Disclosure: Session L3

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CDC did not accept commercial support for this continuing education activity.
Outreach to Amish and Mennonite Communities’ Under Immunized School Population

Alexandra D. McFall, RN, BSN
Program Operations Section Manager

May 17, 2018
According to Amish Studies, a website developed by the Young Center for Anabaptist and Pietist Studies at Elizabethtown College, Pennsylvania had an estimated Amish population in 2017 of 74,250, followed closely by Ohio, where the 2017 Amish population was estimated at 73,780.
• LARGEST AMISH SETTLEMENTS
• The Lancaster County area Amish settlement is not only the largest in the U.S. by population – estimated at 36,920 people in 2017 – but in terms of age, as the oldest settlement. The Holmes County area settlement in Ohio ranks second, with a population of 35,130.
In 2012, Pennsylvania was awarded federal grant funds to enhance collection of school immunization coverage rates.

- Non-medical reporting on School Immunization Law Report (SILR).
- Decision made to visit all Amish and Mennonite schools in Pennsylvania to obtain valid school immunization coverage rates.
Bridging the Gap

• March 2014 initiated communication
• May 2014 meeting
  • Seven members of the Amish Community (Amish Book Society)
  • One member of the Old Order Mennonite Community
  • Three-hour meeting
Issues Discussed

- SILR
- School Immunization Requirements
- Site visit issues
  - Timeframe
  - Hours
  - Days
  - Nurses
  - Identification
  - Accompanied by chairperson of school
Respecting Cultural Differences

- Religion
- Dress
- Technology
- Health Practices
- Language
- Views on Immunization
Keep Communication Open

• Gave them my personal cell number and office telephone number
• Call them on a monthly basis
• Respect their visit requests
• “Giving same opportunities as the English”
• Fairness in opportunities
Communication to Staff

• Site visit issues conveyed to district Immunization Nurses at the annual Pennsylvania Immunization Conference.
  • Timeframe, hours, days, female nurses, identification, minimal disruption of class time.
Learned Barriers to Immunization

- No present threat or scare
- Misinformation
- Generational immunization myths
- Fear of adverse affects
- Vaccine safety
- Not trusting the government
- Vaccines made from aborted fetuses
• Educational tool needed
  - Stories sell
  - Pull together pediatric nurses and other situational experiences
  - Plain booklet in black and white with simple language
  - Had to sell my idea internally first
  - Presented booklet to Amish and Mennonite contacts
Educational Tool

• Received many phone calls regarding vaccines from our contacts.
• Contacts approved printing of 1,500 booklets for the 2015 school term.
• Contacts made me aware they have communities that will not be receptive, but wanted booklet to be available to all.
• Booklets were made available in:
  - Businesses
  - Hospitals
  - Health Centers
  - Physician offices
  - Schools
  - Board meetings
  - Parent-teacher meetings
Infant, Child and Adolescent Immunizations
### Immunizations Covered

#### Infant, Child and Adolescent Immunizations

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccination(s)</th>
</tr>
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<tbody>
<tr>
<td>Birth</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>2 Months</td>
<td>DTaP, Hepatitis B, Hib, PCV, Polio, RV</td>
</tr>
<tr>
<td>4 Months</td>
<td>DTaP, Hib, PCV, Polio, RV</td>
</tr>
<tr>
<td>6 Months</td>
<td>DTaP, Hib, PCV, RV</td>
</tr>
<tr>
<td>6 Months and older</td>
<td>Flu (every year)</td>
</tr>
<tr>
<td>6-18 Months</td>
<td>Hepatitis B, Polio</td>
</tr>
<tr>
<td>12-15 Months</td>
<td>Hepatitis A, Hib, MMR, PCV, Varicella</td>
</tr>
<tr>
<td>15-18 Months</td>
<td>DTaP</td>
</tr>
<tr>
<td>18-23 Months</td>
<td>Hepatitis A</td>
</tr>
<tr>
<td>4-6 Years</td>
<td>DTaP, MMR, Polio, Varicella</td>
</tr>
<tr>
<td>11-12 Years</td>
<td>Tdap, MCV</td>
</tr>
</tbody>
</table>
Meningitis

Meningitis is a vaccine-preventable disease that can spread from one person to another by coughing, kissing or sharing eating utensils. The meningococcal germ can make large amounts of poisons once inside the body. It causes infection in the blood, lining of the brain and spinal cord. Symptoms include fever, chills, rash, headache, confusion, stiff neck and dark purple spots on the arms and legs. This disease can take a child’s life in a few hours. Adolescents and teens are most likely to die from this disease.

