

Delivering Adolescent Vaccinations in the Medical Home: A New Era?

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ABSTRACT

BACKGROUND. Medical homes are health care settings that offer continuous, comprehensive, accessible primary care; these settings generally involve pediatric and family physician practices or community health centers but can also involve gynecologists or internists.

OBJECTIVES. In this article, we review available evidence on the role of the medical home in optimizing adolescent immunization delivery, particularly with respect to health care utilization patterns and barriers to vaccinations in medical homes, and solutions.

METHODS. We conducted a systematic review of the existing immunization and adolescent literature and used a Delphi process to solicit opinions from content experts across the United States.

RESULTS. Most adolescents across the United States do have a medical home, and many pay a health care visit to their medical home within any given year. Barriers exist in regards to the receipt of adolescent immunizations, and they are related to the adolescent/family, health care provider, and health care system. Although few studies have evaluated adolescent vaccination delivery, many strategies recommended for childhood or adult vaccinations should be effective for adolescent vaccination delivery as well. These strategies include education of health care providers and adolescents/parents; having appropriate health insurance coverage; tracking and reminder/recall of adolescents who need vaccination; practice-level interventions to ensure that needed vaccinations are provided to eligible adolescents at the time of any health care visit; practice-level audits to measure vaccination coverage; and linkages across health care sites to exchange information about needed vaccinations. Medical homes should perform a quality improvement project to improve their delivery of adolescent vaccinations. Because many adolescents use a variety of health care sites, it is critical to effectively transfer vaccination information across health care settings to identify adolescents who are eligible for vaccinations and to encourage receipt of comprehensive preventive.

CONCLUSIONS. Medical homes are integral to both the delivery of adolescent immunizations and comprehensive adolescent preventive health care. Many strategies recommended for childhood and adult vaccinations should work for adolescent vaccinations and should be evaluated and implemented if they are successful. By incorporating evidence-based strategies and coordinating effectively with other health care sites used by adolescents, medical homes will be the pivotal settings for the delivery of adolescent vaccinations.

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Key Words

medical home, vaccinations, preventive care

Abbreviations

STI—sexually transmitted infection
AAP—American Academy of Pediatrics
VFC—Vaccines for Children

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ADOLESCENTS PLAYED A prominent role in the 2000 Institute of Medicine¹ analysis of 26 candidate vaccines considered for use against diseases that are significant threats to public health. Recent licensure of meningococcal, pertussis, and human papillomavirus²⁻⁴ vaccines highlighted the need to focus on the delivery of vaccinations

to the adolescent population. New vaccines⁵ are being developed to protect against other sexually transmitted infections (STIs) such as genital herpes simplex virus, *Chlamydia trachomatis*, and *Neisseria gonorrhoea*, as well as HIV, cytomegalovirus, respiratory syncytial virus, and group B streptococcus.

Implementation of adolescent vaccinations represents both a challenge and an opportunity to engage adolescents, their parents, and health care providers in a strategy to optimize both vaccination delivery and the receipt of comprehensive preventive health care. At the center of this strategy lies an ongoing source of coordinated, family-centered care, or the medical home.

In this article we examine the role of the medical home in optimizing adolescent immunization delivery and consider (1) adolescent health care utilization patterns with regards to the medical home, (2) barriers to adolescent immunizations in the medical home and possible solutions, and (3) overlap between medical homes and complementary sources of health care.

Between February and December, 2005, we assessed the available evidence base for the role of the medical home in adolescent immunizations. We reviewed the peer-reviewed literature, materials published by the Centers for Disease Control and Prevention, American Academy of Pediatrics (AAP), and other professional organizations, and presentations and materials known to us. We used a Delphi process⁶ to solicit and examine written opinions from immunization and adolescent health care experts. Persons external to the group contributed opinions on adolescent utilization of health care, barriers to care, strategies for overcoming barriers, the interrelationship between medical homes and complementary settings, and national-level strategies for professional organizations to optimize adolescent immunization delivery.

