



**This survey addresses pediatricians' practices surrounding the delivery of IMMUNIZATIONS.**

*Everyone's response is important! While most of these questions apply to those pediatricians who provide patient care, if you do not we still need you to complete the demographic questions and return the survey.*

▶ If you do NOT provide ANY direct patient care, please check this box  and go to Question #28.

Please answer the questions by circling the number of the appropriate response or by filling in the blanks and RETURN THE SURVEY TO US.

1a. Do you provide preventive (well child) care? Yes ..... 1 No ..... 2

1b. Do you currently offer age appropriate immunizations to all or some of the children in your practice?

Yes..... 1 No ..... 2 → Go to Q#25

**INFLUENZA VACCINE**

2. Do you currently offer an annual influenza vaccine to all of your patients 6 months of age or older?

Yes..... 1 → 2a. (A) Have you done any of the following to accommodate annual influenza?  
No..... 2 (B) If so, how effective do you think it is in increasing influenza immunization rates?

(A) Have you done?  
Check ALL that apply

(B) How Effective?  
Circle ONE response for each  
item checked in (A)

		Very	Some- what	Not at all	Don't know/ Don't measure
Added vaccination sessions outside of regular office hours	<input type="checkbox"/>	1	2	3	4
Added staff to handle these immunizations	<input type="checkbox"/>	1	2	3	4
Offer accompanying sibling(s) a flu vaccine at each visit	<input type="checkbox"/>	1	2	3	4
Used electronic records to track influenza immunization	<input type="checkbox"/>	1	2	3	4
Updated immunization protocols (such as standing orders)	<input type="checkbox"/>	1	2	3	4
Met with staff to discuss (or provided training on) office policies regarding influenza immunization	<input type="checkbox"/>	1	2	3	4
Placed reminders in patient charts	<input type="checkbox"/>	1	2	3	4
Notified patients of need for influenza immunization (via telephone/email/US mail)	<input type="checkbox"/>	1	2	3	4
Immunized patients at sick or injury visits when appropriate	<input type="checkbox"/>	1	2	3	4
Other (specify)	<input type="checkbox"/>	1	2	3	4

2b. What are your reasons for not offering universal influenza vaccine? Circle ALL that apply

- Don't agree with the current AAP/CDC influenza immunization guidelines .....01
- Difficulty obtaining adequate supply of vaccine .....02
- Lack adequate storage capacity for vaccine.....03
- Too costly to maintain adequate supply of vaccine .....04
- Lack sufficient number of office staff to handle universal immunizations .....05
- Don't have the time to immunize the number of patients required .....06
- Most of my patients get their influenza vaccine elsewhere .....07
- Lack adequate payment for the immunization administration .....08
- Other (specify).....98

3. Does your office identify patients at high risk for complications of influenza (e.g., those with asthma, congenital heart disease, diabetes, etc.)?

Yes..... 1 →  
 No ..... 2

**3a. Which of the following methods do you use to identify and contact these patients?**  
*Circle ALL that apply*

No systematic method of identification (ID made on patient-by-patient basis) ..... 1  
 An office list identifying high risk patients ..... 2  
 Systematic chart review each fall ..... 3  
 Use of billing data to identify high risk children in need of vaccination ..... 4  
 Use of electronic health record to identify high risk children in need of vaccination ..... 5  
 Review of state immunization registry to identify children who had flu vaccine at another site ..... 6  
 An autodialer to call identified families..... 7  
 An automailer to send families reminder notices ..... 8  
 Manual mailing of reminder notices to families ..... 9

4. Does your office have a mandatory annual influenza vaccination policy for all employees, including physicians?

Yes..... 1 → **4a. What percentage of your office personnel were immunized for influenza this year?** *Enter a % or "0" if none, or check the box if don't know* \_\_\_\_\_% or Don't know

No ..... 2

5. Do you offer an influenza vaccine to parents during the child's office visit, and/or do you offer the Tdap vaccine to parents of infants?