An easy way to prevent this from happening is to get your child protected with meningococcal vaccine (MCV) at the appropriate age.

The Stoltzfus Farm

Abram is 13 years old and the only son of five children in the Stoltzfus family. Abram loves helping his father on the family farm. Rain or shine, you could always find Abram working alongside his father Noah. The dairy farm had 60 dairy cows that needed to be milked and fed every day. This farm used mechanical milkers, which allowed for many cows to be milked in all at once. Bulk cooling tanks and milk agitators in the back of the barn housed the raw milk until the milkman came (every other day except Sundays).

Abram enjoyed socializing with his friends on Sundays after worship. Worship was to be held at the Stoltzfus farm this Sunday, and Abram was looking forward to serving as a hostler along with his father. Being the only male child, he enjoyed being with the other males. Abram’s mother, sister and women of the church community prepared the meal after the worship. After eating, Abram followed his friends and played baseball. It was a hot day, and the boys drank a lot of cold water.
**SILR Visits**

- All Amish and Mennonite Schools are required to complete a “certification” form.
  - Lists name of school, address and contact person
- Addresses received from the PA Department of Education (PDE) through their database.
Barriers First Year

• Going to the school chairperson first, then to school.
• Wrong location addresses.
• Hesitancy of some communities.
• SILR forms not completed correctly.
• Met with Amish Book Society Chairperson regarding barriers.
• Nurses no longer needed to be accompanied to school.
• Addresses would be corrected.
• Reminder to all communities to allow nurses to complete SILR.
West Nickel Mine

• For many years PDE only had a chairperson location for the school address.

• October 2, 2006 shooting of female students at West Nickel Mine School.
  5 died, 5 wounded, ages 6-13 years of age.
• School location addresses were still incorrect.
• Nurses familiar with their districts instructed to correct addresses.
• Immunizations program kept a spreadsheet with correct addresses.
• Sent PDE our spreadsheet with correct addresses.
## 2014 vs 2015

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amish</td>
<td>444</td>
<td>527</td>
</tr>
<tr>
<td>Old Order</td>
<td>122</td>
<td>137</td>
</tr>
<tr>
<td>New Order</td>
<td>79</td>
<td>110</td>
</tr>
<tr>
<td>Total</td>
<td>645</td>
<td>774</td>
</tr>
</tbody>
</table>

Total increase: +129
Clinics

- Clinics are often held at:
  - Firehouses
  - Church halls
  - Individual homes
  - Barns
  - State health centers
  - Barn raisings
• Spring of 2015 met with Amish Book Society Chairman and Old Order Mennonite Chairman separately to discuss school immunization rates and how we can work together to improve them.

• Old Order Mennonite coverage rates are higher.
• Copies of immunization coverage rates given.
• List of upcoming clinic dates given.
  📢 Try to put clinic dates in the “Amish Newspaper”
• Discussed potential ways to improve rates.
  🔄 Both took immunizations seriously
Change of School Leader

• Location of schools was still an issue.
• Never received a completed address list of all Amish schools.
• Getting to know a new leader in July 2016.
• Trying to gain trust of the new leader.
• Reviewed our purpose and accomplishments to date.
Assistant Leader Change

• Shared the ongoing accomplishments and purpose.
• Sent up-to-date addresses for his jurisdiction.
• Continues to call even though he is out of the leadership role.
Leader Communication

• The ongoing communication and purpose was explained by outgoing leader and incoming leader was very welcoming.

• Aware of all collaboration to date.

• Wanted to continue.

• Field issues.

• Good working relationship to alleviate these problems.
### 2015 vs 2016

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th></th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amish</td>
<td>527</td>
<td>Old Order</td>
<td>133</td>
</tr>
<tr>
<td>Old Order</td>
<td>137</td>
<td>New Order</td>
<td>113</td>
</tr>
<tr>
<td>New Order</td>
<td>110</td>
<td></td>
<td></td>
</tr>
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</table>