THE MEDICAL HOME AND HEALTH CARE UTILIZATION OF ADOLESCENTS

Adolescents 11 to 21 years of age represent >40 million persons, or 14% of the US population.⁷ The AAP and other organizations recommend that all adolescents receive primary care within a medical home, which is defined as a health care setting that is “accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”⁸ Critical elements of the medical home include preventive, acute, and chronic illness care,⁹ initial-contact care for new problems that is available at all times, comprehensive care, longitudinal care, and coordinated care¹⁰ by providers who are familiar with the family and the adolescent’s cultural environment. Such settings typically include primary care pediatric and family medicine practices and federally qualified community health centers. For older adolescents, internal medicine practices may serve this role, and for some adolescent girls, gynecologists may serve as medical homes. Some health care sites that are considered as complementary settings, such as teen centers (see the article by Schaffer et al¹¹ in this issue), may function as medical homes if they provide comprehensive services.

A variety of preventive services are recommended to be delivered during adolescent preventive care visits to

medical homes^{12–15} (see the article by Broder et al¹⁶ in this issue). These services range from screening for disease by using patient history, physical examination, and laboratory tests to anticipatory guidance about a variety of topics. Adolescent immunizations have traditionally comprised a small part of these preventive services, because few vaccines were administered to this age group.

The type of primary care providers seen by adolescents for health care visits varies according to their age.¹⁷ Recent analyses (Fig 1)¹⁸ by the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey showed that among early (11- to 14-year-olds) and middle (15- to 17-year-olds) adolescents, more than two thirds of health care visits are made to pediatric or family practice physicians. Among older adolescents (18–21 years old), less than half of all health care visits are to pediatricians or family physicians, particularly among females. Among older female adolescents, the majority of visits are to gynecologists, whereas male adolescents often do not have any contact with the health care system. Subspecialty visits are common, and most are with specialists in orthopedics, dermatology, and psychiatry, who tend not to provide routine immunizations. Many adolescents use a combination of health care settings for care, including primary care offices, family planning clinics, emergency departments, and community health centers.^{19–21}

Most adolescents do report having a usual source of health care.²⁰ In 1 study of adolescents attending grades 5 through 12, the majority reported having a traditional medical home setting as their usual source of care, including a physician’s office (62%), a clinic (24%), a hospital (7%), and an emergency department (5%). In addition, 81% reported having a usual sick-care provider.¹⁹

The pattern of adolescent preventive health care visits is similar to their overall visit pattern, with younger adolescents being more likely than older teens to have preventive visits (see the article by Broder et al¹⁶ in this issue). For reasons that are unclear, there is a discrepancy between rates of preventive visits, depending on the source of information. Self-reported data from national surveys of adolescents or parents have suggested that more than two thirds of adolescents have a checkup within the past year (depending on the age group),^{19,22} whereas Health Plan Employer Data and Information Set chart review measures in 2000 revealed that, nationally, only one third of adolescents had at least 1 preventive visit in the previous year.²³

Some adolescents do not receive any health care.^{20,24} Across the entire spectrum of US adolescents aged 11 to 21 years in 2002, 29% of females and 39% of males reported not having any health care visits in a 12-month period.²⁰ Uninsured and nearly poor adolescents are more likely to lack a health care visit.²² In a review performed in 2003, half of the studies of adolescent utilization of primary care services showed that black and Hispanic adolescents received less primary care than did white adolescents, and half showed that all 3 groups received equal care.²⁵ When all adolescents under the age of 18 are included, most studies have identified a disparity in primary care use, with lower levels among

