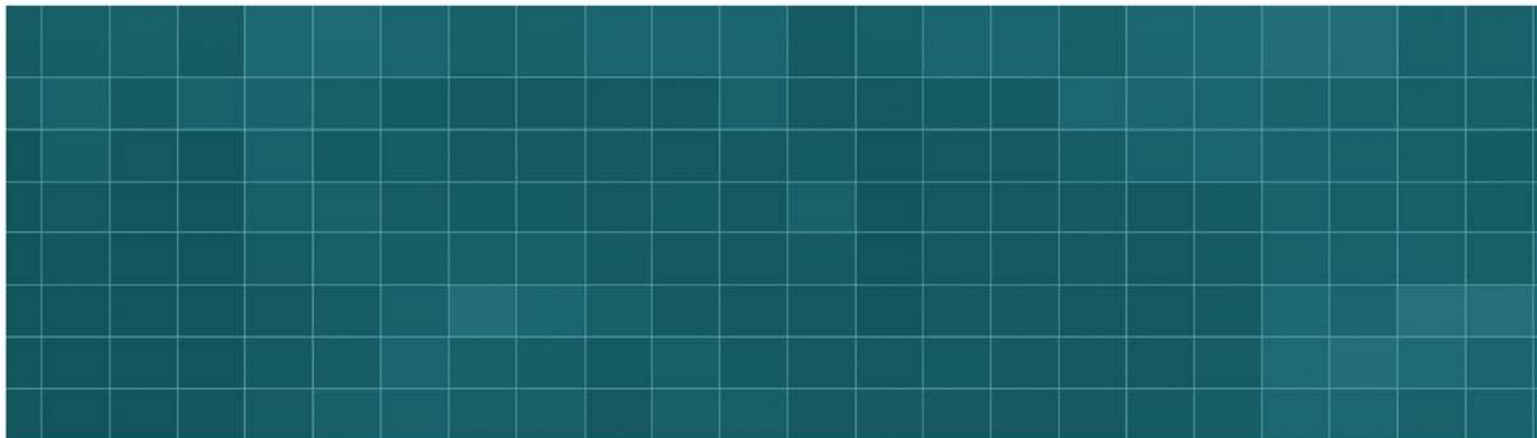


National Vaccine Plan Implementation

Summary of Stakeholder Meetings



EXECUTIVE SUMMARY

Before the development and widespread use of safe and effective vaccines, infectious diseases caused serious illness in millions of children and adults across this country. Today, children, adolescents, and adults can receive immunizations to protect against 17 infectious diseases once common in the United States.

The 2010 National Vaccine Plan provides a strategic approach to prevent infectious diseases through vaccination efforts and focuses on methods to advance vaccine research and development, financing, supply, distribution, safety, global cooperation, and informed decision-making among consumers and health care providers. Implementation of the National Vaccine Plan will require the efforts of all stakeholders involved in the vaccine enterprise.

Public health partners and consumers gathered to provide feedback and techniques to achieve the strategies identified in the National Vaccine Plan. Participants specifically addressed implementation barriers including communication, vaccine safety, measurement, and funding challenges.

Recurring Stakeholder Engagement Recommendations

- Identify local barriers to achieve high vaccination coverage rates and examine current policies to address these challenges.
- Improve immunization information systems to allow for sharing of vaccine data between states, and perhaps across country borders or between tribal and state systems.
- Communicate vaccine safety data and provide education regarding vaccine-monitoring techniques.
- Build and foster collaborative relationships between state health departments, tribal nations, and border communities within their respective regions. Consider combining efforts and sharing lessons learned.
- Identify communication partners and methods to address the targeted audience using familiar channels to provide credible information in a culturally and linguistically competent manner.
- Collaborate with community organizations in the local and regional area to understand the needs of the targeted population and provide consistent messages between partners.

This document contains a summary of stakeholder discussions intended to inform implementation methods for achieving the National Vaccine Plan. The success of this plan will require all relevant stakeholders, including federal, state, and local agencies, public health, health care providers, and consumers to work together to ensure a coordinated response.



INTRODUCTION

A series of regional stakeholder meetings, hosted by the National Vaccine Program Office (NVPO) in collaboration with the Association of State and Territorial Health Officials (ASTHO), were held to seek guidance from immunization partners on methods to shape implementation of the National Vaccine Plan.