	Usually	Occasionally	Never
Influenza vaccine .....	1	2	3
Tdap vaccine .....	1	2	3

**USE OF RECOMMENDED VACCINES**

6. Do you offer the human papillomavirus (HPV) vaccine to male and/or female patients?

Male Female  
 No .....2      2 → **If 'No' to both male and female, go to Q#7**  
 Yes.....1      1

**6a. About what percent of your patients given HPV vaccine complete their 3-dose series:**  
*Don't know*

Within a 6-month period \_\_\_\_\_ %  
 Within 6 to 12 months \_\_\_\_\_ %  
 In more than 12 months \_\_\_\_\_ %  
 Do not complete the 3-dose series \_\_\_\_\_ %  
 100%

**6b. Do you have a system to routinely contact patients given the initial immunization to encourage completion of the series?**

No	Yes	Don't know
1	2	3

7. To what degree are the following factors barriers to you giving HPV vaccine in your practice?

*Circle ONE response for each item*

	Not a barrier at all	A minor barrier	Somewhat of a barrier	Definitely a barrier
Parents of <b>female</b> patients refusing HPV vaccination	1	2	3	4
Parents of <b>male</b> patients refusing HPV vaccination	1	2	3	4
Lack of adequate payment for this vaccination	1	2	3	4
The "up-front" costs for my practice to purchase the vaccine	1	2	3	4
The need to give three doses to complete the series	1	2	3	4
The age recommendation for the vaccine	1	2	3	4
Adolescents often not seen annually	1	2	3	4

**8a. Do you currently offer all vaccines on the national routine childhood immunization schedule to eligible age-appropriate patients in your practice?**

Every patient..... 1      Most patients ..... 2      Some patients ..... 3      Few patients.....4      No patients..... 5

**8b. When you have a choice, do you currently offer combined vaccines to your patients at the recommended ages?**

I offer all combination vaccines where combined options exist .....1

I offer some combination vaccines where combined options exist .....2

I do not offer combined vaccines to any patients .....3

**9. Please indicate your reasons for (A) not offering all routinely recommended vaccines or (B) not offering a schedule that incorporates approved combined vaccines (where some combined option exists) to all age-appropriate patients not previously vaccinated. Check ALL that apply**

	(A) All vaccines	(B) Combined vaccines
	✓ here <input type="checkbox"/> if offer ALL recommended vaccines to every patient	✓ here <input type="checkbox"/> if offer ALL combined vaccines where options exist
I am planning to start in the near future	<input type="checkbox"/>	<input type="checkbox"/>
Some vaccines are not available in my practice/shortage of vaccine	<input type="checkbox"/>	<input type="checkbox"/>
My managed care contract(s) does not cover the costs for some new vaccines	<input type="checkbox"/>	<input type="checkbox"/>
There are problems with patients' getting reimbursed by insurance companies	<input type="checkbox"/>	<input type="checkbox"/>
Uncertainty regarding the side effects of some vaccines	<input type="checkbox"/>	<input type="checkbox"/>
Parents object for safety reasons	<input type="checkbox"/>	<input type="checkbox"/>
Parents object because they don't believe some vaccines are necessary	<input type="checkbox"/>	<input type="checkbox"/>
There are no school and/or child care requirements for some vaccines in my state	<input type="checkbox"/>	<input type="checkbox"/>
I do not have adequate storage and handling facilities for different vaccines	<input type="checkbox"/>	<input type="checkbox"/>
I lack equipment that meets needs for safely storing vaccines	<input type="checkbox"/>	<input type="checkbox"/>
High vaccine acquisition and storage costs do not make it feasible to offer some vaccines	<input type="checkbox"/>	<input type="checkbox"/>
Unclear agency or organization recommendation	<input type="checkbox"/>	<input type="checkbox"/>
State registry doesn't recognize combination vaccines	n/a	<input type="checkbox"/>
I lose multiple administration fees when using combination vaccines	n/a	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>