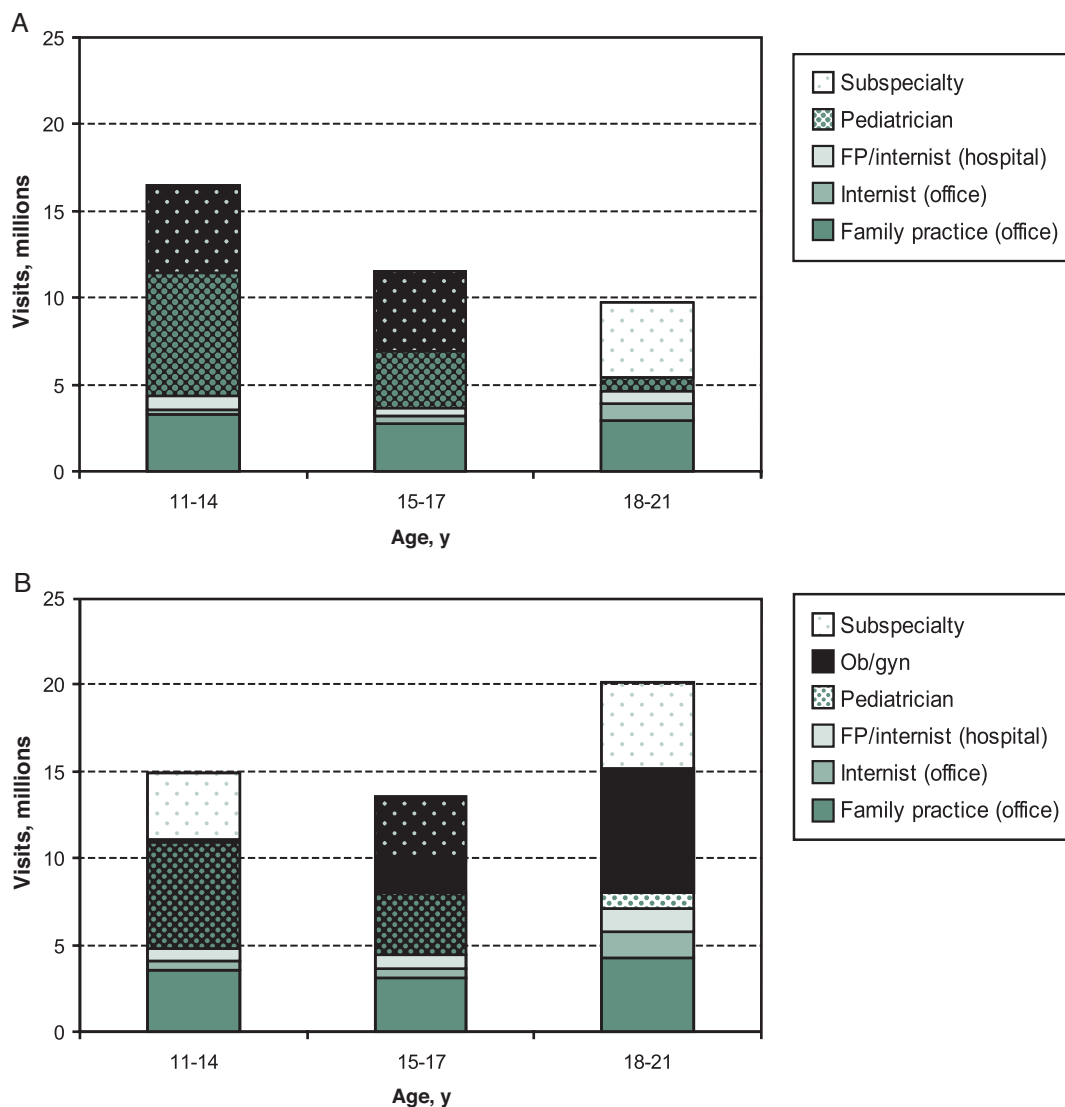


FIGURE 1 Average annual number of health care visits by adolescents across the United States: 2000–2002. Shown are the overall visits for boys (A) and girls (B). FP indicates family practice; Ob/gyn, obstetrics/gynecology. Source: analyses of the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey.¹⁸

black and Hispanic adolescents. Rural adolescents are equally likely to have health care visits as those living in urban areas.²⁶ Males are less likely to have a health care visit in the past year than females. Adolescents who are involved in sports activities, are infrequent or nonsmokers, and are sexually active are more likely than their counterparts to report having a checkup in the past year.²⁷

In summary, medical homes are the major source of health care among adolescents and are critical for delivering comprehensive care. Most adolescents do report having a medical home, and some studies have reported that most adolescents have a health care visit within 1 year to their medical home. Most medical homes for adolescents involve primary care pediatric and family physician practices, although the role of these settings is diminished among older adolescents who are more likely to visit gynecologists or specialists and to lack any health care visits.

