Improving influenza vaccination rates in the elderly

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- BACKGROUND. Vaccination coverage for influenza in elderly remains low when the physician is the only person responsible for immunization. Integration of other health care workers may improve the coverage rate of at-risk groups.

- OBJECTIVES. To estimate vaccination coverage rate using a strategy based on the systematic intervention of a health care professional proposing vaccination prior to the doctor's consultation; to evaluate the changes in coverage rates before and after introduction of this strategy; and to assess the feasibility of this intervention and the achieved coverage rate in family physician offices.

- STUDY DESIGN. Prospective study in a medical outpatient clinic and 5 family physician practices in Switzerland.

- POPULATION. Participants consisted of all patients ≥65 years attending a medical outpatient clinic during the vaccination period in 1999 (n = 401); patients ≥65 years regularly followed at a medical outpatient clinic in 1998 and 1999 (n = 195); and patients ≥65 years presenting to 5 family physician offices in 1999 (n = 598).

- OUTCOME MEASURED. Rates of vaccination coverage.

- RESULTS. Among all participants, vaccination coverage in 1999 was 85% at a medical outpatient clinic and 88% in family physician offices. Among participants regularly followed at the medical outpatient clinic, vaccination coverage increased from 48% in 1998 to 76% in 1999. Rate of refusal was 9% at the medical outpatient clinic and 14% in the family physician offices.

- CONCLUSIONS. The systematic intervention of a health care professional to suggest vaccination before the doctor's visit is an effective measure to achieve high coverage rate. Such a strategy also improves outpatient clinic or private practice efficiency by reducing pressures on physicians.

Cancer risk assessment from family history: Gaps in primary care practice

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- OBJECTIVES. To determine whether an adequate amount of family history is being collected and recorded by family practitioners to appropriately identify patients at increased risk for cancer.

- STUDY DESIGN. Retrospective chart audit.

- POPULATION. Charts from 500 randomly chosen patients, 40 to 60 years of age, were audited. Of those charts, 400 were from a large academic family practice and 50 charts each were from 2 small community family practices in the greater Philadelphia area.

- OUTCOMES. MEASURED. General features of family history-taking were recorded, including presence of a family history and date when recorded, evidence of updated family history data, and presence of a genogram. Cancer features recorded included mention of family history of cancer or colo-rectal polyps and if positive, identification of which relative was affected, site of cancer, and age of diagnosis or death.

- RESULTS. Most charts (89%) had some family history information recorded, and 55% listed a family history of cancer, either positive or negative. Of the 556 relatives affected with cancer, an age of diagnosis was documented in only 8%, and for 183 first-degree relatives with cancer, only 7% had a documented age of diagnosis. Two percent of all charts had any mention of a family history of colorectal polyps. Sixty-five percent of family histories were recorded at the first visit and only 35% had any updated family history information.

- CONCLUSIONS. The number and type of family histories currently being recorded by family practitioners are not adequate to fully assess familial risk of cancer. New strategies will need to be developed to better prepare providers for risk-based clinical decision-making.