**10. In the past year has your practice (A) used any of the following strategies to increase immunization rates in general, and if so, (B) how effective would you say the strategy is in increasing immunization rates?**

(A) Do You Use? Check ALL that apply      (B) How Effective? Circle ONE response for each item checked in (A)

		(B) How Effective?			
		Very	Some-what	Not at all	Don't know/Don't measure
Initiated Quality Improvement projects focused on immunizations	<input type="checkbox"/>	1	2	3	4
Performed chart reviews to identify immunization needs at each visit	<input type="checkbox"/>	1	2	3	4
Used electronic records to track and indicate missing vaccines	<input type="checkbox"/>	1	2	3	4
Updated immunization protocols	<input type="checkbox"/>	1	2	3	4
Met with staff to discuss (or provided training on) office policies	<input type="checkbox"/>	1	2	3	4
Placed reminders in patient charts at each visit	<input type="checkbox"/>	1	2	3	4
Notified patients of missed or not-up-to-date vaccines (via telephone/email/US mail)	<input type="checkbox"/>	1	2	3	4
Given all immunizations due at one visit	<input type="checkbox"/>	1	2	3	4
Immunized all patients at sick or injury visits when appropriate	<input type="checkbox"/>	1	2	3	4
Other (specify)	<input type="checkbox"/>	1	2	3	4

**VACCINE REFUSAL/DELAY**

**11. Within the last 12 months, have any parents in your practice asked to delay a vaccine/asked for an alternative vaccine schedule?**

Yes .....1  
 No .....2

**11a. Approximately what proportion of all parents in your practice requested an alternative schedule for:** *Please enter a number or "0" if none*  
 One vaccine: ..... %  
 Some vaccines (>1 but less than all): ..... %  
 All vaccines ..... %

**12. Within the last 12 months, have any parents in your practice refused permission for a vaccination?**

Yes .....1  
 No .....2

**12a. Approximately what proportion of all parents in your practice refused:** *Please enter a number or "0" if none*  
 One vaccine: ..... %  
 Some vaccines (>1 but less than all): ..... %  
 All vaccines ..... %

**If you said "No" to BOTH Q11 and Q12 (i.e., have had no parents request an alternative schedule and no parents refuse a vaccination within the last 12 months), check here  and go to Q#15**

**13. What was the reason(s) for the request to delay or refuse vaccination? Check ALL that apply for each**

	Delay	Refusal
Baby is too small .....	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort to the child of having too many shots at one time .....	<input type="checkbox"/>	<input type="checkbox"/>
Too costly to pay for multiple vaccinations .....	<input type="checkbox"/>	<input type="checkbox"/>
Believe immunization is unnecessary.....	<input type="checkbox"/>	<input type="checkbox"/>
Concern about thimerosal .....	<input type="checkbox"/>	<input type="checkbox"/>
Concern about autism .....	<input type="checkbox"/>	<input type="checkbox"/>
Other concerns about a vaccine's safety/adverse side effects.....	<input type="checkbox"/>	<input type="checkbox"/>
Philosophical opposition to immunizations .....	<input type="checkbox"/>	<input type="checkbox"/>
Mistrust of pharmaceutical industry/government advisory groups/physician organizations.....	<input type="checkbox"/>	<input type="checkbox"/>
Too many vaccines are a burden on the child's immune system .....	<input type="checkbox"/>	<input type="checkbox"/>
Other concerns (specify).....	<input type="checkbox"/>	<input type="checkbox"/>

**14. If a parent requests an alternative schedule or refuses permission for a vaccination, how frequently do you:**  
*Circle ONE response for each item*

