1. The American College of Obstetricians and Gynecologists Immunization Program: Tdap Resources: S. Carroll

2. Laws and Regulations on Medical Assistants’ Role Under Standing Orders- K. Webb

3. Updates from jurisdictions on implementing the Scope of Work Activity- ALL

4. New Pertussis Case Report Form: What has been added & deleted- K. Winter

5. Updated Letters to Providers and Managed Care Plans- A. Christiansen
   • Any other suggested changes before launching?

6. Plans for future calls- R. Boyte
   • What other tools/information do you need?
   • Continue meeting or meet in a few months?
ACOG

- ACOG is a non-profit corporation 501C3, tax-exempt charitable, educational organization
- 95% of board-certified ob-gyns are members of ACOG (a total of 56,000 members)
- Ob-gyns are a major source of ambulatory care for women in the U.S.
- 85% of deliveries attended by ob-gyns
ACOG’s Immunization and Emerging Infections Expert Work Group

In 2010, ACOG convened an Immunization Expert Work Group to further enhance the role of ob-gyns as vaccinators of adolescent and adult women. Over the years, the work group’s role has expanded from immunization to a range of infectious diseases and emerging infections. As such, in 2017, the work group expanded its name to the “Immunization and Emerging Infections Expert Work Group”. The work group provides valuable contributions to all resources, activities, and programs related to immunization and infectious disease.

- The IEIEWG serves in advisory and leadership capacity to all ACOG’s IZ, ID and Emergency Preparedness (e.g. Zika, Ebola) resources, activities, and programs.
- Members are volunteer members, comprised of 15 ob-gyns and 1 pediatrician who are experts in ID, IZ, coding, practice management and emergency response and do most work virtually.
- The Work Group Chair is the 1st ob-gyn appointed as a voting member on ACIP
- Vice chair is the former co-chair of NVAC’s Maternal IZ Work Group
- Members are liaisons on numerous federal and professional groups e.g. ACIP, AIM, ASCO, IAC, ECBT, NFID, USPSTF, VAMPSS, Families Fighting Flu, California Immunization Coalition, and more.
Revised Tdap Committee Opinion

- Immediately following the updated ACIP recommendations on Tdap vaccination, the ACOG Committee on Obstetric Practice and the Immunization and Emerging Infections Expert Work Group reviewed and revised ACOG’s Committee Opinion on Tdap vaccination during pregnancy.

- ACOG worked very closely with CDC to ensure consistency between the CDC recommendations and the forthcoming ACOG Committee Opinion.

- An updated Committee Opinion was published in September 2017.

Committee Opinion: Key Updates

- Emphasis on administration of Tdap as early in the 27-36 week window as possible
- Emphasis for ob-gyns to stock and administer Tdap vaccine in their office
- Recommendation for referral system for those who are not able to stock
- Tips to administer Tdap at the same time as the GTT or RhoGAM
- Updated safety and efficacy data and references, including several from California.
Updated Tdap Resources for Providers and Patients

Based on the revised Tdap Committee Opinion, provider and patient resources were updated. These materials include:

- Frequently Asked Questions for providers, posted on the [Immunization for Women](https://www.immunizationforwomen.org) website.
- Frequently Asked Questions for patients in tear pad form (in English and Spanish)
Updated Tdap Tool Kit: September 2017

Distributed to ACOG Residents and Jr. Fellows later this month

Letter from Dr. Zahn and Dr. Riley

Frequently Asked Questions for Patients

Revised Tdap Committee Opinion

Tool kit is available electronically on the Immunization for Women website!
ACOG Immunization for Women Website

Find all the Immunization Resources you need in one spot at ACOG’s Immunization for Women website:

» Up to date immunization recommendations
» Specific immunization information for pregnant and breastfeeding women
» Information on how to set up and expand an office-based immunization program
» Latest immunization news and updates
» Features separate provider and patient sections

Immunizationforwomen.org
Online Resources: Practice Management

Practice Management Overview

- How to Start an Office-based Immunization Program
- Coding
- Financing & the Affordable Care Act
- Storage & Handling
- Liability & Adverse Events Reporting (VAERS)
- Communicating with Patients
- Increasing Immunization Rates
- Leading by Example
- Office Forms
- Immunization Information Systems (IS)
- Practice Management Resources
Coding and Reimbursement Resources: Immunization Coding Guide

*Immunization Coding for Obstetrician-Gynecologists 2017* provides common immunization codes as part of ACOG’s comprehensive Immunization Resources.