The National Vaccine Plan

The National Vaccine Plan aims to prevent infectious disease and reduce vaccine adverse reactions by providing policy and scientific direction. This 10-year strategic plan aspires to achieve five broad goals:

- Develop new and improved vaccines.
- Enhance the vaccine safety system.
- Support communications to enhance informed vaccine decision-making.
- Ensure a stable supply of, access to, and better use of recommended vaccines in the United States.
- Increase global prevention of death and disease through safe and effective vaccination.

The Implementation Plan

An implementation plan, developed to complement the National Vaccine Plan, addresses priorities, identifies barriers for specific goals and populations, defines strategies for achieving objectives, and designates indicators for measuring success.

A series of stakeholder meetings were held to gain local perspectives and input on implementation of the plan. Meetings focused on topics derived from the National Vaccine Plan priorities, and organizers sought to gain insight from different communities on how to measure progress, implement innovative solutions to barriers, and recognize new opportunities for action.

A summary of the following stakeholder meetings is included in this document. This summary represents a synthesis of comments and opinions shared during the meetings that were generally supported by those in attendance, but no formal consensus process was employed.

Meeting Name	Location	Date
I. Third Party Billing for Vaccines	Washington, DC	July 28, 2011
II. Adult Vaccination, Communication Campaigns, and Health Disparities	Philadelphia, PA	September 13, 2011
III. Health Information Technology and Immunizations	Ann Arbor, MI	September 22, 2011
IV. Tribal Health	Anchorage, AK Lawrence, KS	September 26, 2011 November 3, 2011
V. Border Health—U.S. Department of Health and Human Services Region IX and VI	San Diego, CA Brownsville, TX	October 5, 2011

Learn more about the National Vaccine Plan by visiting http://www.hhs.gov/nvpo/vacc_plan/

I. THIRD PARTY BILLING FOR VACCINES: WASHINGTON, DC – JULY 28, 2011

BACKGROUND

An increasing number of patients with private insurance utilizing health department clinics and the changing financial landscape have prompted the federal government to support state and local health departments in their efforts to bill for services rendered to insured clients. In 2009, the Centers for Disease Control and Prevention (CDC) granted funding to 14 states to develop strategies that would enable them to bill private insurance companies for vaccine. In 2011, the CDC provided supplementary financial support to the states to implement their plans, and funded an additional 14 states to begin to develop reimbursement strategies within public health department clinics. Billing private insurance is new to many public health clinics and has consequently been a challenge for many states.

MEETING OUTCOME

The stakeholder meeting addressed some of the barriers that health departments have encountered. The group identified how national-level policies or practices might simplify the efforts of state and local health departments in setting up billing systems. Some of the challenges included becoming an in-network provider, credentialing requirements, and eligibility determination.

Some of the specific potential solutions discussed during the meeting include:

- Determining the types of insurance coverage for clients who use public health department services and conducting an analysis of the potential costs and savings when implementing a sustainable billing system for vaccines.
- Recommending that public health departments become in-network providers.
- Determining at the national level how best to categorize public health departments for the purpose of contracting.
- Credentialing the health department as an entity rather than each individual within the facility; recognizing that each state has specific requirements for this process.
- Developing a contract for each state health department and then separate billing subcontracts with each of the local health departments.
- Public health and private insurance companies working together to develop a toolkit to guide state and local health departments through the process.
- National-level insurance companies communicating with their regional and local branches about this project while identifying best practices and consistent policies in working with public health.



NEXT STEPS

- Insurance companies should develop a payer fact sheet to help health departments understand the payer's perspective.
- America's Health Insurance Plans (AHIP) agreed to outline the key elements of a "typical" contract for public health departments.
- The meeting participants emphasized the importance and necessity of this project. All agreed to continue to identify issues that can be addressed and simplified at the national level to assist state and local health departments to work effectively with insurance companies.
- The National Association of County and City Health Officials (NACCHO) plans to develop a toolkit to assist state and local health departments with billing practices.
- Participants plan to work together to explore national level tools and strategies to assist state and local health departments with this billing effort.