**Total**    | **774**| **Total**  | **786**|

**Change**   |      | **+12**    |
<table>
<thead>
<tr>
<th>Year</th>
<th>DTAP</th>
<th>Polio</th>
<th>MMR</th>
<th>HepB</th>
<th>Var. Had Disease</th>
<th>Var2</th>
<th>Tdap</th>
<th>MCV</th>
<th># of schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 Amish</td>
<td>20.4%</td>
<td>21.3%</td>
<td>18.0%</td>
<td>20.3%</td>
<td>4.7%</td>
<td>10.7%</td>
<td>8.1%</td>
<td>6.7%</td>
<td>527</td>
</tr>
<tr>
<td>Old Order Mennonite</td>
<td>72.0%</td>
<td>73.3%</td>
<td>68.4%</td>
<td>69.3%</td>
<td>26.8%</td>
<td>26.2%</td>
<td>52.2%</td>
<td>51.4%</td>
<td>137</td>
</tr>
<tr>
<td>New Order Mennonite</td>
<td>80.5%</td>
<td>81.1%</td>
<td>73.8%</td>
<td>76.2%</td>
<td>23.0%</td>
<td>48.4%</td>
<td>55.6%</td>
<td>51.3%</td>
<td>110</td>
</tr>
<tr>
<td>2016 Amish</td>
<td>26.2%+5.8%</td>
<td>26.5%+5.2%</td>
<td>22.8%+4.8%</td>
<td>25.4%+5.1%</td>
<td>5.0%+0.3%</td>
<td>14.2%+3.5%</td>
<td>9.1%+1.0%</td>
<td>7.1%+0.4%</td>
<td>540+13</td>
</tr>
<tr>
<td>Old Order Mennonite</td>
<td>72.9%+0.9%</td>
<td>73.5%+0.2%</td>
<td>68.6%+0.2%</td>
<td>70.6%+1.3%</td>
<td>26.4%-0.4%</td>
<td>30.9%+4.7%</td>
<td>48.2%-4.0%</td>
<td>46.2%-5.2%</td>
<td>133-4</td>
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<tr>
<td>New Order Mennonite</td>
<td>79.4%-1.1%</td>
<td>81.6%+0.5%</td>
<td>75.0%+1.2%</td>
<td>74.4%-1.8%</td>
<td>19.6%-3.4%</td>
<td>50.1%+1.7%</td>
<td>44.6%-11.0%</td>
<td>43.7%-7.3%</td>
<td>113+3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>786 Total Schools +12</td>
</tr>
</tbody>
</table>
Differences in 2015 and 2016

- Addresses are improving, but still not complete.
- Only 12 additional sites visited.
- Noticing areas of acceptance.
- Waiting for list of Amish schools directly from Chairman.
- Ordered 350 additional booklets.
2017 Meeting

• June 2017: 16 attendees from the Amish Community and three from the Old Order Mennonite Community.

• Coverage rates shared with all.

• Offered again to have a clinic at any time, place or location.

• State had approved new school regulations and these were reviewed.
• Even though most of the school immunization regulation changes did not apply to them, they were still reviewed.
  - Felt they were being kept in the loop for school regulations.
• Received a comprehensive list of Amish Schools with correct addresses from their new leader.
Change of Mennonite Leadership

- Once more had to review goals and accomplishments to date.
- Aware of our purpose.
- Open communication.
<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>540</td>
<td>786</td>
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<td>22.8%</td>
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<tr>
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<tr>
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<td></td>
<td>75.0%</td>
<td>74.4%</td>
</tr>
<tr>
<td></td>
<td>44.6%</td>
<td>43.7%</td>
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2017

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<tr>
<th></th>
<th>574</th>
<th>148</th>
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<tr>
<td></td>
<td>+34</td>
<td>+15</td>
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<tr>
<td>Amish</td>
<td>-3.66</td>
<td>-7.28</td>
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<tr>
<td></td>
<td>-3.77</td>
<td>-3.55</td>
</tr>
<tr>
<td></td>
<td>-1.38</td>
<td>-2.64</td>
</tr>
<tr>
<td></td>
<td>-53</td>
<td>+.64</td>
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<tr>
<td>Old Order Mennonite</td>
<td>-1.53</td>
<td>65.75</td>
</tr>
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<td></td>
<td>-7.75</td>
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<td>+3.71</td>
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<td>-0.08</td>
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<td></td>
<td>-5.89</td>
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<td>15.48</td>
</tr>
<tr>
<td></td>
<td>+6.28</td>
<td>47.39</td>
</tr>
</tbody>
</table>

839

+53

Total Schools
Lessons Learned

• Patience, Patience, Patience
• Ongoing learning
• Being available at all times
• Awareness of cultural beliefs
• Friendly community
• Willingness to cooperate
• Belief in immunization myths are hard to break
Questions
Thank You

- Pennsylvania Department of Health, Division of Immunizations
- 717-787-5681
- Alexandra McFall (amcfall@pa.gov)
Results of a Childhood Immunization Needs Assessment at Clinics Serving American Indian/Alaska Native Communities

National Immunization Conference
Atlanta, GA
May 17, 2018

Meghan Porter, MPH\(^1\)   Gifty Crabbe, MPH\(^1\)   Deb Smith, RN, PHN, MSN\(^2\)

\(^1\)Great Lakes Inter-Tribal Epidemiology Center, Great Lakes Inter-Tribal Council, Inc.