- Updated to ICD-10 Codes
- Available electronically on the Immunization for Women website at [www.immunizationforwomen.org/coding](http://www.immunizationforwomen.org/coding)
Evaluation of ACOG’s Efforts to Improve Adult Immunization through Ob-Gyns (Published January 2016*)

► ACOG’s Research department and Immunization staff conducted a prospective, longitudinal study to determine ACOG’s efforts to increase ob-gyn use of ACOG IZ toolkits and vax administration were effective

► Pre- and post-intervention surveys to random sample 1,500 ACOG members between August 2012 and July 2015. ACOG distributed 3 immunization toolkits between August 2012 and March 2013 to 35,000 active practice ob-gyn members

► 87% of survey ob-gyns reviewed the IZ toolkits

► Large majority reported that they offered or planned to offer flu and Tdap vax to patients

► Postintervention respondents significantly more likely to use standing orders, had increased access to patient records and decreased cost as a barrier to IZ

► Ob-gyns in group practice more likely to offer Tdap, flu and have standing orders than solo practice or academic

*Supported by CDC Cooperative Agreement 5U66IP000667
### Table 3: Statistically significant differences between pre- and postintervention study providers.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Preintervention study (%)</th>
<th>Postintervention study (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received ACOG’s immunization toolkit mailings†</td>
<td>67.0</td>
<td>84.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Valuable immunization resources to include in future toolkit mailings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical guidelines from ACOG†</td>
<td>71.2</td>
<td>58.0</td>
<td>.001</td>
</tr>
<tr>
<td>Coding information and tips†</td>
<td>30.7</td>
<td>18.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Reimbursement information and tips†</td>
<td>15.2</td>
<td>9.4</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Barriers to offering immunizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost†</td>
<td>45.5</td>
<td>34.8</td>
<td>.006</td>
</tr>
<tr>
<td>Time*</td>
<td>25.4</td>
<td>33.0</td>
<td>.036</td>
</tr>
<tr>
<td>Lack of access to patient records*</td>
<td>7.5</td>
<td>3.7</td>
<td>.048</td>
</tr>
<tr>
<td>Lack of patient interest*</td>
<td>29.9</td>
<td>37.5</td>
<td>.043</td>
</tr>
<tr>
<td>Use standing orders for immunizations*</td>
<td>36.5</td>
<td>46.6</td>
<td>.011</td>
</tr>
<tr>
<td>Routinely offer Tdap to all pregnant patients*</td>
<td>59.3</td>
<td>76.8</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Common reasons patients decline vaccinations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>They do not think they need vaccines†</td>
<td>70.4</td>
<td>80.6</td>
<td>.003</td>
</tr>
<tr>
<td>Percentage of patients that decline vaccinations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one-third†</td>
<td>64.4</td>
<td>76.5</td>
<td>.001</td>
</tr>
<tr>
<td>Receive annual influenza vaccination themselves*</td>
<td>90.7</td>
<td>96.1</td>
<td>.024</td>
</tr>
<tr>
<td>Require staff to receive annual influenza vaccination*</td>
<td>78.1</td>
<td>86.2</td>
<td>.011</td>
</tr>
</tbody>
</table>

ACOG, American College of Obstetricians and Gynecologists; Tdap, tetanus-diptheria-acellular pertussis.

*p < .05, †p < .01.

Contact Information

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Immunization Program: immunization@acog.org
Laws and Regulations on Medical Assistants’ Role Under Standing Orders

Kerrie Webb, Senior Staff Counsel
WHERE TO FIND
LAWS AND REGULATIONS
APPLICABLE TO MEDICAL ASSISTANTS

- Business and Professions Code Sections 2069 – 2071
- California Code of Regulations, Title 16, Sections 1366 – 1366.4
“Specific authorization” means a specific written order prepared by the supervising physician, physician assistant, nurse practitioner, or nurse midwife authorizing the procedures to be performed on a patient, which shall be placed in the patient’s medical record; or a standing order prepared by the supervisor authorizing procedures to be performed. A notation of the standing order shall be placed in the patient’s medical record.

(B&P Code Section 2069(b)(2))
IMPORTANT:

◦ “Supervision” requires the physical presence of a supervisor in the treatment facility while the medical assistant is performing procedures.

◦ A supervisor can be a physician, physician assistant, nurse practitioner, or certified nurse-midwife.

