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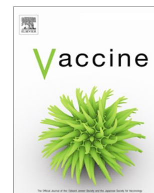

The evolution of immunization waiver education in Michigan: A qualitative study of vaccine educators

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Background: In 2015, Michigan implemented an education requirement for parents who requested nonmedical exemptions from school or daycare immunization mandates. Michigan required parents to receive education from public health staff, unlike other states, whose vaccine education requirements could be completed online or at physicians' offices.

Methods and Findings: Results of focus group interviews with 39 of Michigan's vaccine waiver educators, conducted during 2016 and 2017, were analyzed to identify themes describing educators' experiences of waiver education. The core theme that emerged from the data was that educators changed their perception of the purpose of waiver education, from convincing vaccine-refusing parents to vaccinate their children to promoting more diffuse and forward-looking goals.

Conclusions: Michigan, and other communities that require vaccine waiver education, ought to investigate whether and how waiver education contributes to public health goals other than short-term vaccination compliance. Research shows that education requirements can decrease nonmedical exemption rates by discouraging some parents from applying for exemptions, but further studies are needed to identify ways in which waiver education can promote other public health goals, while minimizing costs and burdens on staff.

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1. Introduction

In 2014, Michigan had one of the United States' easiest processes for receiving nonmedical exemptions (NMEs) from daycare and school immunization mandates, and it had one of the country's highest NME rates [1]. In December of that year, the Michigan Legislature made it more difficult for parents to receive NMEs [2]. A new rule required parents to attend an immunization education session at a local health department (LHD) if they wanted an exemption [3]. The new rule did not require additional scrutiny of exemptions requests, but only modified the method by which exemptions could be obtained. Michigan's decision to make the NME application process more difficult was informed by research showing that communities with more burdensome exemption application processes have lower NME rates [4–6]. Michigan's experience was consistent with the results of that research: the number of NMEs for kindergartners declined by 35% in 2015 [7].

Michigan is the only US state to require parents who request a NME to attend an in-person education session at an LHD. (Michigan's public health authorities call this 'waiver education', and the people who provide it are usually called 'waiver educators'. We follow this usage, though we continue to use 'exemption' and 'NME' to name the corresponding policies.) Other states that have education requirements for NMEs offer online education modules or allow health care providers to certify that they have educated parents about vaccines. For example, Oregon offers both of these options [8]. Michigan's LHDs and their waiver education staff had significant discretion in interpreting and implementing the new requirements because Michigan's LHDs are instruments of local government [9], and because the new rules provided little guidance other than that parents should receive education about "the risks of not receiving the vaccines being waived and the benefits of vaccination to the individual and the community" [3].

We wondered how staff at Michigan's LHDs responded to their new mission to provide waiver education. In particular, there was interest in exploring the implementation of this education requirement given recent evidence that similar public health education strategies about vaccines are ineffective [10,11]. Indeed, vaccine

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hesitant parents who have more information about vaccines may be less likely to vaccinate [12].

Our focus group study aimed to identify the goals that Michigan's waiver education staff pursued in their work, the methods they used to address those goals, and their judgments about whether their work was successful. In particular, we wanted to reveal how waiver education staff perceived their obligation to 'educate' parents who refused vaccines, in light of research about the difficulties surrounding this sort of communication, and because waiver educators initially received limited training and guidance. For example, research participants reported that in 2015 the Michigan Department of Health and Human Services offered one webinar and one in-person training session to prepare waiver educators for their work. Individual LHDs were otherwise left to prepare and support waiver educators at their own discretion. This was an exploratory study of the novel practice of vaccine education provision by public health staff.

2. Methods

We sent a recruitment email to all waiver educators from eight Michigan LHDs: one urban, three suburban, and four rural. At first, we scheduled focus groups based on the available dates and times staff communicated to us. Later, we scheduled focus groups in advance and informed waiver staff that they could attend whatever session worked best for their schedule. In the interest of enrolling as many participants as possible, the only inclusion criterion was that participants had conducted at least one vaccine waiver education session. While we did not record the number of waiver education sessions each educator had provided, most study participants regularly provided waiver education as part of their work requirements.