\(^2\)Indian Health Service Bemidji Area Office

Disclaimer: The findings and opinions expressed in this presentation are those of the author(s) and do not necessarily reflect the view of the Indian Health Service IHS
GLITEC Mission

To support Tribal communities in their efforts to improve health by assisting with data needs through partnership development, community-based research, education, and technical assistance.
Background

- Tribes are sovereign nations.
- American Indian/Alaska Natives face numerous health, social, and economic disparities:
  - Population decimation: extermination, termination, assimilation;
  - Collective trauma and grief;
  - Disparities in incidence and prevalence of diseases and mortality rates;
  - Maternal and child health disparities.
Indian Health Service (IHS)

- IHS works to fulfill the U.S.’s trust responsibly to provide healthcare to AI/AN people.
- Three kinds of facilities within IHS (abbreviated as I/T/U):
  - Indian Health Service (federally-run) facilities;
  - Tribally-run facilities;
  - Urban Indian facilities.
In 2013, on average IHS received only 59% of the funding necessary to cover the calculated full costs.*


Image from: The National Tribal Budget Formulation Workgroup’s Recommendations on the Indian Health Service Fiscal Year 2019 Budget. Honoring the federal trust responsibility: a new partnership to provide quality healthcare to America’s first citizens
IHS and immunization

• Partnership between CDC and IHS, working with IHS and tribal immunization programs across the country;
• Each Area has a designated immunization coordinator;
• Runs the National Immunization Reporting System (NIRS).

https://www.ihs.gov/epi/vaccine/
Bemidji Childhood Immunization Needs Assessment (BACINA) origin

• GLITEC and IHS had noted Bemidji Area’s declining childhood immunization rate.

• GLITEC and IHS collaborated on a proposal to HRSA’s Graduate Student Epidemiology Program (GSEP) for a student intern to assist with a project to:
  • Better understand reasons for decrease;
  • Inform a future quality improvement project.

• BACINA began in May 2017.
Methods
Components of BACINA

• Analysis of NIRS data;
• Analysis of three-state area (Michigan, Minnesota, Wisconsin) Immunization Information System (IIS) data;
• Interviews with Bemidji Area Immunization Coordinators.
Methods overview

- Immunization Coordinators and Health Directors were sent a letter explaining project and asking for participation;
- Structured interviews administered via telephone by intern;
- Analyzed quantitative and qualitative data;
- Reviewed open-ended comments, jointly developed codes, individually assigned codes to responses, and then finalized codes by consensus;
- Reviewing interviews responses overall, developed themes;
- Created recommendations to address themes.
Results
Results summary

• 37 of 38 Bemidji Area immunization coordinators participated in interviews;

• Data requested/received from Michigan, Minnesota, Wisconsin IISes;

• NIRS data retrieved and analyzed;

• GLITEC formulated 12 draft themes and 52 draft recommendations:
  • Shared themes/recommendations with immunization coordinators and other partners to help strengthen them and ensure applicability.
Trends in Bemidji Area childhood vaccine coverage, NIRS, FY12Q3-FY17Q3

3-27 month olds: decrease from 66% to 61%

Source: National Immunization Reporting System (NIRS); Health People 2020 Objective IID-8
Selected Draft Themes and Recommendations
A note about recommendations

• Recommendations may be applicable to I/T/Us, state immunization programs, CDC, IHS, and/or community partners (including GLITEC):
  • In this presentation, IHS refers to the Area and/or National programs.

• Not all recommendations apply equally to all sites/organizations.

• Recommendations are only suggestions:
  • Tribes are sovereign nations;
  • GLITEC has no authority over I/T/Us or other agencies.

• We do NOT anticipate that all the recommendations will be implemented.
Theme: Immunization coordinators want to improve childhood vaccination rates.
View of importance of childhood immunization to population and patient health

Interested in potentially participating in a future quality improvement project
Theme: Immunization coordinators want to improve childhood vaccination rates.

- Conduct quality improvement activities to improve vaccination rates.
- Federal, state and other partners support I/T/Us with training and technical assistance.
- Monitor up-to-date coverage of children before they turn two years old.
Theme: Many immunization coordinators want more immunization-related training.
Theme: Many immunization coordinators want more immunization-related training.

