

CLINICAL ASSESSMENT SOFTWARE APPLICATION (CASA) AND IMMUNIZATION COVERAGE RATES

We read with interest the recent article by O'Connor et al. comparing immunization coverage rates based on different definitions of active patients seen in a pediatric practice of an urban children's hospital.¹ O'Connor et al. concluded that the Clinical Assessment Software Application (CASA) designed by the Centers for Disease Control and Prevention (CDC) underestimated immunization coverage rates. While we applaud the authors for reinforcing some important issues in assessing provider-level vaccination practices, we would like to clarify some points concerning the recommended uses of CASA.

CASA is a multifunctional public domain software application and not a rigidly prescribed protocol for measuring immunization coverage. We developed CASA to help providers assess and improve immunization practices and conduct reminder and recall. Which children are behind on vaccinations? Are opportunities missed to vaccinate patients during office visits? Have any doses been given at invalid ages or intervals? Is vaccination coverage at an acceptable level? CASA can be used to answer these questions.

CASA was designed with standard reports as well as optional features for assessing practices. Although O'Connor et al. mention using CASA to evaluate missed opportunities, it is unclear whether they fully used the features of CASA. The default reports look only at the impact of eliminating missed opportunities on the most recent vaccination date. Reviewers can use CASA to enter dates of the most recent patient visit, a sample of visits, or all visits to get more complete information on missed opportunities. Unless these capabilities are exploited, reviewers should be cautious in concluding that it is unnecessary to address practices regarding missed opportunities.

A more fundamental issue in interpreting reports from CASA stems from the selec-

tion of records to be entered. Any assessment of provider performance must define which patients are eligible to be selected for the review. Eligibility criteria typically include age and any number of proxies intended to generate a set of patients for whom the provider is responsible. The eligibility criteria used by O'Connor et al. were published by CDC in 1992² and were selected to match the broad, inclusive role that public clinics play as an essential safety net for vaccination services. Although the 1992 CDC guidelines have been widely implemented, the use of CASA should not be constrained by these specific guidelines.

Alternative sets of eligibility criteria have been proposed to accommodate different practice settings and purposes.³⁻⁵ It is unlikely that a single set of eligibility criteria will prove optimal for all practice settings and for assessments with different purposes. Public clinics, private practices with high or low numbers of Medicaid patients, managed care organizations, and hospital-based practices differ with respect to the conceptual set of active patients. Our experience in assessing private providers in Maine highlighted the importance of forging a private-public partnership in which eligibility criteria used by public health reviewers in private practices are agreeable to and endorsed by the professional organizations.⁶

On the basis of the strong evidence of numerous studies,⁷ we encourage the use of assessments in provider offices in conjunction with other strategies to improve delivery of immunizations and other preventive services. The most effective means for accessing provider offices is through the coordinated efforts of the public and private sectors. CASA is flexible enough to accommodate virtually any set of eligibility criteria that might be considered. More research is needed to elucidate how the use of a particular definition may or may not limit conclusions about opportunities for improving vaccination practices. ■

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