II. ADULT VACCINATION, COMMUNICATION CAMPAIGNS, AND HEALTH DISPARITIES: PHILADELPHIA, PA – SEPTEMBER 13, 2011

BACKGROUND

A series of panel presentations and discussions offered an opportunity for providers and community partners to learn about and discuss adult vaccination campaigns, vaccine risk communications, and vaccine coverage disparities among minority populations.

MEETING OUTCOME

Session I: Adult and Young Adult Vaccine Campaigns

Adult vaccination is especially difficult due to limited funding, and co-pays or upfront out-of-pocket costs remain barriers to improved vaccination coverage for this cohort. Speakers stressed the importance of receiving vaccines in a consistent and convenient medical care setting.

Session II: Risk Communication and Vaccine

Risk communication surrounding the 2009 H1N1 influenza pandemic was well coordinated; however, challenges remained due to concurrent vaccination campaigns (seasonal and 2009 H1N1 influenza), delays in 2009 H1N1 influenza vaccine production, and the public's perception of swift vaccine approval without adequate testing.

Speakers discussed the importance of using familiar channels to provide credible information in an appropriate, consistent, and culturally competent manner, and to educate providers on how to frame discussions. To be more effective, providers could discuss vaccination risk from the perspective of a parent or caretaker's interests and responsibilities. Presenters believed the public perception of vaccine safety would be enhanced by communicating Vaccine Adverse Event Reporting System (VAERS) results and informing the public of the attention to detail to ensure vaccine safety.

Best Practice Example

Tracking immunization coverage rates in a college setting can be difficult. The University of Pennsylvania had success when they instituted a rule that students cannot sign up for their next semester's courses or receive transcripts until they are up-to-date with their required immunizations; however, challenges still exist due to limited mandates for part-time students, faculty, summer students, and off-campus students.

Best Practice Example

Traditionally, healthcare worker influenza vaccination rates have been below national goals. A successful healthcare worker vaccination program at the Children's Hospital of Philadelphia (CHOP) integrated mandatory participation over a period of years. As of May 2009, CHOP had a 99.6 percent influenza immunization compliance rate, up from 57 percent during the 2004-2005 influenza season before mandatory vaccination was enacted.

Session III: Racial and Ethnic Disparities in Vaccine Coverage

Presenters discussed working with partners to address low vaccination rates among minority populations and stressed the importance of understanding important influencers within different racial and ethnic groups. Stakeholders also expressed the importance of strengthening systems within minority healthcare practices such as standing orders, electronic health record systems, and consistent vaccine distribution methods.

NEXT STEPS

- Identify local barriers to achieve high vaccination coverage rates and examine current policies to address these obstacles.
- Educate providers and the public about VAERS.
- Identify communication partners and methods to address the targeted audience.
- Collaborate with community organizations in the local and regional area that understand the needs of targeted populations and how to reach them.

Best Practice Example

During the 2009 H1N1 influenza pandemic, the West Virginia Department of Health and Human Resources (DHHR) used focus groups with parents of school-aged children to shape their messaging campaign. Parents indicated the messenger was very important and that they trusted public health professionals. They also pointed out that messages should be fact-based and not intimidating or threatening. The resulting messaging campaign used Dr. Catherine Slemp, the acting state health officer, as the face on materials. The West Virginia DHHR also collaborated with the West Virginia Department of Education to create “get the facts” video clips. Dr. Slemp encouraged vaccination against 2009 H1N1 and seasonal influenza as both a healthcare professional and a mother. As a result, West Virginia achieved comparable vaccination coverage for seasonal influenza and higher coverage for 2009 H1N1 influenza compared to national coverage rates.



Best Practice Example

During the 2009 H1N1 influenza outbreak, the Minority Outreach and Technical Assistance program in Maryland provided linguistically and culturally appropriate educational materials to the public. Lessons learned were to plan programs well, have incentives, and build capacity before an outbreak.

