



Provider Recruitment and Retention Following Novel 2009 H1N1 Influenza: Results from a Registry User Consortium¹

The 2009 H1N1 response effort provided a unique opportunity for states to recruit, train and possibly retain new providers in the IIS. With new providers comes increased use of the registry resulting in increased data input and ultimately more complete centralized records. Further, it provides opportunity for a new mix of providers and a pool of already trained users for future response efforts. State Immunization Programs, having enrolled hundreds of H1N1 vaccine providers new to their state registry systems, are now seeking to sustain their participation beyond the H1N1 response, thereby multiplying their vaccination efforts and the scope of their registries.

Provider Enrolment During H1N1

Six STC IIS COTS client states shared comparisons of their provider participation metrics from before and after their initial H1N1 Influenza response (*Table 1, Experience With Provider Enrolment During H1N1 – Selected States*). Some states reported doubling their participating provider sites – one state observed an eight-fold increase in participating providers within a three-month period. A significant proportion of newly-participating providers were “non-traditional” providers: pharmacies, OB/GYN and other specialty practices. In several states, pharmacies represented one of the largest categories of new providers. Some states enrolled all providers meeting their criteria and determined separately which providers would receive vaccine shipments. Many of the new providers were practices serving adult populations – some states do not currently have legislative authority to collect adult immunizations in their registries.

Table 1. Experience with Provider Enrolment During H1N1 -- Selected States (through 3/5/10)

| | State A | State B | State C | State D | State E | State F |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------|
| Number of Providers in the Registry before H1N1 | 42 | 1109 | 321 | 1,094 ^{***} | 498 | 2,455 |
| Number of Providers added to the Registry specifically for H1N1 doses administered reporting | 298 | 30 [*] | 436 | Two statewide pharmacy chains; 0 to few additional Providers ^{****} | 391 | 682 |
| Type of Providers joining specifically for H1N1 efforts | OB/GYN: 18 FP/Internal Med: 78 Pediatrics: 11 Hospitals: 23 Pharmacy: 16 State PH: 21 Tribal health: 22 Schools: 6 Other: 103 | Unknown distribution (Includes FP/Internal Med.; Specialty care Providers; clinics; Urgent Care) | OB/GYN: 27 (6%) Fam Pract: 114 (26%) Pharmacy: 100 (23%) Hospitals: 41 (9%) Other ^{**} : 154 (35%) | Pharmacy Chains (2) | Indeterminate mix of OB/GYN, Hospitals, and Pharmacies ^{*****} | OB/GYN 17 Fam. Pract. 538 Hospitals 2 Pharmacies 125 |
| Number of new Providers likely to continue utilizing | ~150 (50%) | ~20 | None | Pharmacies | Estimates 5% to 10% will remain | Estimates 5% |



| | State A | State B | State C | State D | State E | State F |
|-------------------------------------------------------------|---------------------------------------------------------|---------|---------|---------|---------------------------------------------------------|----------------------------|
| the Registry | | | | | participants | |
| Type of Providers likely to continue utilizing the Registry | Unknown – expect representation from all Provider types | Unknown | N/A | N/A | Unknown – expect representation from all Provider types | Unknown – Family Practices |

* Undercounts pharmacies due to confounding caused by coincident legislation adding pharmacies to list of eligible vaccine provider. Also, Registry participation was not a requirement of H1N1 Providers.

** Includes: pediatrics, public health, urgent care, nursing homes, etc.

*** Excludes two statewide pharmacy chains added specifically for H1N1.

**** Some Local Health Jurisdictions entered data on behalf of a few non-participating Providers.

Challenges of Working With New and “Non-Traditional” Providers

Dealing with new H1N1-specific providers while also managing the distribution and tracking of millions of vaccine doses posed unique challenges for state Immunization Programs. Among those most commonly observed were the following:

- *Problems with mandating or enforcing provider reporting to the registry.* - About half of states sharing information about their H1N1 experience were able to require that providers report H1N1 doses-administered to the state’s registry. However, the remaining states did not have an enforcement mechanism and subsequently felt that this negatively impacted reporting to their registry.
- *Managing the influx of new providers placed new staffing burdens for Immunization Programs.* - The volume of new providers typically required a large effort to validate their status before enrolling them. Most states registered providers before determining who and how many would receive vaccine shipments. In some instances this may have created unfulfilled expectations among some new providers, with little time and resources available for Immunization Programs to address such concerns.
- *“Non-Traditional” providers are unique.* - Many new providers served exclusively adult clientele which, in some states, were not required to be reported to the registry. Hospitals providing H1N1 vaccinations do not typically “own” a patient or serve as their medical “home.” Pharmacies represented one of the largest categories of “new” providers, and states reported that many have expressed interest in continuing as “routine” vaccine providers (although legislation would be required in some states).
- *Training of new providers was often incomplete.* - Enrolled providers did not always participate in registry training, leading several states to anticipate some future data quality issues.

Strategies to Sustain H1N1 Provider Participation in the Registry

The dramatic increase in providers participating in the registry for H1N1 in many states presents a unique opportunity to Immunization Programs if they can find ways for them to continue as “routine” vaccine providers. Among the several strategies shared by several states were the following:



- *Identify high-volume new providers* – Immunization Programs should consider evaluating the observed or expected yield in terms of submissions to the registry) from these providers.
- *Identify high-error rate providers* – Based on an analysis of data submitted for H1N1 vaccinations it should be possible to identify new providers in need of counseling or other interventions to improve data quality.
- *Deliver supplementary training and continuing education* – H1N1 vaccination reporting differs from routine vaccination reporting in enough ways that Immunization Programs should consider supplementary training for new providers who will remain registry participants.
- *Create appropriate incentives* – Inducements such as identifying cost savings associated with registry participation (such as labor savings when generating school immunization records, reminder-recall, and patient reports) may be an effective strategy.
- *Strengthen the content of Provider Agreements* –These agreements, as well as associated training materials and user guides, should be reevaluated when transitioning new H1N1 vaccine providers to routine immunization reporters.
- *Establish more electronic interfaces* – With H1N1 response efforts beginning to wind down, creating registry interfaces with new providers may be a sound investment, particularly for ongoing routine immunization reporting. Current federal incentives for establishing such connections may serve as an added inducement.

Conclusion

States are just beginning to consider their goals and strategies for sustaining the participation of H1N1 vaccine providers in their registry. Options that may not have been feasible during the initial response to H1N1 Influenza – such as creating interfaces with provider’s Electronic Medical Records systems – may now be possible. A careful analysis of how these new providers can allow the Immunization Program to reach more vulnerable populations will likely yield significant long-term benefits.

¹ Submitted to AIRA, www.immregistries.org , March 2010 by Danielle Reader-Jolley and Erich Daub, Scientific Technologies Corporation