	(A) ALTERNATIVE SCHEDULE <i>Check here if no requests in past 12 mos <input type="checkbox"/></i>			(B) REFUSALS <i>Check here if no refusals in past 12 mos <input type="checkbox"/></i>		
	Always	Sometimes	Never	Always	Sometimes	Never
Attempt to educate the parents regarding the importance/safety of the immunization	1	2	3	1	2	3
Document provision of information on benefits/risks of vaccine v. risk of disease in the patient's record	1	2	3	1	2	3
Document the request for an alternative schedule in the patient's record	1	2	3			
Obtain parent's signature as evidence of having received information and request for alternative schedule	1	2	3			
Document the refusal in the patient's record				1	2	3
Obtain parent's signature as evidence of having received information and refusal				1	2	3
<i>(If, after educational efforts, the parents continue to refuse permission for a vaccine)</i> Tell parents you will no longer be their doctor				1	2	3

**14a. What are your reasons for dismissing a patient from your practice whose parents refuse permission for an immunization? Circle ALL that apply**

Lack of trust between physician and patient ..... 1  
 Potential costs to the practice for this patient's care ..... 2  
 Concern about being sued..... 3  
 Lack of payment (for educational efforts at each visit)..... 4  
 Concern about other patients ..... 5  
 Other (specify) ..... 6

**15. During the last 12 months:** Please enter a number or "0" if none

Check here if no refusals in past 12 months  and go to Q#16

What proportion of those parents who initially refused a vaccine changed their mind after your educational efforts and gave permission? \_\_\_\_\_ %

What proportion of those patients who initially refused a vaccine have you actually dismissed for continually refusing permission for a vaccine? \_\_\_\_\_ %

Approximately how many times have you personally asked a patient to find another practice because of vaccine refusal? \_\_\_\_\_ (number)

**15a. On average, how much time elapsed between initial refusal and permission?**  
 \_\_\_\_\_ (weeks) or  
 \_\_\_\_\_ (months)

At what age do you dismiss a family if they refuse vaccines from birth? \_\_\_\_\_(months) or \_\_\_\_\_(years)

If you do not dismiss these families ✓ here

**VACCINE INFORMATION**

**16. Overall, how good of a job do you think the Academy does in informing its members about new developments/information on issues surrounding immunizations (i.e., information about new vaccines/schedules, side effects, media coverage, etc.)? Circle ONE response for each**

	Very good	Adequate	Poor
Routinely recommended vaccines .....	1	2	3
Influenza vaccine for health care workers .....	1	2	3
Tdap/Influenza vaccine for parents of newborns .....	1	2	3

**17. How strongly do you agree or disagree with the following statement? Circle ONE response**

*"Immunization information from the AAP provides me with the information I need to address parents' concerns regarding vaccine safety, long term effects, side effects, and risks/benefits."*

<b>Strongly Agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
1	2	3	4	5

**18. How much new information on vaccines do you receive from the following resources? Circle ONE response for each item**

	A lot	Some	None
AAP web site	1	2	3
CDC web site	1	2	3
Childhood Immunization Support Program (CISP) web site	1	2	3
AAP email ( <i>eBreaking News, AAP OnCall</i> )	1	2	3
Other organizations	1	2	3
Pharmaceutical companies/ reps	1	2	3
AAP CME meetings	1	2	3
AAP News	1	2	3
Redbook (print edition)	1	2	3
Redbook (on-line edition)	1	2	3
Journal articles	1	2	3
County/State public health sources	1	2	3
Local infectious disease experts	1	2	3
Other meetings/conferences	1	2	3
Other websites/online resources	1	2	3
Other (specify)	1	2	3

19. (A) In which of the following ways do you currently receive new developments/information on issues surrounding immunizations (i.e., information on new vaccines/schedules, side effects, media coverage, etc.) from the AAP, and (B) how would you like to receive such information?