BARRIERS TO ADOLESCENT IMMUNIZATION DELIVERY IN MEDICAL HOMES AND PRACTICAL SOLUTIONS

Table 1 contains a summary of barriers (and solutions) to adolescent immunizations, which are grouped into 3 overlapping categories²⁸: adolescent/family, health care providers, and the health care system. Because barriers vary across health care settings,^{25,29} medical homes and communities should assess their own barriers to address those that are the most relevant.

Adolescent and Family

Lacking a Medical Home or Preventive Visits

Because a medical home and a preventive visit are often the entrée to preventive services, lacking either of them results in a major challenge to immunization delivery. Education of adolescents and parents about the importance of a medical home and preventive care visits

TABLE 1 Barriers and Solutions to Adolescent Immunizations

Category	Barriers ^a	Solutions
Adolescent or family	No medical home	Education from multiple sources
	No preventive visit	Education, reminders from many sources
	Costs (for health care visit or vaccine)	Health insurance (eg, increase VFC coverage until 21 y)
	Schedule; unaware of need for vaccine	Vaccination cards, patient reminders
	Safety concerns	Education from multiple sources
	Consent and confidentiality issues	Education from multiple sources
	Health beliefs (importance of vaccines)	Education from multiple sources
	Other activities having higher priority	Education from multiple sources
	Pain of vaccines and multiple shots	Pharmacologic and complementary care
	Health care providers	Complicated agenda for adolescent preventive services (many issues to cover)
Missed opportunities for vaccination		Policy changes with self-audits, office guidelines, standing orders
Schedule: not recommending annual visits		Policy changes (provider groups)
Implement reminder/recall systems, link with registries		Implementing systems; link with registries
Not using recommended strategies		Practice-level changes
Lack of quality assurance process within the practice		Comprehensive Assessment Software Application for adolescent vaccines; health maintenance organizations; quality improvement
Costs		VFC program and insurance policies
Health beliefs		Provider education
Consent and confidentiality issues		Provider education (eg, about laws)
System		No medical home for many adolescents
	No preventive visit	Integrate medical home with other sites, insurers; outreach
	No tracking of individuals needing vaccines	Registries, managed care, health systems universal vaccines
	Costs for health care or vaccines	VFC program for adolescent vaccines (until 21 y)
	Scattering of health care across sites	Managed care and other systems
	Lack of uniformity of state vaccination laws	School vaccination laws and school-entry requirements; legal counsel
	Lack of uniformity of interpretation of laws	Clarification of consent
	Lack of uniformity of guidelines	Provider groups and state recommendations
	Insufficient education about vaccines	School-based education Vaccine Information System forms and other materials

^a Barriers are ordered within each category according to importance, as measured by author and expert consultant rankings. These barriers are applicable to the medical home but may also apply to vaccinations received elsewhere.

should stem from multiple sources including health care sites, schools, and the media.³⁰

Cost

As adolescents assume greater responsibility for their own health care, direct costs of health care visits and immunizations and indirect costs such as time lost from work or school can become barriers to immunizations. In addition, health insurance coverage often declines after the age of 18.³¹ In 2002, 12% of 10- to 18-year olds were uninsured,³² whereas during the same period, 33% of men and 27% of women among 19- to 24-year olds were uninsured.³³

Note that the Vaccine for Children (VFC) program covers adolescents <19 years old, but no such program exists for adults. In addition, some experts are concerned about the recent insurance-related trend toward consumers having to pay more out-of-pocket costs for primary care services³⁴ (some possible solutions are discussed in “Health Care System” below).

Knowledge, Health Beliefs, and Concerns About Vaccinations

Many adolescents lack knowledge about recommendations for annual preventive care visits.³⁵ Although most teens value preventive health care, practical barriers such as time and conflicting activities may interfere with their attendance to these visits. It is interesting to note that, although safety concerns³⁶ and overall motivation are often cited as

patient barriers to vaccination, there is little evidence that these are major barriers for the general population,³⁷ and they are unlikely to be any more problematic among adolescents or their parents than they are among parents of younger children. The pain of injectable vaccines³⁸ is a potential practical barrier for some adolescents who may either refuse vaccination or miss health care visits because of their concern about injections.

