

Prenatal Tdap Workgroup

November 30, 2017



Immunization Branch
California Department of Public Health

Agenda

- i. Welcome and Introductions
- ii. Review Prenatal Tdap Toolkit: What's still needed?
- iii. Local Health Department Toolkits & Efforts
- iv. SGF Tdap Doses Guidelines
- v. Announcements

Prenatal Tdap Toolkit

- Check it out at: <http://eziz.org/resources/pertussis-promo-materials/prenatal-tdap/>
- **Just added:**
 - FAQs: Medi-Cal Coverage of Immunizations
 - Prenatal Declination Form in Spanish

Question: Are we missing anything?

LHD Efforts

Fresno County Educational Efforts

- Contact top 3 local hospitals and provide education and distribute prescription pads to labor and delivery to refer to local Health Department Immunization Clinic for Tdap vaccination to include mom and other family members that will be around the newborn.
- A Health Alert that can turn into a news release has been drafted and will be used when the number of pertussis cases start to increase to alert providers and media

The health Alert is faxed/emailed to all medical providers in Fresno county

- A Pertussis Fact sheet has been developed and included in the packet being distributed to CPSP Providers and Hospitals
- Pertussis talking points have been developed
- A draft of a pertussis flyer has been created
- :30 PSA has been created
- Met with local PBS television station to discuss airing of the :30 PSA
- Letter from the Health Officer has been faxed/e-mailed to all providers in Fresno county and included in the packet being distributed.

Outreach to CPSP Providers

- A packet of information was created based on information shared by Carol Simmers-Tilma, PSC Merced County. One side of the packet has information for the provider including letters from the state and our Medical Director, Dr. Bird, the Declination form and prescription pads; the other side has a sampling of available education materials and how to order them as well as information on transportation as a covered benefit from Medi-Cal.
- Fresno County has 52 CPSP Certified Provider sites. There are 4 Federally Qualified Health Centers (FQHC's), with 24 sites; 1 Rural Health Center (RHC) with 8 sites; and 20 Fee-for-Service Provider sites.
- We also plan to reach out to non-CPSP providers.
- Schedule a conversation with the providers to discuss:
 - Promoting/providing the Tdap vaccine during every pregnancy between 27 & 36 weeks.
 - Emphasize the importance of minimizing the delay from recommendation to receipt of vaccine.
 - Enrolling in CAIR if not currently using.
 - Prescription to local Pharmacy or Public Health Department.
 - Document: referral and follow-up or declination on each client.
 - Answer question as they arise.

Barriers to Success

- Pharmacies are sending patients back to their MD/OB's:
- come back closer to your due date.
- Your insurance doesn't cover this.
- We are out of vaccine, waiting for vaccine, etc.

SGF Tdap Guidelines

1. **LHDs ensure site meets all program requirements**
2. **Provider signs MOU and is enrolled**
3. **First order:** Order up to 100 Tdap doses!
4. **Second order:** Order up to 100 Tdap doses *and* “match” with your own private supply

LHDs interview sites 1 month, 3 months (if no 2nd order is placed) and 6 months after initial order.

Announcements

Counts of pertussis cases, hospitalizations and deaths among infants < 4 months of age, California 2012 - 2017

	2012	2013	2014	2015	2016	2017*
Cases	127	195	534	327	118	87
Hospitalizations	68	105	282	179	51	36
Deaths	0	2	3	1	2	0

* Data are preliminary

FREE Gestational Wheels

Use and order
CDPH's FREE
gestational wheel!
Order sheet:

[http://eziz.org/assets/
docs/PNSsuppliersor
derform.pdf](http://eziz.org/assets/docs/PNSsuppliersorderform.pdf)



ACOG Antepartum Records

The American College of Obstetricians and Gynecologists
ACOG Antepartum Record

ANTEPARTUM RECORD

NEWBORN CARE PROVIDER: _____ Refused By: _____
 PRIMARY CARE PROVIDER/GROUP: _____ Address: _____
 Final EDD: _____
 Birth Date: _____ Age: _____ Race: _____ Marital Status: _____ Address: _____
 Education (Last Grade Completed): _____ Sex: M F D Sex: _____
 Occupation: _____ E-Mail: _____
 Language: _____ Ethnicity: _____ Insurance Carrier/Medicaid #: _____
 Partner: _____ Phone: _____ Policy #: _____
 Father Of Baby: _____ Phone: _____ Emergency Contact: _____ Phone: _____
 Total Preg: _____ Full Term: _____ Ab. Induced: _____ Ectopic: _____ Multiple Births: _____ Living: _____