III. HEALTH INFORMATION TECHNOLOGY AND IMMUNIZATIONS: ANN ARBOR, MI – SEPTEMBER 22, 2011

BACKGROUND

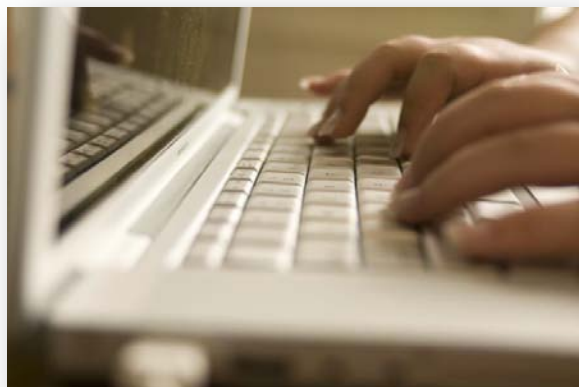
In 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH) was passed to improve healthcare delivery through support of meaningful use of electronic health records (EHR). An incentive program was established to provide funding for eligible professionals, hospitals, and critical access hospitals when they adopted certified EHR technology and successfully demonstrated meaningful use of EHRs to improve quality, safety, and patient-centered care. One opportunity to achieve meaningful use is to attain interoperability between EHRs and immunization information systems (IIS).

MEETING OUTCOME

This meeting provided a forum for grantees to share challenges and lessons learned when working toward interoperability between EHR and IIS. Representatives from the Utah, New York City, Minnesota, Michigan, Arizona, Colorado, Wyoming, and Rhode Island health departments presented and participated in panel discussions.

Challenges in Achieving EHR and IIS Interoperability

- Programmatic challenges include fiscal delays, varying expectations, competing agency priorities, reduced funding, hiring freezes, and interface failures when upgrades are introduced.
- Each product requires a separate development effort, and the contract process with vendors can be time consuming.
- Vendors have different timelines than users and their level of knowledge varies.
- There is limited interest in bi-directional communication among vendors, a large number of vendors to collaborate with, and technical support is not always prompt.
- Federal transport requirements need to be better aligned with IIS needs.
- Providers can still send bad data utilizing Health Level 7 (HL7) mechanisms and therefore data quality testing will need to continue.
- Some provider offices are not interested in developing an IIS interface. Providers intend to meet Stage 1 requirements, but some are hesitant to implement additional requisites.
- Working with a central IT office to provide clarification on testing and differences between meaningful use and lab reporting can take time and effort.
- The Family Educational Rights and Privacy Act (FERPA) prevents schools from providing immunization information to EHRs, however, in many states staff are able to query the IIS system to find student immunization histories.
- In some states, adult data collection is not legislatively authorized and this creates gaps in immunization information among this population.



Lessons Learned When Working Toward Attaining EHR and IIS Interoperability

- Implementation guidelines, work plans, and action items should be set up early to motivate both EHR vendors and providers.
- Interface development takes time, and although data may test accurately, this does not always translate into a successful pilot.
- During initial meetings with vendors, states should reach a common understanding of expectations, develop a manual template, inquire about procedures for handling errors, and ask for a demonstration of the user interface. States should also reach out to vendors proactively and regularly, remain realistic about the workload, and monitor upgrades closely.
- It is helpful to work closely with the implementation site from the start, offer various support mechanisms, have a champion on site, and provide progress reports to providers.
- It is beneficial to collaborate with the Regional Extension Centers (REC), to update federal partners about the complexity of state processes, and push providers to follow steps for successful implementation.

NEXT STEPS

- Consider combining efforts and sharing lessons learned when working with vendors.
- Determine methods to address barriers including competing visions, lack of funding, timing pressures, and difficulty communicating to providers the capacity of meaningful use.
- Look to the Centers for Medicare and Medicaid Services (CMS) for assistance, and work with RECs, health information exchanges, medical or information technology societies (e.g., Healthcare Information and Management Systems Society or the state or local American Academy of Pediatrics chapter), primary care providers, and hospital associations to assist with efforts.

IV. TRIBAL HEALTH:

ANCHORAGE, AK – SEPTEMBER 26, 2011

LAWRENCE, KS – NOVEMBER 3, 2011

BACKGROUND

The Indian Health Service (IHS) provides medical and public health services to members from one of more than 500 federally recognized tribes and Alaska Natives; this includes care to 1.9 million¹ of the approximately 3.7 million² people who self-identify as American Indian or Alaska Native (AI/AN) in the United States. While all federally recognized AI/AN people are entitled to healthcare through IHS or tribal-contract facilities, there needs to be a broader approach to healthcare for this population. This is especially true given that approximately 57 percent³ of AI/AN people live in urban areas, and with IHS facilities traditionally located in rural communities, this leaves a large AI/AN population utilizing other services.