Immunization experts have described a knowledge gap in regards to immunizations in that neither parents/adolescents nor health care providers recognize those individuals who need vaccinations at a particular time.^{39,40} The solution rests in providing timely information to both families and health care providers so that everyone recognizes when an adolescent requires a vaccination. Unfortunately, this solution is one that is easier said than done. One strategy involves better education for parents and adolescents about the need for follow-up visits at a particular time. The use of handheld immunization cards has not been adequately studied in the United States. A second strategy involves the use of provider-based reminders/recall systems, which have been found to be effective in many,⁴¹⁻⁴⁴ but not all, settings for young children and adults.⁴⁵⁻⁴⁷ It is notable that a recent randomized clinical trial of telephone reminder/recall for urban adolescents observed small but significant improvements in immunizations and preventive visits.⁴² A third potential strategy is to enlist the help

of schools in educating parents and adolescents about the need for vaccinations at certain ages; this could be performed as part of the fall registration, the annual health assessment, or during health class.

Safety concerns need to be addressed with proper education, including the use of magazines, television, newspapers, and the Internet; media sources that are used by adolescents.⁴⁸ To address concerns about the pain of vaccinations,⁴⁹ medical homes and other settings might consider the use of either pharmacologic numbing agents or complementary medicine strategies such as relaxation techniques that have been studied among school-aged children⁵⁰ but are likely to be equally important for fearful adolescents.

Consent and Confidentiality

Consent^{51,52} and confidentiality^{19,53} are relatively unique barriers in this age group (see the article by English et al⁵⁴ in this issue). Many older adolescents attend health care visits by themselves but cannot provide consent for immunizations. There is a lack of clarity about laws in regards to the need for parental consent for vaccines that protect against STIs, and substantial variation exists across states in the wording and interpretation of vaccination laws. Also, it may be more difficult when parents are present, than when they are not, for providers to discuss sensitive topics such as STIs and their prevention with adolescents. This may become increasingly relevant, because discussion of the STI-related vaccines such as human papillomavirus may often lead to a discussion of sexuality. Parental consent is required for other vaccines such as those against pertussis, meningococcal, and influenza. Confidentiality and health beliefs need to be addressed forthright within medical homes by using appropriate policies and procedures and cultural sensitivity.

Health Care Providers

Provider barriers to timely vaccination delivery have been described for young children and adults, but they also apply to adolescents. Missed opportunities for vaccinations^{55,56} (health care visits at which a patient is eligible to receive a vaccination but does not receive one) are particularly important, because adolescents have fewer visits than do younger children. In addition, some providers still recommend biennial preventive visits for adolescents, although most current guidelines recommend annual preventive visits.^{14,15}

Health care providers should take advantage of new adolescent vaccination guidelines to review their own practice's overall vaccination efforts. Table 2 shows 6 quality improvement steps (adapted from quality improvement principles) for optimizing adolescent vaccination delivery within medical homes. Each medical home should have a core group that sets the practice's policies and procedures and reviews and adopts evidence-based strategies^{41,43,44} for optimizing vaccination delivery. On the basis of the principles of quality improvement, we suggest that each practice perform 1 small-change intervention to improve adolescent immunization rates and assess the impact of the intervention

TABLE 2 Quality Improvement Steps to Optimize Adolescent Vaccination Delivery Within Medical Homes

Set up a multidisciplinary vaccination team that is in charge of evaluating and improving vaccination delivery (for all relevant age groups)
Develop office-based policies and procedures for new adolescent vaccinations
Review evidence-based strategies for optimizing childhood or adult vaccinations and assess which strategies are being used within the office; implement strategies that might be feasible for adolescents
Perform 1 well-defined, feasible, and purposefully small office-based intervention to improve 1 aspect of adolescent immunization delivery
Measure vaccination coverage for the adolescent population and make adjustments on the basis of coverage
Collaborate with other sectors: managed care for Healthcare Effectiveness Data and Information Set measures, immunization registries for adolescent vaccinations, health care systems for electronic medical charts, including vaccinations, local health departments for practice-based Comprehensive Assessment Software Application audits, and other provider sites such as school health clinics for sharing vaccination records of mutual patients