	(A) Currently Receive (Circle ALL that apply)	(B) Preferred Method (Choose ONE)
1 <sup>st</sup> class mail (e.g., PedCom)	01	01
AAP Web site – members only page ( <i>MyAAP</i> )	02	02
<i>Pediatrics</i>	03	03
Redbook (print edition)	04	04
Redbook (on-line edition)	05	05
<i>AAP News</i>	06	06
E-mail	07	07
Fax	08	08
Facebook	09	09
Twitter	10	10
Other (specify)	11	11

20. Does your state/area have an immunization registry (e.g. Immunization Information System (IIS))?

Yes ..... 1 → **20a. Do you use it?**

No ..... 2

Don't know ..... 3

	Yes ..... 1 →	Very	Somewhat	Not at all
<b>20b. How useful is it in:</b>				
Reducing unnecessary immunizations.....	1		2	3
Recalling patients for immunizations.....	1		2	3
Improving your immunization rates .....	1		2	3
<b>20c. What are your reasons for not using it?</b>				
Too cumbersome to input data .....	1			
Too cumbersome to get data .....	2			
Not enough patients are covered .....	3			
Other (specify).....	4			

21. Have the new vaccine administration codes recognizing the components in combination vaccines (90460 and 90461) improved payment in your practice?

Yes.....1      No .....2      Don't know .....3

22. Does your office have the following:

	Yes	No	Don't know
A calibrated thermometer with a current Certificate of Traceability and Calibration in each refrigerator and freezer used for vaccine storage.....	1	2	3
A monitored alarm capable of dialing one or more phone numbers to notify of power failure or temperature deviations of vaccine refrigerators/freezers .....	1	2	3
A system for daily tracking temperatures of refrigerators/freezers.....	1	2	3
A backup generator for vaccine refrigerators/freezers .....	1	2	3
An emergency plan in the event of a power failure.....	1	2	3

23a. How familiar are you with the National Childhood Vaccine Injury Act (NCVIA) regulations requiring health care providers to give their patients current Vaccine Information Statements (VISs)?

Very familiar (*I could describe it fairly accurately*) ..... 1  
 Somewhat familiar (*I have a general concept of it, but I don't know the details*) ..... 2  
 Vaguely familiar (*I know I've heard of it/I think I've heard of it, but I'm not sure of what it is*) ..... 3  
 Not at all familiar (*I haven't heard of it before*) ..... 4

23b. When administering vaccines, how frequently do you or your staff do the following? Please circle ONE response for each

	First Dose Only	Every Dose	Some Vaccines	Never
Verbally discuss the risks/benefits with the patient	1	2	3	4
Document verbal consent in the patient's record	1	2	3	4
Obtain the parent/guardian's signature to document your actions	1	2	3	4

**GLOBAL IMMUNIZATION**

**24. How strongly do you agree or disagree with the following statements? Please circle ONE response for each**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
High vaccination rates in other countries will help reduce risk of disease for U.S. children and youth	1	2	3	4	5
Global immunization should be a priority issue for U.S. pediatricians	1	2	3	4	5
Pediatricians should support government initiatives to increase global vaccination rates	1	2	3	4	5
Parents/patients in my practice are not interested in global immunization issues	1	2	3	4	5
Pediatricians in my community are not interested in global immunization issues	1	2	3	4	5
It is the role of pediatricians to discuss global immunization issues with patients/parents	1	2	3	4	5
Pediatricians should include information on global immunization when discussing vaccines with patients/parents	1	2	3	4	5
Written information on global immunization efforts should be available in pediatric offices/waiting rooms	1	2	3	4	5
The AAP should develop patient/parent education materials about global immunization issues	1	2	3	4	5
Discussion of global immunization issues during pediatric office visits is feasible	1	2	3	4	5
There is adequate time during preventive care visits to discuss global immunization issues	1	2	3	4	5
Providing written information about global immunization during pediatric office visits is feasible	1	2	3	4	5
Providing written information about global immunization during office visits would be effective at increasing parents' awareness of this issue	1	2	3	4	5
Eradication of polio is an important global child health goal	1	2	3	4	5
Eradication of polio is a feasible global child health goal	1	2	3	4	5
AAP should support U.S. government funding of global immunization programs	1	2	3	4	5
AAP should support efforts to increase funding for immunizations within the U.S.	1	2	3	4	5
AAP should lead the fight against anti-vaccine efforts	1	2	3	4	5

