated these patients?

- If they don't... You don't use those doses in determining series completion. So if they don't have enough doses of OPV either before 4/1, 2016 or IPV doses to complete the series, then you would give additional IPV doses needed to complete the series.

- Somebody asked what do they do if they have a refugee student without immunization records? Are they able to start school?

- They're gonna need to get at least the first dose in the series of the required vaccines to start. So getting them connected with a healthcare provider as quickly as possible. Many refugees have already had some of the vaccines as they come in as part of their refugee status. It depends on what path they came in through.

- Let's see. Somebody said we have been using the IIS for a couple years, and we are not on the school module list, just to clarify. Is the school module new? Do we need to get set up again? So if you're a clinic, you don't need access to the school module.

- If you're a clinic... Right. It's for school staff. It's for schools to take care of their school immunization and their students. If you're a school, then go to the school module website, which is linked on the school and childcare page, and there's information about how to get set up. School module has been rolling out since 2016, so not new.

- Oh, they said they're... To clarify, they said they're a childcare.

- Oh. Yeah, childcares, we're working on getting access. You do have to have access to a nurse or somebody else with a medical license. But we're working on that. Hopefully we'll get you access too.

- Okay. Let's see. One more question, and I think we'll wrap it up as we're a little bit over time. Somebody was asking, they said, am I correct that Tdap Boostrix and Adacel are not licensed for seven year olds? So when they're needing Tdap at seven, are we going off license?

- You are. So Tdap is... You are correct. Tdap is only licensed for age 10 and older, however, ACIP recommendations very clearly state that a Tdap should be used in this situation, and immunize.org's ask the experts has a question explaining just this, that sometimes the ACIP recommendations differ from the package inserts. And this is one of those situations. So you'd have the backing of CDC ACIP in making that decision to use Tdap.

- Great. Well, I hope you all found this information useful. Obviously there's a lot of stuff packed in, so please go on the website, download the slides. I'm hoping to have the recording up early next week so you can refer to that as well. When the webinar ends, you should get a browser popup that will have the evaluation. If you don't have time to do the evaluation, you'll get an email from Zoom tomorrow with the link to complete the evaluation. So I hope everybody has a great day, and thanks for attending.

- Bye everybody.