MEETING OUTCOME

Stakeholders convened at the 2011 National Indian Health Board (NIHB) Annual Consumer Conference in Anchorage, AK, and at Haskell Indian Nations University in Lawrence, KS to gather feedback on improving vaccine communications, safety, financing, and measurement issues specifically within tribal populations.

Participants suggested:

Communication

- Streamlining communications to ensure consistent messages among state, local, and tribal entities, and using success stories as a way to advocate for vaccination.
- Providing culturally and linguistically appropriate communication that is specific to the audience and candid about the benefits and risks of vaccination.
- Building relationships and infrastructure to connect smaller tribes that have traditionally experienced challenges gaining access to health services.
- Addressing misinformation and using sympathy as a tool to get the message across. It is essential to use trusted sources of health information (e.g., tribal leaders, physicians) and understand tribal values (e.g., elders and children come first).
- Using community settings to deliver the message (e.g., daycare centers, senior centers, and empowering youth to be messengers) and advocating for better communication technology systems (e.g., radio, newsletters, mass mailings) to improve communication methods.

Vaccine Safety

- Communicating the mechanisms in place to ensure vaccine safety and providing a better explanation of the VAERS program. In addition, uniform guidelines for reporting VAERS incidents, if adopted, would create data consistency and criteria for collecting information on vaccine adverse events.
- Supplying vaccine reaction data to the public and including AI/ANs in post-licensure studies.

- Providing consumers with supplementary information rather than solely Vaccine Information Statements (VIS) and acknowledging that while vaccines are not 100 percent safe, the benefits of immunization far outweigh the risks.
- Offering an immunization certification curriculum to help shape consistent messaging, and educating healthcare providers on immunization techniques and schedules with an emphasis on safety and proper storage of vaccines.
- Using the diabetes education model and translating evidence-based strategies to vaccine safety.

Finance

- Proposing a national adult immunization program modeled after the Vaccines for Children (VFC) program.
- Communicating to the AI/AN population the services covered within their health plan and recognizing the health plan procedures (e.g., method for completing forms or time to process a claim).
- Forming a “Tribal United Healthcare Insurance” plan for all tribes and nations in the United States or regional united tribal healthcare insurance coalitions. These coalitions would work with the large insurance companies in the region to negotiate contracts and coverage.
- Utilizing strategies such as private/public partnerships or voucher programs.
- Understanding that while many tribal nations recognize the importance of making healthcare more affordable, they are sovereign and therefore have independent authority regarding healthcare reform decisions.

Measurement

- Improving interoperability of EHRs to enhance communication between states and systems (e.g., state IIS talking with IHS's Resource and Patient Management System [RPMS]).
- Enhancing systems to identify AI/ANs as part of a native or tribal community. Many AI/ANs live in urban areas and, with increased movement, it may be difficult to measure successes and identify needs among AI/AN people.
- Recording children who opt-out of school immunization requirements and strengthening disease-reporting systems.
- Addressing barriers such as incomplete state reporting of racial/ethnic data, lack of private providers utilizing IIS, and limited training on complex multiple IIS data systems.
- Exploring the potential to bar code vaccine vials to help with registry data collection input and including race and ethnicity information in registry data.
- Unifying the fragmented network of care for the AI/AN population and fostering relationships between tribal groups and health departments.

During the recent H1N1 influenza outbreak, AI/ANs experienced four times⁴ higher death rates when compared to the general United States population, demonstrating persistent disparities among this community.

NEXT STEPS

- Work with IHS and organizations such as the NIHB and Alaska Native Tribal Health Consortium to identify opportunities for partnership and innovation.
- Share success stories from IHS and tribal health systems to improve financing, measurement, communication, and vaccine safety. Work with local and regional tribes, and IHS to identify ways to incorporate these lessons learned into new settings.
- Collaborate with IHS, CDC, and federal agencies to identify methods to improve inclusion of AI/AN people in data collection.
- Engage with healthcare providers of AI/AN people to identify opportunities to improve immunizations.
- Build and foster collaborative relationships between state health departments and tribal nations within their respective regions.
- Improve linkage between tribal and state IIS.