by using simple measures. For example, a practice may wish to reduce missed opportunities and measure the impact of a policy change of vaccinating eligible adolescents during all medical encounters. Another practice may develop better communication strategies with school-based health centers or health departments for updating vaccination records. A third practice may use billing or electronic medical chart systems to develop a patient-reminder system for influenza vaccination for eligible adolescents at high risk. The key is to measure the impact of these changes. Also, medical homes should develop a method for assessing adolescent vaccination coverage by using such strategies as free chart-review assessments by their local public health department (by using the Comprehensive Clinical Assessment Software Application at www.cdc.gov/nip/cocasa), linkages with immunization registries containing adolescent immunizations, and coordination with managed care.

Missed opportunities for vaccination represent low-hanging fruit, because it is easier to incorporate strategies for vaccinating the eligible adolescent during a medical visit than to implement strategies for generating health care visits.⁵⁷ Although rigorous studies have noted only limited success with interventions to eliminate missed opportunities in children^{55,56} and adults,⁵⁸ interventions to reduce missed opportunities may still be more feasible than other strategies that require more resources.

The inability to track patients who need vaccinations or to perform systematic reminder/recall⁵⁹ is a known barrier for medical homes. Tracking, reminders, and recall are almost certain to be needed to achieve high adolescent vaccination rates^{56,60} except in those populations in which adolescents already have high rates of health care visits.

In addition to costs being a barrier for individuals, the high costs of vaccines represent a barrier for health care providers and highlight the importance of adequate insurance coverage,^{61,62} because medical homes need to purchase vaccines up front at considerable expense.⁶³ Possible solutions are discussed below.

Providers' health beliefs have been shown to affect

vaccination coverage in certain situations (eg, influenza, varicella, and hepatitis B vaccinations).⁶⁴⁻⁶⁷ Professional organizations (eg, the AAP and the American Academy of Family Physicians) can reinforce the need for annual preventive visits and address health beliefs and safety issues regarding new adolescent vaccines. Studies have demonstrated that primary care providers pay attention to policies that are promoted by their professional organizations.⁶⁸

Other barriers at the provider level are particularly relevant for adolescent vaccinations. Prioritizing adolescent vaccination in the setting of numerous critical health care issues may be difficult, because adolescent health care visits are often filled with discussions of multiple critical topics. Because many new vaccines relate to sexuality, the sensitivity of topics is an issue, particularly for young adolescents.⁶⁹

Health Care System

Barriers include inadequate access to medical homes, lack of system-wide tracking, cost issues⁵⁷ such as inadequate health insurance coverage,³² and the lack of uniformity of school laws or interpretation of state consent or other policies. The pattern of health care visits of adolescents, with frequent reliance by some adolescents on multiple sites, presents system-wide challenges of coordination and exchange of information. Consent can become a barrier in attempts to coordinate care across sites. Lack of insurance portability across state lines can also be a barrier.

Comprehensive insurance coverage of both vaccinations and preventive visits is critical for minimizing cost-related barriers to adolescent vaccinations and is particularly relevant for the new adolescent vaccinations, which are very expensive. Expansions in public insurance such as the State Children's Health Insurance Program^{70,71} may improve access for low-income adolescents. However, the State Children's Health Insurance Program does not cover adolescents beyond the age of 18 years. The availability of additional funding to support vaccination of adolescents 19 to 21 years of age (who are no longer eligible for the VFC program) should be explored. Studies have noted that providing health insurance can improve immunization coverage for younger children.^{27,72,73} The VFC program has enhanced immunization delivery within the medical home for infants and toddlers.^{62,74} For the older-adolescent group, more extensive insurance coverage and adequate financing for health care providers might accrue similar benefits in improved vaccination delivery and promotion of the medical home. In addition, insurance benefits should be portable across both providers and state lines.