**PRACTICE CHARACTERISTICS**

**25. During a typical workweek, approximately how many patient visits in an office-based or other ambulatory care setting do you conduct?**

\_\_\_\_\_ (enter a number or "0" if none)

**26. What percentage of your patients would you estimate to be in the following ethnic or cultural groups?**

*If you have no patients in a specific group, please place a zero (0) in that space. (Note: Percents should sum to 100%)*

White, non-Hispanic/Latino .....	_____%	Asian .....	_____%
Hispanic/Latino origin .....	_____%	Native Hawaiian/other Pacific Islander ...	_____%
Black/African American.....	_____%	American Indian/Alaska Native .....	_____%
<b>100%</b>			

**27. Approximately what percentage of your patients are covered by the following insurance sources and systems?**

*If you have no patients in a specific group, please place a zero (0) in that space. (Note: Percents should sum to 100%)*

Don't know patients' insurance sources (check if applicable)

Private insurance .....	_____%
Public insurance .....	_____%
TRICARE (military insurance) .....	_____%
Uninsured.....	_____%
<b>100%</b>	

**28. During a typical complete workweek, how many hours per week do you spend in the following professional activities?**  
*If you do not spend any time in a particular activity, please indicate this by entering zero (0) hours in the appropriate space.*

Activity:	Hours:
Direct patient care .....	_____
Administration .....	_____
Academic medicine (medical teaching).....	_____
Research .....	_____
Fellowship training .....	_____
Other (specify) .....	_____
TOTAL HOURS/WEEK .....	

**29. Are you currently a pediatric resident?**

Yes..... 1    No..... 2    **→ 29a. In what year did you complete your residency training?** \_\_\_\_\_

**30. Approximately what percentage of your time is spent in the following areas?**

General Pediatrics .....	_____ %
Other specialty/ subspecialty area (specify - please print).....	_____ %
<b>100%</b>	

**31. Please indicate your primary employment setting, that is, the setting in which you spend the most time.**

*Please circle only ONE response*

Solo or two-physician practice.....	01	Medical school/hospital (or parent university) .....	08
Pediatric group practice: 3-5 pediatricians .....	02	Government hospital or clinic .....	09
6-10 pediatricians.....	03	Nongovernment hospital or clinic .....	10
11-15 pediatricians.....	04	Nonprofit community health center.....	11
>15 pediatricians.....	05	Other patient care or non-patient care employment	
Multispecialty group practice (not staff model HMO) ....	06	(specify).....	12
Staff/group model HMO.....	07		

**32. At your primary work setting (i.e., the setting where you spend the most time), are you an:**

Employee .....	1	Independent contractor.....	3
Full- or part-owner.....	2	Other (specify).....	4

**33. How would you describe your primary practice/position area? Is it: *Circle ONE response***

Urban (inner city).....	1	Rural.....	4
Urban (non-inner city) .....	2	Other (specify) .....	5
Suburban .....	3		

**34. With what racial group do you identify yourself? *Circle ALL that apply***

White, non-Hispanic/Latino .....	1	Asian .....	4
Hispanic/Latino origin .....	2	Native Hawaiian/other Pacific Islander .....	5
Black/African American.....	3	American Indian/Alaska Native.....	6

**35. In what year were you born?** 19\_\_\_\_\_

**36. What is your sex?**

Male .....	1
Female .....	2

**THANK YOU.** Please return in the enclosed envelope to:

**Periodic Survey  
 Division of Health Services Research  
 American Academy of Pediatrics  
 PO Box 927  
 Elk Grove Village, IL 60009-0927**