V. BORDER HEALTH – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES REGION IX and VI: SAN DIEGO, CA and BROWNSVILLE, TX – OCTOBER 5, 2011

BACKGROUND

In coordination with Border Bi-national Health Week, stakeholders gathered to discuss implementing immunization priorities within United States-Mexico border communities. A success story within border communities has been the relatively high immunization rates, especially among Hispanic children; however, limited access to healthcare and negative healthcare provider or parental attitudes toward immunizations are potential barriers to receiving vaccine. In addition, socioeconomic barriers, information gaps, and a delay in starting a vaccination series can contribute to lower completion rates. Adolescents face unique barriers, such as lack of parental consent and low healthcare utilization rates.

Potential interventions to increase immunization coverage include recall-reminder notification, lower out-of-pocket immunization costs, and feedback to healthcare providers on the status of their patient's immunization completion rates.

Enhanced communication and coordination among border communities has led to increased surveillance and attention to health outcomes.

MEETING OUTCOME

Stakeholders convened to determine strategies to increase awareness of vaccines among border communities, eliminate financial barriers, and improve global surveillance systems for vaccine-preventable disease.

Participants suggested:

Communication

- Creating a culturally inclusive bi-national communications plan utilizing evidence-based models with multiple evaluation components. A federal communications plan or toolkit could be of assistance, but state or local health departments ultimately need to evaluate their district to create a relevant community-based program for maximum success.
- Providing culturally appropriate messages developed from the standpoint of pride in protecting the family and utilizing celebrities, teachers, doctors, nurses, and admired local citizens to promote positive messages about vaccines. A variety of mediums, such as social media, public service announcements, billboards, radio, television, newspaper or waiting room advertisements, and promotions during telenovelas could be utilized.

Promotoras, also known as health advocates or peer leaders, could play an important role in the promotion of community-based health education and prevention in a culturally and linguistically appropriate manner, and should be considered important partners to reach out to underserved populations in border communities.

- Tools such as text, phone, and e-mail reminders can be beneficial, but it is important to remember there are limitations to social media and technology.
- Coalitions between medical associations and local health departments could help determine outreach strategies.
- Continuing education for healthcare providers on the importance of vaccine is essential.

Finance

- Creating user-friendly grants and requiring a needs-assessment prior to awarding funds.
- Schools are an ideal place to establish educational outreach; however, funding for school-located clinics can be challenging, and equipment, such as proper refrigeration, is not always available.
- Educating the community about services provided by federal and state programs.

Global Measurement

- Better communication to explain the vaccine schedule differences between Mexico and United States. Tools for healthcare providers on how to read immunization cards from Mexico have been developed and could be shared with a larger audience to help providers better comprehend variations between schedules.
- Strengthening global health information systems to monitor vaccine coverage, effectiveness, and safety. Incentives or penalties connected to reporting could generate motivation.
- Developing a bi-national EHR system. Lack of information sharing and duplication of IIS entries remain barriers to efficient bi-national immunization programs. Participants also pointed out differences in measuring vaccination coverage (Mexico counts total doses of vaccine administered rather than completion rates as done in the United States) could lead to difficulties in comparing immunization rates.

Children who migrate across the border may receive duplicate vaccine doses due to misplaced records, lack of immunization information systems, or complexity of the immunization record.

NEXT STEPS

- Explore grants to state and local health departments to tailor communications efforts to their unique needs.
- Pilot test local communication strategies for border health communities and migrant health issues, and share findings with a wider community.
- Improve immunization information systems capabilities to allow for sharing of vaccine data between states and perhaps across country borders.
- Provide education and create widely available tools to assist United States healthcare providers with understanding the Mexican vaccination schedule.
- Pilot test school-located vaccination clinics to measure effectiveness and determine utility of vaccine administration in this setting.

APPENDIX

Future Deliverables to Address Identified Barriers

As part of other vaccine-related efforts, initiatives to address barriers identified during stakeholder meetings are underway. The information gained from stakeholder meetings further supports and advances the programs already in place. This chart illustrates ongoing activities to address identified barriers. This list is not all-inclusive, and focuses on national-level projects and initiatives that may have outcomes at the state and local level.