(B&P Code Section 2069(b)(3))
General Guidelines:

- Medical assistants may not diagnose, treat or perform any task that is invasive or requires an assessment.
- Medical assistants are there to assist and perform supportive services in the physician’s office appropriate with their training, which cannot be compared with licensed health professionals who must meet rigorous educational and examination requirements.

Training of medical assistants and their demonstrated competence must be documented and certified by the supervising physician. (16 CCR 1366.3)
Medical Assistants Can (not all inclusive):

- Administer medication orally, sublingually, topically, vaginally or rectally, or
- by intramuscular, subcutaneous and intradermal injection (injections require additional training).

**NOTE:** The supervisor must verify the correct medication and dosage and authorize the administration. The supervisor must be physically present in the treatment facility when the drug is administered.

(16 CCR Sections 1366(b)(1) and 1366.1)
TRAINING FOR INJECTIONS/VENIPUNCTURE

- In order to administer medications by intramuscular, subcutaneous and intradermal injection, the medical assistant shall have completed the minimum training prescribed. Training shall be for the duration required by the medical assistant to demonstrate to the supervising physician (or instructor) proficiency in the procedures to be performed, but shall include no less than:
  
  - 10 clock hours of training in administering injections and performing skin tests and/or
  
  - 10 clock hours of training in venipuncture and skin puncture for the purpose of withdrawing blood, and
  
  - Satisfactory performance by the trainee of at least 10 each of intramuscular, subcutaneous, and intradermal injections and 10 skin tests, and/or at least 10 venipunctures and 10 skin punctures.

(16 CCR Sections 1366(b)(1) and 1366.1)
Medical Assistants **Cannot** (not all inclusive):

- Diagnose or determine a treatment plan.
- Determine that a test is required.
- Interpret results of tests.
- Administer any kind of anesthetic agent.

(B&P Code section 2069(c)(2) & (3) and 16 CCR Section 1366(b)(1))
RESOURCES & INFORMATION

Medical Board Website:
www.mbc.ca.gov

- FAQs
- Newsletter Articles
- Specific Laws and Regulations

Contacts:
AnnaMarie Sewell, Medical Assistant Program Analyst
AnnaMarie.Sewell@mbc.ca.gov
916–263–2393

Kerrie Webb, Senior Staff Counsel
Kerrie.Webb@mbc.ca.gov
916–263–2389
Local Health Department Scope of Work

**Objective 6.1:** Assist with the prevention, surveillance and control of vaccine preventable disease (VPD) within the jurisdiction.

**Required Activities:**
iv. Support investigation of infant pertussis cases.
Inform LHD Maternal, Child and Adolescent Heath (MCAH) Program of each new infant case, and work together to contact the mother’s prenatal care provider to determine barriers to prenatal Tdap vaccination.
Follow up and assist the provider to meet the standard of care including providing strong recommendations for Tdap and a strong referral (if Tdap is not offered on-site).
Questions for LHDs:

- What tools have you chosen for your toolkit?
- Were you able to create/obtain a list of your MCP’s in-network pharmacies?
- If you encounter problems try to:
  - Work with the plan first
  - **Medi-Cal FAQs** may help
  - For additional help, contact:
    - Amber Christiansen at 510-620-3759 or Amber.Christiansen@cdph.ca.gov
### Update to Pertussis Surveillance Form

#### FOR INFANTS <4 MONTHS OF AGE

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s name</td>
<td>(last, first, middle initial)</td>
</tr>
<tr>
<td>Prenatal care provider name</td>
<td>(Clinician and/or Practice)</td>
</tr>
<tr>
<td>Prenatal care provider location</td>
<td>(street, city/town, state)</td>
</tr>
<tr>
<td>Does prenatal care provider participate in CPSP?</td>
<td>Yes/No/Unk</td>
</tr>
<tr>
<td>Mother’s insurance type for prenatal care</td>
<td>Private/Medi-Cal Fee for Service (Pregnancy-only)/Medi-Cal Managed Care/Other</td>
</tr>
<tr>
<td>Member ID #</td>
<td></td>
</tr>
<tr>
<td>Plan name</td>
<td></td>
</tr>
<tr>
<td>Did mother receive Tdap during pregnancy?</td>
<td>Yes/No-she declined/No-never recommended/No–Other, why:</td>
</tr>
<tr>
<td>Date of Tdap vaccination</td>
<td>/ /</td>
</tr>
<tr>
<td>Weeks’ Gestation</td>
<td></td>
</tr>
<tr>
<td>Trimester</td>
<td></td>
</tr>
<tr>
<td>Where did mother receive Tdap during this pregnancy?</td>
<td>Prenatal care provider’s office/Pharmacy/LHD or other medical office</td>
</tr>
</tbody>
</table>
Prenatal Tdap as Quality of Care Issue

