June 2007
Issue Number 44

AMERICAN IMMUNIZATION REGISTRY ASSOCIATION
Immunization Information Systems for a New Era

SNAPSHOTS

Immunization registry news from the American Immunization Registry Association (AIRA)

Welcome to SnapShots, the American Immunization Registry Association's newsletter about the progress, best practices, and accomplishments of immunization information systems across the country. We invite you to share news about your registry. Email us at aira@immregistries.org or call us at (212) 676-2325 with information about a successful programmatic or technical innovation, major accomplishment, or milestone that your registry has reached. SnapShots is sent to subscribers quarterly and posted on AIRA's web site: www.immregistries.org.

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President's Report

I'm always amazed at the great enhancements Immunization Information Systems have made over the past several years. A few years ago there were discussions about all hazard planning and tracking systems being needed during an event. The answer was simple as we already have that capability in the IIS. And today, so many jurisdictions are using their IIS as their CRA (Countermeasure Response Administration) solution … Outstanding!

Now we have grantees going live with the new Vaccine Management Business Improvement Plan (VMBIP). It's great to have a central distribution method that all the grantees will use to order VFC, but there is so much more that IIS can help address than vaccine distribution – storage, handling, and providing the vaccine to eligible children. Oklahoma and Washington State have gone live with VMBIP and have chosen to use their IIS for ordering, inventory and accountability. Read the article in this snapshot about Maine and how they have enhanced their registry. Maine has a scan form for temperature logs that providers submit to the project. What a great idea. Another important feature of population based systems is the capability to help determine the right amount of vaccine needed during a year for the VFC population within that jurisdiction. IIS are a great tool for a grantee's VFC program.

IIS are the electronic immunization record of today. The AIRA Board of Directors and Staff are so proud of the work of all the committees and workgroups their efforts to help IIS achieve their full potential. I hope you enjoy this version of SnapShots and sit back and think about the enhancements implemented in your system over the past few years. We tend to forget how much we have accomplished!

Submitted by Therese Hoyle (MI), AIRA President

IIS to Perform Role in CDC's Countermeasure Response Administration System

The Countermeasure Response Administration System

Events including the threat of pandemic influenza, SARS outbreaks, smallpox preparedness and the anthrax attacks have all demonstrated that information systems are critical to managing the response and tracking the countermeasures administered for containing and preventing further outbreaks. During a public health emergency there is a need to manage information about the event, what countermeasures are available, who has received them, monitor their effectiveness, and identify any resulting adverse events. After the event, there is also a need to analyze the information to help better prepare for future emergencies.

In 2004 the CDC began developing the Countermeasure Response Administration (CRA) system to serve as the primary tool to collect and analyze this information. To those of us in the Immunization Information Systems community, IIS are a natural partner in this effort. The CRA administration has recognized the potential IIS have to supply needed information to CRA, and have identified a role for IIS in the event of pandemic influenza.

IIS and the National Pandemic Influenza Plan

A portion of the National Pandemic Influenza Plan requires that administered doses of pandemic influenza vaccine be assessed to ensure supplies are reaching target populations and to help determine the efficacy and impact vaccination has on the course of the disease. As part of the 2006 Public Health Emergency Preparedness Cooperative Agreement Pandemic Influenza Supplemental Guidance, CDC requires that states have the capability to track the number of administered doses and report them on an aggregate basis to CDC. IIS have been identified as one of three options for states and partners to meet this requirement. The three options are as follows:

> **Option 1:** For states and partners collecting data via an existing immunization information system (IIS) or other application, technical specifications were developed for three different data exchange formats.
> **Option 2:** For states and partners collecting data manually, an aggregate reporting screen was added to CDC's CRA application to allow direct data entry via a web browser.
> **Option 3:** For states and partners using CDC's CRA application to collect patient level information, selected data elements will be automatically aggregated.

The CRA team, together with the Immunization Services Division at CDC, is currently working with project areas to determine how each will provide the aggregate reporting data to CDC on a weekly basis.

Webinars on Aggregate Reporting of Pandemic Influenza Vaccine Doses

CDC has put together a timeline for working with projects to develop a plan for reporting doses administered information and has hosted a series of webinars to communicate with public health project areas on this task. The webinar held on May 9 focused on describing the three reporting options mentioned above that are available to states and partners, the process and technical considerations involved for each option, plans for testing the reporting process, and the need to identify a point of contact at each public health project for this effort. The June 6 webinar focused on examining Option 1 for aggregate reporting of pandemic influenza doses administered, which involves the use of IIS.