An important system-wide strategy involves coordinated, integrated care across medical homes, public health, and other organizations that serve adolescents. Integration across health care sites needs to be conducted at the local level, because the needs vary geographically. One method of coordination across health care sites is community-wide participation in immunization registries that include adolescents. Another strategy is more effective communication of vaccination in-

formation across sites, such as automatic faxed reports of immunizations received in complementary settings that are consistent with Health Insurance Portability and Accountability Act guidelines. Third, because managed care organizations have computerized records of many health care visits received by enrolled adolescents, they can implement patient reminders about needed services and provide medical homes with lists of adolescents who seem to be behind in recommended services; this would address family and provider needs simultaneously. State and federal public health organizations can provide educational materials and interpretation of laws, consent guidelines, and school-entry requirements to assist medical homes. Finally, multisite outreach programs that have been developed for young children to ensure receipt of preventive services⁷⁵ could be adapted for adolescents.

Schools can become an important factor in ensuring adolescent vaccinations, even if vaccinations are not actually administered by schools (see the article by Lindley et al⁷⁶ in this issue). One of the most important policy levers for immunizations is school-entry vaccination laws (see the article by Horlick et al⁷⁷ in this issue). A potential strategy might involve school requirements for preventive visits according to national guidelines. A third strategy is for schools to verify adolescent immunization records and encourage receipt of needed vaccines. This is one area in which a strategy can improve both vaccination coverage and receipt of comprehensive preventive care.

National, state, and local organizations can help overcome barriers at the level of parents/adolescents, health care providers, and the health care system. Table 3 lists key organizations that can promote effective adolescent vaccination delivery within medical homes. The first group is involved in strategies for the education of the general public and for outreach to vulnerable populations that may be disenfranchised from traditional medical homes. The second group, which overlaps substantially with the first group, focuses on primary health care settings. The third group includes organizations with influence on governmental and state policies and expertise in systems-level change.

Lessons Learned From Experiences With Recent New Vaccines

During the 1980s, a risk-based strategy for hepatitis B vaccine recommendations for adolescents was difficult for medical homes to follow, because health care providers could not easily determine who was at a high risk for the virus. Instituting a risk-based strategy for adults⁷⁸ and children who are eligible for influenza vaccine is equally challenging. Thus, universal adolescent vaccination is likely to be more effective than using a risk-based strategy. Second, during the 1990s, the introduction of varicella vaccine encountered variable buy-in among health care providers⁴⁰; clinicians who tended to believe less in the vaccine may have had lower patient immunization coverage rates. New vaccine policy must be accompanied by targeted education of health care providers. Third, during the recent introduction of conjugate pneumococcal vaccine (Prevnar; Wyeth), the lack

TABLE 3 National, State, and Local Organizations That Can Promote Adolescent Vaccination Delivery Within Medical Homes

Overcoming adolescent and family barriers
Traditional medical professional organizations (AAP, American Academy of Family Physicians, National Association of Pediatric Nurse Practitioners, American Academy of Nurse Practitioners, American Academy of Physician Assistants, Society for Adolescent Medicine, Academic Pediatrics Association, American College of Physicians, American College of Obstetricians and Gynecologists, American Medical Association, National Association of Community Health Centers, Migrant Clinicians Network)
Traditional school-based partners in childhood immunizations (American Association for Health Education, National Association for School Nurses, American Association of School Administrators, Parent Teachers Associations)
Nontraditional organizations (Big Brothers, Big Sisters, athletic clubs, faith-based and community organizations)
State immunization coalitions (including the Association of Immunization Managers)
Overcoming health care provider barriers
Traditional medical professional organizations (see above)
The Partners in Program Planning for Adolescent Health ^a
Traditional school-based partners (see above)
Nontraditional organizations (see above)
State immunization coalitions (including the Association of Immunization Managers)
Quality improvement organizations (Institute for Healthcare Improvement, National Initiative for Children's Healthcare Quality)
Addressing barriers within the health care system
Traditional medical professional organizations, the Partners in Program Planning for Adolescent Health
Organizations focusing on coding (American Medical Association's <i>Current Procedural Terminology</i> , Association of Health Insurance Plans, individual insurers with national leadership)
Electronic medical charts and registries (Office of the National Coordinator of Health Information Technology, Health Information Management Systems Society)

^a A multidisciplinary organization composed of representatives from a large number of stakeholders.

of VFC coverage and variability in insurance coverage for an initial period⁷⁹⁻⁸¹ created problems for providers within medical homes when it was time to decide which children to vaccinate. New vaccine policies should be accompanied by simultaneous VFC and insurance coverage. Finally, vaccine shortages highlight that any comprehensive strategy will be challenged if vaccines are not available.