This study was approved by the Oakland University Human Subjects Institutional Review Board (HSIRB). All focus groups took place in private conference rooms at LHD offices. This setting was chosen to encourage participation. Some participants may have been less likely to make critical comments about the conditions of their employment while at work, but it is also possible that some participants were more comfortable participating in a focus group in a familiar setting. Also, we were able to meet with participants during convenient times (e.g., immediately before or after work) by conducting focus groups on site.

Participants read the informed consent form and a research team member answered questions in the informed consent process. Authors 1 and 2 facilitated focus groups. (Credentials are available from the corresponding author.) Focus groups were audio-recorded and undergraduate research assistants took notes to facilitate transcription. Each focus group began by reminding participants about session goals, asking participants not to provide identifiable information, and explaining the importance of confidentiality. We used a semi-structured approach such that focus group facilitators prioritized questions from an HSIRB-approved list of Core questions, and introduced items from an HSIRB-approved list of Supplemental questions when relevant, and as time permitted. We drew from research about vaccine hesitancy and refusal to identify Core and Supplemental questions [10,13–18]. Specific probes were instituted for follow-up and clarification of participant comments. See Table 1 for a list of core focus group questions. (A full copy of the interview schedule is available from the corresponding author.) Data saturation was reached after 10 focus groups.

Digital audio-recordings and notes were used to create a transcript for each focus group. Two research assistants created transcripts and checked them for accuracy and completeness. We did not design the study with primary and secondary hypotheses in mind. We instead relied on grounded theory which involves using an inductive approach to generate themes (e.g., lower-level concepts, categories) from the data with the purpose of identifying a core category/theme or theory [19–21]. We used the constant comparative method to generate themes [22], and all coding was completed by hand. Authors 1 and 2 independently read each transcript and noted possible themes and relevant transcript text. Possible themes and accompanying text were discussed and the list of themes was edited to reflect a consensus between the authors. The transcripts were reviewed a second time using the revised theme list and more accompanying text was identified [23]. We report below the core theme/theory and related themes in this revised list.

3. Results

39 vaccine educators participated in hour-long focus group sessions. Most participants were female, all but two were registered nurses, and most had worked in public health for more than 10 years. Given the relatively small number of waiver education staff in Michigan, we did not directly solicit demographic information from participants, to avoid the possibility of identifying research participants.

The core theme/theory that emerged was that vaccine educators changed their perception regarding the purpose of waiver education. When waiver education began in early 2015, staff believed they would be able to convince vaccine-refusing parents to vaccinate their children. Many waiver educators had little previous experience with vaccine refusers, and while they were used to

Table 1
Human subjects institutional review board approved questions for focus groups.

Core Questions	Supplemental Questions
1. How does your work conducting vaccine education sessions connect with the other work you do (or have done) in public health (nursing)?	1. What do you think about the CDC/ACIP immunization schedule? Do you think some vaccines are more important than others and do you try to communicate this to parents during vaccine education sessions?
2. What do you think is reasonable for vaccine educators to hope to accomplish in vaccine education sessions?	2. What do you think about Michigan's school and daycare immunization mandates? What do you think about the vaccine education requirement?
3. If you received training in how to conduct vaccine education sessions, did you find some aspects of that training more or less helpful than other aspects? Why or why not?	3. Please describe some of the feelings you have experienced before, during, and after vaccine education sessions.
4. Have your views about parents/guardians who refuse vaccines changed since you began conducting vaccine education sessions? If so, how?	4. Have you had personal experiences with vaccine preventable diseases or with vaccine complications, and (how) do you draw on these experiences in vaccine education sessions?
5. What are some of the things you say and do during vaccine education sessions that you think are especially important? Why?	5. What would it mean for a vaccine education session to be successful? Are there ways to be successful, even when parents receive a waiver? What do those other forms of success look like?
6. Please share some memorable experiences you have had while conducting vaccine education sessions.	6. Do you think that your sessions are run similarly to the sessions of your peers? If not, what do you think you do differently?

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