A variety of operational and technical considerations should be taken into account when using your IIS to report aggregate pandemic influenza doses administered, such as:

- Ensuring the timely and complete reporting of vaccine data;
- Being familiar with clinic sites and/or distribution sites;
- Ensuring staff are trained and equipped;
- Developing data entry capacity as needed; and
- Developing quality assurance measures and follow-up plans.

Pilot testing of plans and approaches will take place in the fall.

IIS' role in fulfilling the National Pandemic Influenza Plan represents an exceptional opportunity for IIS to demonstrate their utility and value as a public health response tool. Work with your doses administered point of contact to address technical and operational challenges, plan for pilot testing efforts, and strengthen the public health community ability to respond.

For more detailed information on CRA, pandemic influenza reporting, webinar slides and data exchange requirements, visit the main CRA website at http://www.cdc.gov/phin/preparedness/cra.html.

Submitted by Amanda Bryant and Warren Williams, CDC/NCIRD/ISD/IISSB

AIRA Launches New Initiatives Aimed at Reaching HP 2010 IIS Goal

With the year 2010 rapidly approaching, all Immunization Information Systems (IIS) are working to meet the Healthy People 2010 IIS goal of having 95% of children <6 years of age in their population with two or more immunizations recorded in the registry. AIRA has launched two new initiatives aimed at giving IIS tools to help them reach that goal: Provider Participation Performance Indicators and IIS/Schools Data Exchange Capacity Building.

Provider Participation Performance Indicators – The purpose of these new performance indicators is to give IIS a tool to more accurately assess the degree to which the providers in their area are contributing to and utilizing the data from their regional or state IIS.

These indicators will go beyond the provider participation questions on the Immunization Information System Annual Report (IISAR) that is filed with the CDC and encourage IIS to measure provider participation in new and possibly more meaningful ways. The ultimate goal of the indicators is to use the results of the queries to help IIS determine where intervention needs to occur to improve the completeness, timeliness and accuracy of immunization data submitted to the IIS by providers.

Ten demonstration sites have volunteered to test out the four performance indicators and will report back on the following: How easy were they to implement? How meaningful was the data that resulted? How useful was the data when strategizing on improving provider participation? How can the indicators be improved to make them more meaningful and useful tools for all IIS?

Once the demonstration site phase of this initiative is complete, the Provider Participation Committee will develop tools that all IIS can use to measure and increase their provider participation.

IIS/Schools Data Exchange Capacity Building Workgroup – A new workgroup has been convened to carry out activities designed to increase the number of IIS interested in exchanging data with schools.

The workgroup will start off by assessing the current state of IIS/schools data sharing around the country – which IIS are doing data exchange, what are their challenges, what are their best practices for overcoming the challenges, and which IIS want to work at improving their data exchange with schools. Activities such as conference calls, sharing of best practices, conference workshops, and mentoring will then be developed to build data exchange capacity for those IIS.

Development and implementation of tools for use by all IIS and schools will be promoted and available on the AIRA web site.

Submitted by Ina Kichen, AIRA

Improved Vaccine Processing in Maine

In 1999, Maine performed a study that showed our per dose distribution cost for our Self-Distribution/Depot model to be approximately $1.32 per dose distributed. The decision was made at that point to engage the CDC to assist us in moving to 3rd Party distribution as a cost savings measure, and to negotiate the method of preserving the appropriate amount of that savings to remain within the program budget for use in associated business task.

Those conversations and strategies were put into place over the course of the following couple of years, leading in 2002 to our initial RFP for third party distribution. Maine used a contract model from a state already engaged in 3rd Party distribution and we implemented a very raw hybrid model of 3rd Party distribution while still utilizing core policies learned during our Depot Distribution Period. Note: management change slowed the process of conversion as each new person (3 in 3 years) needed to be rededicated to program change.

From 2002 to Present, the current staff has worked to analyze, modify, and implement solid policy and procedure methods to maximize our funding, while providing a positive business environment for the program and for the provider.

We have integrated technology with distribution from the beginning and continuously try to find the balance between overhead and provider requirements. We currently service 700+ providers monthly with direct 3rd Party distribution utilizing three positions for a combined effort of 2 FTE. We collect monthly Usage reports, wastage reports, and temperature logs, and at the providers discretion they may order monthly. This is facilitated through the layered use of the Hand Keying (implemented "legacy" - minimal - aggregate), IIS (1999 - 35% of Providers - Per Dose), and Optical Character Reader (2004 - 60% - Aggregate).

MIP does provide ordering recommendations to providers based on size, but works with providers to address factors such as fridge size and/or cold chain issues that might require exceptions.
2006: MIP added the School Based Survey and Day Care Surveys as OCR compatible, expanding the OCR use beyond Vaccine Management and into Provider QA/Service Delivery Program Components. All forms are returned via fax, auto processed into the OCR verifier, and then exported out into the appropriate survey tool.