Areas of Overlap Between Medical Homes and Other Sites of Adolescent Health Care

Adolescents often receive care at additional sites such as sports physical clinics held at schools, school health centers, precollege or premilitary physicals, teen clinics, STD or family planning centers, public health centers, homeless shelters, and faith-based outreach programs. In addition, many adolescents receive subspecialty care or are seen in emergency departments or urgent care settings for acute care.

In addressing the overlap between medical homes and complementary sites of care, 3 components of coordinated care need attention: (1) effectively transferring

immunization-related information; (2) identifying adolescents who are eligible for vaccinations and ensuring timely vaccination; and (3) encouraging receipt of comprehensive primary care. Regarding the first issue, reciprocity of health and immunization information between sites of care should be routine. Examples of these tools are networked computer registries, electronic records, faxed immunization forms, and mailed copies of medical charts. The federal Migrant Health Program has been successful with a chart-tracking system in which the patient carries a wallet card that identifies them as belonging to a cooperative medical record-exchange system. Immunization registries developed for childhood vaccinations should be adapted for adolescent vaccines.

The second critical issue is to identify eligible adolescents and vaccinate them. Linkages between medical homes and alternative sites should be enhanced. In addition to transferring vaccination information, complementary sites could screen adolescents for eligibility for vaccinations and encourage them to receive vaccinations in their medical homes. Immunizations can be provided at complementary sites, or outreach can be focused on bringing adolescents to the medical home for vaccinations and comprehensive preventive services. Some local models of care have lay health workers or case managers who coordinate care among different providers while also educating parents and adolescents about the importance of preventive health measures.

Third, adolescents who receive acute or chronic care at a complementary health care site (whether they receive a vaccination) should be counseled that they still need a comprehensive preventive visit, which most likely would occur within the medical home.

CONCLUSIONS

Medical homes are optimally suited to provide adolescent immunizations in the context of comprehensive primary care. However, barriers exist in regards to the receipt of adolescent immunizations. These barriers are related to the adolescent/family, health care provider, and health care system. Many strategies recommended for childhood or adult vaccinations should be effective for adolescent vaccination delivery as well. These strategies include education of providers and adolescents/parents, appropriate health insurance coverage, and implementation of evidence-based strategies such as tracking, reminder/recall, standing orders, practice-level audits, and linkages across health care sites. Medical homes may wish to perform a quality improvement project to improve their delivery of adolescent vaccinations.

For a successful national adolescent immunization program, major professional organizations must coordinate educational efforts, public relations campaigns, and policies. Because adolescents use a variety of health care sites, it is critical to effectively transfer vaccination information across health care settings, identify adolescents who are eligible for vaccinations, and ensure that comprehensive primary care beyond vaccinations is received. Finally, the evidence base for optimal delivery of adolescent vaccinations is sparse, and research is needed

to evaluate optimal means of delivering vaccinations to the general adolescent population and to high-risk, vulnerable populations.

Efforts to enhance immunization of adolescents must occur within the context of the larger goal of improving overall preventive services for adolescents. From a standpoint of immunizations only, delivery of vaccinations at sites other than medical homes could be considered. For example, a school-based immunization program might be successful, avoiding medical homes altogether. However, just as for younger children and adults, adolescent immunizations are likely to be a marker of preventive services in general. Programs that separate adolescents from their medical home might result in a reduction of other preventive services. Conversely, programs that strengthen the delivery of adolescent immunizations within the medical home might improve additional adolescent preventive services.

Because most adolescents have and use a medical home, it is logical to build a national adolescent immunization program by using the medical home as a foundation. By incorporating evidence-based strategies to address and overcome barriers to immunizations, medical homes can become pivotal settings in the new era of adolescent immunizations.

WORKING GROUP ON ADOLESCENT VACCINATION IN THE MEDICAL HOME

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