Menstrual History

Onset: Oligo Amenorrhea (Month known) Duration: _____ Days Frequency: Day Menstrue (Age Onset) _____
 Unknow Normal Amount/Duration Prior Menses: _____ Date Contraception: Yes No Hq Lq Hc Lc

Past Pregnancies (Last Five)

Date Month/Year	GA Weeks	Length of Labor	Birth Weight	Sex	Type Of Delivery	Asses	Place Of Delivery	Birthweight Duration	Lactation Contact Needed Yes/No	Comments/Complications

Medical History

Detail Positive Remarks include Date & Treatment			Detail Positive Remarks include Date & Treatment		
p*	†		p*	†	
<input type="checkbox"/>	<input type="checkbox"/>	1. Allergic (Food, Seasonal, Environmental)	<input type="checkbox"/>	<input type="checkbox"/>	17. Dermatologic Disorders
<input type="checkbox"/>	<input type="checkbox"/>	2. Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	18. Operative/Invasive Procedures (Year & Reason)
<input type="checkbox"/>	<input type="checkbox"/>	3. Breast Disease/Surgical	<input type="checkbox"/>	<input type="checkbox"/>	19. Gyn history (Year & Reason)
<input type="checkbox"/>	<input type="checkbox"/>	4. Pulmonary (COPD, Asthma)	<input type="checkbox"/>	<input type="checkbox"/>	20. Anesthetic Complications
<input type="checkbox"/>	<input type="checkbox"/>	5. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	21. History Of Blood Transfusions
<input type="checkbox"/>	<input type="checkbox"/>	6. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	22. Infertility
<input type="checkbox"/>	<input type="checkbox"/>	7. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	23. Art (DM, CK, FxT)
<input type="checkbox"/>	<input type="checkbox"/>	8. Hematologic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	24. History of Abnormal Pap
<input type="checkbox"/>	<input type="checkbox"/>	9. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	25. History of STI
<input type="checkbox"/>	<input type="checkbox"/>	10. Immunological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	26. Psychiatric Issues
<input type="checkbox"/>	<input type="checkbox"/>	11. Rheumatoid Disease	<input type="checkbox"/>	<input type="checkbox"/>	27. Depression/Postpartum Depression
<input type="checkbox"/>	<input type="checkbox"/>	12. Kidney Disease(s)	<input type="checkbox"/>	<input type="checkbox"/>	28. Trauma/Violence
<input type="checkbox"/>	<input type="checkbox"/>	13. Deep Vein Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	29. Tobacco (Current, Cigarette, ENCS, Vapes) (MMT/Day)
<input type="checkbox"/>	<input type="checkbox"/>	14. Diabetes (Type 1 Or Type 2)	<input type="checkbox"/>	<input type="checkbox"/>	30. Alcohol (MMT/Wk)
			<input type="checkbox"/>	<input type="checkbox"/>	31. Drug Use (Including Cannabis) (Last 12 Mo)

Prepreg Prog *Vacc Use

ANTEPARTUM RECORD (FORM A, P)

- **Now** in our warehouse!
- Available as single copies, not pads of 50.
- Please send email: Rebeca.Boyte@cdph.ca.gov indicating desired quantity by Dec 5th.

Immunizations	Yes (Month/Year)		If No, Vaccine Indicated?*		Immunizations	Yes (Month/Year)		If No, Vaccine Indicated?*	
	___ / ___	No				___ / ___	No		
TDAP (Each pregnancy, between 27-36 weeks)					Hepatitis A (When Indicated)				
Influenza† (Each pregnancy as soon as vaccine is available)					Hepatitis B (When Indicated)				
Varicella†					Meningococcal (When Indicated)				
MMR (Rubella-containing vaccine)†					Pneumococcal (When Indicated)				
HPV									

*Yes/No & date to be administered



Questions?

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