Visit the following link to view graphics describing the process the Maine Immunization Practice documented and submitted on behalf of VMBIP for our transition from 3rd Party (Privatized) Distribution to 3rd Party CDC (Regionalized) Distribution.

http://www.maine.gov/dhhs/boh/mip/files/vmbip/maine_vaccine_processing_08172006.htm

Submitted By Shawn Box (ME)

MCIR Implements a New Clinical Record – *Physicians are Ecstatic!*

A *NEW* Clinical Record has been added to the Michigan Care Improvement Registry. This new advancement will prevent Michigan providers from having to record required immunization administration information in multiple places. Once the information has been reported to the registry, a simply print off can be generated for inclusion in the medical chart.

“This new process will save lots of time by no longer requiring double-data entry,” comments Therese Hoyle, State MCIR Coordinator. “Our physicians are ecstatic!”

In order for the Clinical Record to be operable, the physician offices must notify their regional MCIR coordinator for option enabling and pre-populate the registry using vaccine defaults with their vaccine information (lot number, manufacturer). After entering the dose date and vaccine type, the user will add the initials of the person who administered the vaccine. All of the current Vaccine Information Statement dates have already been added to the registry, and the MCIR training consists of reviewing what current VIS statements a practice is using so that it matches the current VIS dates in MCIR. Interested medical practices are being instructed to keep a signature list on file in the event that they needed to verify the initials for a vaccine administrator for audit purposes.

The clinical record is designed to help the clinician with complete documentation of immunizations on a patient, and the Official Immunization Record in MCIR is the record of choice for the parent. Medium to small practices that do not have an EMR solution will now have the technology at their finger tips to go paperless for all their immunization documentation.

Submitted by Julie Clark, MCIR

Work from the Trenches: *New Guidelines and Evaluation Efforts*

AIRA has published a “best practices” guide on deduplication strategies for Immunization Information Systems (IIS). *Vaccination Level Deduplication in Immunization Information Systems* is a 100-page compendium of rationale, strategy, best practices, and benefits to help IIS managers tackle the increasingly challenging problem of creating and maintaining unique records.

The *Vaccination Level Deduplication in Immunization Information Systems* is the second in a series of "best practice" guidelines developed by Subject Matter Experts convened by the Modeling of Immunization Registry Operations Workgroup (MIROW). The first "best practice" guideline, *Moved or Gone Elsewhere (MOGE) Status and Other Patient Designations in IIS*, was completed in 2005 and disseminated at the 2006 National Immunization Conference. In May 2007, AIRA released an on-line survey to evaluate the usefulness and adoption of the Patient Status Guidelines. The evaluation is of paramount importance because it will aid MIROW as it develops future "best practice" guidelines. Please take a few minutes to respond to the evaluation survey if you have not had a chance to do so: https://webmail.uchsc.edu/exchweb/bin/redir.asp?URL=http://www.immregistries.org/airaSurvey/index.php?sid=22.

The MIROW Steering Committee is preparing for the next "best practice" guideline which will address the data validation checks commonly used in IIS operations. A panel of 12 subject matter experts will meet in a face-to-face meeting in August 2007 in Atlanta, GA for an intense facilitated session to develop this guideline. It is expected that the new guideline will be out by the end of the calendar year.

The "best practice" guidelines are intended to support a uniform alignment of the operational processes in IIS with the ultimate goal of improving data consistency and quality in IIS. Additionally these guidelines and evaluation efforts serve as technology-neutral requirements guidelines for information technology projects and foster collaboration and aid in communication among IIS professionals.

Both guidelines and the evaluation survey are available on the AIRA Web page:

Vaccination Level Deduplication in Immunization Information Systems
http://www.immregistries.org/pdf/AIRA_BP_guide_Vaccine_DeDup_120706.pdf

Moved or Gone Elsewhere (MOGE) Status and Other Patient Designations in IIS
http://www.immregistries.org/docs/MIROW_MOGE_Chapter_Final_122005_rev1.doc

Moved or Gone Elsewhere (MOGE) Status and Other Patient Designations in IIS Evaluation Survey
https://webmail.uchsc.edu/exchweb/bin/redir.asp?URL=http://www.immregistries.org/airaSurvey/index.php?sid=22

Submitted by Warren Williams (CDC) and Elaine Lowery (CO)

Oregon-Washington Immunization Information System (IIS) Data Exchange

In 2006, Oregon and Washington implemented the first large-scale data exchange between Oregon's IIS, Oregon Immunization ALERT, and Washington's IIS, CHILD Profile. This event was the culmination of years of effort in drafting and approving an interstate agreement between the two states. Although data is now being exchanged monthly between the two systems, the road to achieve this scheduled exchange was long, but ultimately fruitful thanks to the cooperative efforts of IIS teams and support from public health officials and immunization program managers on both sides of the border.

