SUMMARY: TAKE-HOME POINTS FROM THE ELIMINATING ADULT IMMUNIZATION DISPARITIES SYMPOSIUM

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1. **Adult Immunization Disparities Are a Significant Public Health Problem**
   a. Eliminating disparities is a major priority of *Healthy People 2010.*
   b. Disparities occur across racial-ethnic groups, socioeconomic classes, and geographic areas (both regional and rural-urban). Both African-American and low-income uninsured groups suffer marked disparities in immunization rates (especially pneumococcal vaccine).
   c. These disparities result in tens of thousands of vaccine-preventable pneumonia hospitalizations and deaths each year.
2. **Immunization Disparities Arise from Barriers at Multiple Levels**
   a. *Patient-Level*—Issues of mistrust, motivation, competing priorities, fears, lack of knowledge, etc lead some patients to choose not to be immunized.
   b. *Provider-Level*—Health professionals have many competing priorities for providing acute care, chronic disease care, and preventive services all within severe time constraints. Practices are also often disorganized or non-systematic in their approach to patient care (ie, one patient at a time in the exam room, no electronic health record, no systematic strategy for reaching at-risk populations).
   c. *Systems-Level*—Many non-elderly, at-risk patients are uninsured, while others lack a primary care home or access to a safety-net provider. Waiting in line at a community vaccination site or waiting for a scheduled provider office visit can be a barrier. Vaccine shortages frequently disrupt effective programs in the community.
3. **We Can Learn from Effective "Best-Practice" Programs**
   a. CDC READII program—Strategies include grassroots community organizing, lay health worker/community health aide (*promotora*) models, partners with community pharmacies and other non-traditional delivery sites, etc.
   b. University of Chicago's Robert Taylor Homes project (Daum et al)—Strategies include aggressive outreach, culturally-relevant outreach staff, person-to-person contact, trust-building, continuity, follow-up, partnerships with community health centers, public health programs, and social service agencies.
   c. BUT: These programs face continuing challenges such as instability of funding streams, and uncertainties in vaccine supply.
4. **Cultural Differences Can Be Both a Challenge and a Resource**
   a. Reality of trust issues tied to historical experiences; Tuskegee is one of many examples.

Bottom Line: The goal of eliminating disparities in adult immunizations is a focused, achievable target that could potentially eliminate at least 5% of disparities-related years of potential life lost (YPLL) from vaccine-preventable pneumonia deaths.

(*Ethn Dis*. 2005;15[suppl 3]:S3-27–S3-28)

b. Lack of diversity, ie, the lack of linguistically, racially, and culturally competent health professionals in high-disparity communities often exacerbates a "medical culture" that under-values community strengths. Non-minority health professionals will often need "*bridge-persons*" such as *promotoras* or outreach workers who can be their community ambassadors (and their teachers!).

c. Community strengths. African-American faith communities are a good example of a community strength, but is not a panacea and must be viewed as a base to reach out to other segments of the community through non-traditional sites (hair salons, barber shops, sports venues, etc). Emphasis should be on a commitment to the good of the community or group in some Asian communities, for example, in contrast to American individualism.

5. **Primary Care Practices Can Be Re-Engineered to Eliminate Missed Opportunities**

a. Missed opportunities for vaccination are frequent in "usual-care" settings due to competing priorities and lack of a systems approach.

b. "Within-practice" systems change (micro-process change) is more effective than programs targeting physician behavior change. Reset the default setting to do the right thing automatically, rather than doing nothing unless the doctor orders it.

c. Teamwork is essential. Within the practice, this might mean adopting standing orders for nurses to give vaccinations to anyone in relevant risk groups, scheduling vaccine-only visits, giving preventive services checklists to patient at check-in, etc.

d. Low-tech solutions can work, but electronic health records can add another dimension, if used to create population-based strategies for systematic care (not just an electronic filing cabinet for a traditional medical record).

6. **Community Partners Are an Untapped Resource**

a. A growing body of evidence suggests that partnering with community pharmacists can dramatically improve preventive services and chronic disease management. An example in this context would be "standing orders" for local pharmacies to give flu shots and pneumonia vaccine.

b. Other partners can extend our reach into communities, especially for populations such as men who are less likely to seek care. Example: partnering with local businesses to provide vaccine days when men could get a flu shot on Saturday mornings at their local home improvement store when they stop by for lumber or tools.

7. **Disparities Are Not Inevitable—We Can Fix This!**

Through a multi-pronged strategy, the United States nearly eliminated childhood immunization disparities during the 1990s. Working to eliminate racial/ethnic and socioeconomic disparities in immunization rates had the added benefit of improving health for all of our nation's children. We can do the same for adult immunizations, *if we so choose.*