• MCPs required to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by providers.
• MCP Quality Improvement Committees review issues

• Trigger: infant pertussis case <4 months of age and no receipt of Tdap between 27-36 weeks gestation
• Strategy: notify MCP/health plan and request assistance to identify/address barriers to IZ
Potential Workflow of Infant Pertussis Case Follow Up with Provider and Plan

LHD notified of pertussis case

CD, IZ, MCAH assign staff for infant <4 months case follow up

LHD calls case mother and prenatal care provider

Prenatal Tdap between 27-36 weeks?

Yes

Offer TA as needed

No

LHD send provider template letter to inform that MCP/health plan may be able to assist

LHD send letter to MCP/health plan Medical Director
Dear Dr. [Provider’s Name]:

Recently, the infant of [Mother’s First and Last Name], a patient who received prenatal care from your practice, was hospitalized/died due to pertussis infection. It is our understanding that [Mother’s First Name] did not receive tetanus, diphtheria and acellular pertussis (Tdap) vaccine between 27-36 weeks gestation of pregnancy and is insured by [name of Medi-Cal Managed Care or Private Health Plan]. (MCP). According to our records, [Mother’s First Name] received Tdap after 36 weeks gestation on xx/xx/xxxx. If this information is incorrect, please let us know as soon as possible.

ACOG, CDC, and the California Department of Public Health (CDPH) recommend that women receive Tdap vaccine at the earliest opportunity between 27 and 36 weeks gestation of every pregnancy, regardless of their Tdap vaccination history. Transplacental transfer of maternal pertussis antibodies from mother to infant can provide protection against pertussis in early life, before infants receive the first dose of diphtheria, tetanus, and pertussis (DTaP) vaccine at age 6-8 weeks.

Rates of prenatal immunization are highest when prenatal providers recommend and administer vaccine onsite rather than refer patients for vaccination. For providers that do not stock vaccine, patients may be referred to a pharmacy for vaccination.

Although prenatal immunization is covered by Medi-Cal and private health plans, we are aware there are still barriers to administering and stocking vaccine or referring patients for immunization. If you’ve experienced difficulty getting reimbursed for Tdap in the past or would like to find out where to refer patients, we urge you to contact your patient’s Medi-Cal Managed Care Plan to troubleshoot this issue. As a reminder, Medi-Cal covers prenatal immunizations as both a medical and pharmacy benefit.

Your patient’s Medi-Cal Managed Care Plan may also be contacting you to evaluate and reduce barriers and better support you in the provision of prenatal care to your patients.

For additional information on prenatal Tdap immunization, please review resources from ACOG: http://www.immunizationforwomen.org
CDPH: http://eziz.org/resources/pertussis-promo-materials/tdap-webinar-obs/
CDC: https://www.cdc.gov/pertussis/pregnant/index.html
MCP/Health Plan Template Letter

Dear Dr. [Medical Director’s Name]:

Recently, the infant of [Mother’s First and Last Name], a member of your Plan, was hospitalized/died due to pertussis infection. It appears that Ms. [Mother’s last Name] did not receive tetanus, diphtheria and acellular pertussis (Tdap) vaccine in the recommended timeframe between 27-36 weeks gestation of pregnancy. The mother’s Medi-Cal identification number is ________________.

In an effort to prevent infant pertussis cases through maternal immunization, the county health department has contacted the prenatal care provider of Ms. [Mother’s last Name] to discuss the recommendations for prenatal Tdap and provide assistance as needed. However, there may be additional barriers the provider is facing in providing quality care.

Since your Plan is a key partner in promoting quality prenatal care for women in our county, we request that your Plan’s Quality Improvement Committee work with the provider to identify and address potential barriers to prenatal immunization.

Case information:
[Mother’s First and Last Name]
[Mother’s Medi-Cal ID#]
[Mother’s DOB]
[Prenatal Care Provider Name]
[Provider Phone Number]

Sincerely,

[Signatory]
[Title]
[County] Public Health Department
Plans for Future Calls

• What other tools/information do you need?
• Continue meeting or meet in a few months?
Questions?

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