Effective in 2004, changes were made to the ALERT statute allowing the interstate exchange. Unlike Oregon, Washington does not have a specific registry law that governs its functioning, so changes did not need to occur in Washington Law. Oregon Revised Statutes (ORS) were amended in 2004 to include the following language: *Before sharing data with any immunization registry, an immunization registry maintained in Oregon must ensure that the immunization registry receiving the data has confidentiality* *and security policies at least as stringent as the policies of the registry sharing the data [1993 c.297 §8; 2003 c.573 §3]*. However, it is important to note that no funding for implementation accompanied this change in statute.

Following passage of the amended law, Oregon Administrative Rules (OARs) were filed in 2004 to include the following: *The Director may receive information from other registries and may share information with other such registries, provided however that the Director makes a determination that other registries have confidentiality protection at least equivalent to those under ORS 433.090 to 433.102 and these rules. The Director shall prescribe the information that may be shared and the forms for sharing information to and from other registries.*

The Oregon and Washington registries had long discussed sharing data. Once the legal steps noted above were complete, the two states formalized a collaborative team that began drafting an interstate agreement primarily from scratch. The group drew some guidance from Every Child By Two's Model Interstate Information Sharing Statute (http://www.ecbt.org/registries/modelinterstate.cfm), In addition, Washington State's data sharing agreement template also provided a structural model for the interstate agreement. The next year was spent modifying this draft agreement, with the help of the respective Attorneys General from each state. Key areas to articulate centered around populations identified in each state, confidentiality and security, and clarifying the data elements that would be exchanged. The final agreement was signed by representatives from each state by April 2006, and a ceremonial signing took place in July 2006 to kick off the official start of the exchange.

Procedures for the exchange were then identified. The decision was made to exchange in batch flat-file format initially, transitioning to HL7 exchange at a later date. The files would be sent SFTP via the Washington Department of Health site. It was decided that records would be exchanged based on patient address. Washington would send records for any children under the age of 18 with an Oregon address in the CHILD Profile system and Oregon's ALERT would do the same for any children in their system with a Washington address. An initial count showed that ALERT contained records for 128,361 children under 18 with a last reported address in Washington, while CHILD Profile contained records for 26,090 children with Oregon addresses. Particular attention was spent on how best to update each others' registries when corrections were needed. Data from the initial loads were reviewed especially carefully, and data quality issues were uncovered with a major Oregon source when it was found that reports of shots were being received when the shot was merely ordered, not when the shot was administered.

As of early 2007, the exchange has been implemented on a monthly basis. Early baseline data were collected to set the stage for measuring the impact of the exchange. Next steps include continuing data quality checks, transitioning to HL7 exchange, and exploring the potential for increased up-to-date rates for individuals living along the border in both states.

Although Oregon and Washington's interstate exchange is well underway, some key recommendations have emerged that would simplify the process for other interstate exchanges moving forward:

- IIS would benefit from a model agreement for adoption by other states
- Data quality functional standards should be identified prior to exchange
- A "certification" process may help pave the way for interstate exchange
- Funding would, of course, make it easier to implement interstate agreements

Submitted by Mary Beth Kurilo, OR

Working with the Michigan Care Improvement Registry

How local providers went from avoidance to acceptance to enthusiastic participation – in just a few years

(Reprinted from Connections Newsletter, Spring, 2007, ©2007 Public Health Informatics Institute)

An anecdote from the early years of the Michigan Care Improvement Registry (MCIR, pronounced “micker”) demonstrates the state’s uphill battle to establish physician participation in reporting immunizations. As the story goes, back in 1998, a MCIR representative was visiting a provider office to explain the new system and offer support. Needing some materials from her car, the MCIR rep left to get them, only to find the office door locked when she returned. With persistence, she was able to regain entry and continue explaining the benefits of participation.

By 2004, however, a remarkable 80 percent of the state’s 2,500 private providers were actively reporting immunization data to MCIR, and all 45 of Michigan’s local health departments were participating in the system. Now, on average, more than 9,000 users access the system every day.

Click on the following link to read the full article.
http://www.phii.org/CXNews/Spring2007/MCIRDataSharingJKiely.html

Click below to read the entire Spring 2007 Issue of the *Connections Newsletter*.
http://phii.org/cxnews/spring2007/spring2007final.html

Submitted by John Kiely, Public Health Informatics Institute

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SnapShots is produced quarterly by the AIRA Education Committee.
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