Current and Ongoing Activities to Address Issues Raised		
Issue	Lead Organization	Product Developed
Communications	ASTHO	Developed a communications toolkit. http://www.astho.org/Communicating_Effectively_About_Vaccines/
	CDC	Develops, tests, and updates messaging and materials to promote immunization among providers and consumers. http://www.cdc.gov/vaccines
	NVPO	Translated vaccines.gov into Spanish, available at: http://es.vaccines.gov/
Vaccine Safety	NVPO	Coordinates vaccine safety activities across the Department of Health and Human Services (HHS).
	NVPO	Coordinating discussions with interagency HHS partners on developing a vaccine safety scientific agenda.
Adult Vaccines	NVPO, AMA, CDC	Held the first National Adult Immunization Summit in 2012.
	NVAC	Developed a set of national recommendations for improving adult immunization in 2011 that will be published in 2012.
Vaccine Financing	NVPO	Leads a cross-HHS working group on vaccine financing, delivery, and access, including, but not limited to, the Affordable Care Act and public and private insurance programs. Engages with non-government partners to discuss solutions to priority financing issues.
Third Party Billing	CDC	Funding and assisting 28 state grantees to develop and implement billing systems for vaccines.
	NACCHO	Developing a national toolkit to help states develop and implement billing systems for vaccines.
Immunization Information Systems (IIS)	CDC	Provides technical assistance to states to improve their IIS; works with Office of the National Coordinator for Health Information Technology (ONC) and CMS to promote improvements in IIS that will lead to bi-directional data exchange.
Electronic Health Records (EHRs)	ONC, CMS, and CDC	Develops and monitors implementation of national standards for health information technology, including bi-directional data exchange between IIS and EHRs. Funds grant programs such as the RECs, Beacon Communities, and Health Information Exchanges (HIE) to promote development and pilot novel implementation projects.
	ASTHO	Monitors and communicates trends in Health Information

		Technology (HIT) to state public health agencies. Provides policy assistance to state public health agencies in dealing with Meaningful Use and HIT.
School Located Vaccine Clinics (SLV)	ASTHO, NACCHO, and NASN	Worked collaboratively to develop an SLV clinics white paper that summarized the deliberations of a meeting to identify barriers and solutions.
Pharmacies	HHS	Working with the American Pharmacists Association to discuss influenza vaccine programs for disparate and underserved populations.
	ASTHO	Created an advisory group to address barriers to providing vaccines at pharmacies (i.e., communication of data to public health departments and reimbursement by insurance).

This publication was supported by cooperative agreement number U38HM000454 from the Centers for Disease Control and Prevention. Its contents are solely the responsibilities of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention. Please contact Kimberly Martin (kmartin@astho.org) regarding any questions about this report.

Acronyms and Abbreviations

AHIP	America's Health Insurance Plans
AI/AN	American Indian and Alaska Native
AMA	American Medical Association
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
EHR	Electronic Health Record
FERPA	Family Educational Rights and Privacy Act
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HL7	Health Level 7
IIS	Immunization Information Systems
IHS	Indian Health Service
NACCHO	National Association of County and City Health Officials
NASN	National Association of School Nurses
NIHB	National Indian Health Board
NVAC	National Vaccine Advisory Committee
NVPO	National Vaccine Program Office
ONC	Office of the National Coordinator for Health Information Technology
REC	Regional Extension Centers
RPMS	IHS's Resource and Patient Management System
VAERS	Vaccine Adverse Event Reporting System
VFC	Vaccine for Children
VIS	Vaccine Information Statements

References

¹U.S. Department of Health and Human Services, Indian Health Services. Available at <http://www.ihs.gov/index.cfm?module=ihsIntro>. Accessed February 1, 2012.

²U.S. Department of Commerce, U.S. Census Bureau. Available at <http://quickfacts.census.gov/qfd/states/00000.html>. Accessed February 1, 2012.

³U.S. Department of Health and Human Services, Indian Health Services. IHS Fact Sheet: 2011. Available at <http://www.ihs.gov/PublicAffairs/IHSBrochure/Population.asp>. Accessed February 1, 2012.

⁴Centers for Disease Control and Prevention. Deaths Related to 2009 Pandemic Influenza A (H1N1) Among American Indian/Alaska Natives --- 12 States, 2009. December 11, 2009 / 58(48);1341-1344. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5848a1.htm>



Association of State and Territorial Health Officials
2231 Crystal Drive, Suite 450
Arlington, VA 22202
202.371.9090 tel
202.371.9797 fax
www.astho.org