- “I have a thought on training—there really is no training-modules or manuals or guide books or anything for immunization coordinators at tribal clinics. There is no new trainings on what the role consists of—there are no guidelines anywhere—what the role of the immunization coordinator is.”

- “I would appreciate knowing changes in new vaccines that are coming out or changes.”

- “Probably will be updates on recommendations for immunizations; training on MIIC system in of itself; training on ways to better reach communities to increase immunization rates.”
Training received

No training received when began in role as Immunization Coordinator

No continuing education/training on childhood immunization in last year

n=37; n=34
Theme: Many immunization coordinators want more immunization-related training.

- Provide training for new immunization coordinators and those wanting a review on basics. ★ ✦ ■ ▼
- Provide training on updates, changes, and catch-up schedules. ✦ ■ ▼
- Provide training on how to pull and use reports from immunization systems like NIRS and IIS. ✦ ▼
- Develop uniform/universal training material for new immunization coordinators. ★ ✦ ■ ▼
Theme: Manual data entry resulting from the lack of interconnectivity between data systems is a burden on immunization coordinators.
Theme: Manual data entry resulting from the lack of interconnectivity between data systems is a burden on immunization coordinators.

- “I think the bidirectional communication with the registry will greatly help.”
- “Get the EHR to communicate with the registry/MIIC.”
- “The only change that I would want is to only have to document once. 'Cause now we are documenting in multiple spots, so if we can document in our EHR or MCIR and have it sent automatically to fill in the missing link, that will be great.”
Manual data entry


What can be done to improve childhood immunization data reporting?

- Eliminating dual data entry/linking systems
- Manual data entry from IIS into EHR
- Manual data entry from EHR into NIRS

How data are input from EHR into NIRS*:

*All data must be input manually into NIRS (no automated upload available)

n = 37; n=31; n=21; open-ended responses grouped by GLITEC (i.e. not a multiple choice question)
Theme: Manual data entry resulting from the lack of interconnectivity between data systems is a burden on immunization coordinators.

- Increase the number of I/T/Us in Bemidji Area that use bidirectional data exchange to connect their EHR to IIS to reduce the time devoted to manual data entry.

Recommendation directed towards: ⭐ I/T/Us  ♦ State immunization programs  🟢 CDC  violet IHS  Community partners (including GLITEC)
Theme:
Socio-economic issues affect childhood immunization rates.
Theme: Socio-economic issues affect childhood immunization rates.

• "At our site here, we have transportation issues, so getting people here to their appointments to get their vaccines done is our biggest challenge here and not having updated phone numbers for correct addresses makes it difficult to get the kids in here. So we try mailing them letters in the mail, but you don't necessarily reach them because they are [no] longer at that address and you can try calling them, but then they don't always have minutes on their phone 'cause they can't afford a phone or they don't have internet access to go online and see things either. So, that's what we struggle with here, just getting them here in general."

• “…the health department, they're only opened during the day. If you have people who work during the day, there is no clinics like that. Go in the evenings.”

• “Just get them whenever they are here-if they are here for well child or if they are here for acute visit.”

• “It will be nice to incorporate immunization administration into WIC outreach.”
In your opinion, what can be done to improve childhood immunization coverage for your site?

- Collaboration with schools/Head Start/WIC
- Immunization clinic/special days/extended hours
- Promoting well-child visits
- Reduce socioeconomic issue-related barriers (e.g., transportation, daycare, outdated contact info)
- Vaccinate at any visit (well child or acute/standing order)
- Walk-in/extended hours

n=37; open-ended responses grouped by GLITEC (i.e. not a multiple choice question)
Theme: Socio-economic issues affect childhood immunization rates.

- Develop locally-relevant strategies to reduce barriers caused by socioeconomic issues, such as developing flexible and user-friendly transportation options to help patients get to the clinic.
- I/T/Us provide walk-in clinic and extended clinic hours, including evenings and weekends, to increase accessibility for parents with inflexible week day schedules.
- Implement standing orders at all I/T/Us so patients can receive vaccinations at any type of visit.
- I/T/Us develop and expand upon existing collaborations with partners to deliver vaccines at partner sites such as pharmacies and WIC.

