IMMUNIZATIONS NEWSLETTER

PROVIDING GSA MEMBERS WITH UPDATES ON ADULT IMMUNIZATIONS

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FEATURES

News

• Influenza should be high on the diagnosis list as clinicians see patients during a difficult influenza season in the United States, the Centers for Disease Control and Prevention (CDC) warns. Remember that it’s not too late for patients to get the flu vaccine—even those who have had influenza this season could be protected against other circulating strains, and those getting the vaccine now will be protected through any late waves of influenza activity. For hospitalized patients and high-risk individuals seen in any health care setting, neuraminidase inhibitors should be used when influenza is suspected. Therapy is most effective when started within 2 days of the onset of symptoms. During early January, influenza activity was widespread in nearly all states in the United States, and 5.8% of people seeing physicians were complaining of influenza-like illness. (See Figure on page 5).

Resources

• The Vaccine Finder is a resource maintained by the CDC and its partners to help patients find nearby locations where vaccines are available. The finder includes influenza, pneumococcal, hepatitis, shingles, and other recommended vaccines.

• View a new What’s Hot publication from GSA on the impact of age-related decline in immunity, the connection between infection and events such as heart attack and stroke, and an overview of new vaccines that have overcome immunosenescence to better protect older adults.
With the Medicare Annual Wellness Visit (AWV) presenting an ideal time to recommend vaccines, there are some efficient and effective ways for a health care provider to do so. The first is using a presumptive approach rather than a participatory one. For example, the participatory approach would involve language such as, “There are a few shots that are recommended for you. Would you like to receive them today?” A presumptive approach is better: “Today, I recommend that you receive these vaccines. I’ll have the nurse bring them in when we are done.”

The second way to make a recommendation is the SHARE model promulgated by the CDC. At the foundation of each component of SHARE (share–highlight–address–remind–explain) is a personalization of the conversation—giving tailored reasons that the vaccine is right for the person’s age, health status, or lifestyle, or explaining the potential costs of getting the disease with activities that mean something to the patient (such as cooking, hiking, spending time with family and friends).

Both of these approaches increase the willingness of individuals to receive the vaccine, although simply hearing a recommendation from their health care provider remains the strongest predictor of getting vaccinated.

TIME AND PLACE: VACCINE PROMOTION DURING MEDICARE ANNUAL WELLNESS VISITS

Despite their importance to public health (and readers of this newsletter), immunizations are not always top of mind when clinicians see patients. If a patient presents with an acute problem or for management of symptoms of a chronic condition, the few minutes physicians have to see the patient are taken up resolving the situation at hand. People typically don’t remember when or even whether they’ve received many vaccines. Immunization status may not be on the radar for many specialists—especially those who assume the primary care providers are taking care of vaccines.

For Medicare beneficiaries, there is now a perfect time and place for a review of vaccine status—during the Annual Wellness Visit (AWV). A recent article reminds us of this opportunity and provides data linking vaccine administration with this visit. The article, published in *Vaccine*, was authored by Angela K. Shen of the National Vaccine Program Office and colleagues from Acumen LLC and the Centers for Medicare & Medicaid Services.
First offered in 2011, the Medicare AWV provides a yearly visit for patients and providers to focus on prevention and health. Analogous to the “well-baby visits” that guide much of pediatric care, AWVs extend the success of the Welcome to Medicare preventive visit, which is a covered benefit for those within their first year under Part B of the program.

Beneficiaries who have been covered for more than 1 year are eligible to have Medicare AWVs. Clinicians should initially conduct a health-risk assessment, take a medical and family history, manage medications, screen for cognitive changes and depression, and give advice on preventive steps such as weight loss, physical activity, smoking cessation, fall prevention, and nutrition. At subsequent AWVs, these areas should be revisited and updated as needed.

In the few years since AWVs were created, relatively few people on Medicare have received the benefit, but the number is growing. According to the recently published analysis, utilization of AWVs increased from 8% of beneficiaries in calendar year 2011 to 20% in 2015.

Given the focus on prevention, AWVs provide a natural opportunity to review vaccine history and provide a strong recommendation to get needed immunizations. Authors of the Vaccine article used Medicare data to study the timing of vaccine administration and the AWVs among Medicare beneficiaries. In the first 2 years after the pneumococcal conjugate vaccine (PCV13) was recommended for people at age 65, the data show a significant relationship between participation in an AWV and receipt of PCV13. Similarly, during the five influenza seasons following establishment of the AWV, those using the new benefit were significantly more likely to be vaccinated against influenza than were other Medicare beneficiaries.

Vaccination on the same day as the AWV was especially high for PCV13; 46% and 55% of those receiving PCV13 were immunized on the day of their AWV in the first 2 years of coverage. Seasonal influenza vaccine had lower same-day figures, in the 14% to 17% range over the 2011–15 timeframe, reflecting the lack of congruence between availability of the vaccine and timing of the AWV and broad availability of influenza vaccine in other health care settings, including pharmacies.
What can be learned about vaccine behaviors from the AWV experiences thus far? While those patients who choose to have an AWV could be more accepting of vaccines because of their general attitudes toward healthy behaviors, the high percentages of pneumococcal vaccines administered on the day of the appointment is encouraging. As the Vaccine authors noted, “The utility of the AWV…demonstrates promise as an efficient, timely, and important platform for implementing the [National Vaccine Advisory Committee] standards and improving adult vaccination uptake.”

Involvement of patients in wellness efforts and care decisions builds self-efficacy and empowerment—and such wellness efforts are critical in management of chronic diseases. After all, the patient is a real determinant of which interventions are made and which are ignored; without a commitment to better lifestyle and medication adherence, chronic diseases only worsen.

For immunization advocates, having this opportunity is crucial to overcoming vaccine myths and hesitancy. When people expect a vibrant conversation about health, they are ready for and receptive to messages of the importance of protecting themselves against pathogens such as pneumococci and influenza. Efforts to expand use of the AWV by Medicare beneficiaries should improve vaccination rates and propel the nation toward better protection against avoidable disease morbidity and mortality.

Highly positive vaccine messages during AWVs are feasible because of advances in the science and technology behind these products. High-dose and adjuvanted vaccines are performing well in those aged 65 or older, and promising new vaccines are in the pipeline. As detailed in past issues of the NAVP Immunizations Newsletter, better vaccines against influenza, pneumococci, and other pathogens are in preclinical and clinical testing. Success at this level will create even better messages for AWVs in the future, leading to better outcomes and reinforcement of the decision to get immunized.
Influenza Positive Tests Reported to CDC by U.S. Clinical Laboratories,
National Summary, 2017-2018 Season


SOURCES AND RESOURCES