Recommendation directed towards: ★ I/T/Us  ♦ State immunization programs  CDC  IHS  Community partners (including GLITEC)
Theme:
Clean and accurate data are not consistently available across Bemidji Area/Lack of reciprocity with neighboring states’ IISes impedes completeness of accurate immunization records.
Theme: Clean and accurate data are not consistently available across Bemidji Area/Lack of reciprocity with neighboring states’ IISes impedes completeness of accurate immunization records.

• “Some of the clinics within the state don’t report to MIIC, so in the past, some of our kiddos have received double shots for that kind of issue.”

• “Data reporting, getting the training on how to clean up our data in terms of how do we get people who may be haven’t been here in two years-how to get them off our list of people we service who don’t come here as often.”

• “Actually, if all states were connected. Because we get a lot of kids from other states and to get their immunization records is almost impossible, because you have to locate their clinic. Sharing information between states- ease of that will be better to improve reporting."
In your opinion, what can be done to improve childhood immunization data reporting?

n=37; open-ended responses grouped by GLITEC (i.e. not a multiple choice question)
American Indian/Alaska Native identification in Bemidji Area IISes*

• **Michigan:**
  • “Good” race field completeness;
  • Linked to birth certificate (for Michigan births);
  • Infant race based on race of mother;
  • Race may NOT be added/corrected;
  • IIS linkage with other files possible.

• **Minnesota:**
  • “Good” race field completeness;
  • Linked to birth certificate (for Minnesota births);
  • Infant race based on race of mother;
  • Race may be added/corrected (providers cannot see/query race through user interface);
  • IIS linkage with other files possible.

• **Wisconsin:**
  • “Good” race field completeness;
  • 75.3% had completed (non-“unknown”) race field;
  • Infant race based on provider and/or local health department entry into IIS;
  • Race may be added/corrected;
  • IIS linkage with other files possible.

*As of summer 2017*
Theme: Clean and accurate data are not consistently available across Bemidji Area. Lack of reciprocity with neighboring states’ IISes impedes completeness of accurate immunization records.

- All clinics (I/T/U and non-I/T/U) use IIS.

- Improve completeness and accuracy of race data by linking IIS to birth certificate, allowing people who move into a state to self-identify race in IIS, and/or linking IIS with IHS patient registry data.

- State Immunization Programs complete inter-state Memoranda of Agreement or other agreements to permit data sharing between IISes so clinic staff have improved access to complete patient vaccine records.

Recommendation directed towards: ★ I/T/U ★ State immunization programs ★ CDC ▽ IHS + Community partners (including GLITEC)
Theme:
Generally, immunization coordinators use IIS more than NIRS.
Theme: Generally, immunization coordinators use IIS more than NIRS.

• “Not familiar with NIRS system, but more familiar with the MIIC system.”

• "I've never even heard of it, actually. We are a tribal health facility independent of the Indian Health Service."
Frequency of data submission to NIRS and IIS

- Yes, always: NIRS n=37, IIS n=37
- Yes, sometimes: NIRS n=37, IIS n=37
- No: NIRS n=37, IIS n=37
- I don’t know: NIRS n=37, IIS n=37
Among NIRS/IIS users: How are NIRS/IIS data used at your facility?

- Data are not used
- I don't know
- At least one example of use given by immunization coordinator

NIRS n=22, IIS n=35
Theme: Generally, immunization coordinators use IIS more than NIRS.

- Provide education on the use of NIRS reports.
- Support the use of IIS among current users.
- Support non-IIS users with resources and technical assistance for implementing IIS at the clinic.
Limitations and Challenges
Limitations and challenges

- Participants’ self-report did not always align with data retrieved from other sources.
- Some immunization coordinators were new, and had little experience with the systems.
- In some facilities, immunization functions were split between staff, making it difficult for the participant to answer all the questions.
- The interview instrument was modified part way through the interviews to incorporate a question about standing orders.
- Inaccuracies exist with transcribing participants’ responses.
- Due to staff turnover, some immunization coordinators did not receive the letter and were taken off guard by interview request.
- One I/T/U declined to participate because they already had an internal immunization QI project.
Recommendation implementation

• Recommendations may provide support for I/T/Us and state, federal, and community partners to take action.

• Building Public Health Infrastructure in Tribal Communities to Accelerate Disease Prevention and Health Promotion in Indian Country (TECPHI):
  • Five-year grant from CDC;
  • Findings from this needs assessment written into grant:
    • Year 1: GLITEC host training for Bemidji Area immunization coordinators;
    • Years 1-5: GLITEC continue examination of childhood immunization data from NIRS and IISes;
    • Years 2-5: Quality improvement initiatives, determined with input from I/T/Us.
Thank you!

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