Indiana State Department of Health Boosts Immunization Rates through Partnerships and Legislation

In the last five years, Indiana used key partnerships to pass three bills to improve immunization rates, vaccine access, and data collection.

In 2008, the Indiana State Department of Health (ISDH) noted that the state’s adolescent immunization rate for two doses of varicella vaccine was only 24 percent. During discussions about adding the second varicella dose to the list of vaccinations required for school attendance, ISDH realized the potential for enhancing Indiana’s entire immunization system, from schools and clinics to public health surveillance.

ISDH built partnerships with stakeholders across the state to ensure that they were on board with the bold requirements of the potential legislation. These collaborations allowed Indiana to pass three bills between 2009 and 2013 that influenced school immunization requirements, pharmacist scope of practice, and data entry specifications for the Children and Hoosier Immunization Registry Program (CHIRP). As a result, Indiana has almost completely eliminated vaccine-covered meningococcal disease, increased vaccine access to patients in underserved areas, and improved tracking systems to halt outbreaks.

Steps Taken:

- In 2009, ISDH helped develop legislation that included a list of mandated vaccines for the following school year and required school nurses to report school immunizations to ISDH through CHIRP. ISDH began working with schools to enforce CDC recommendation to exclude unvaccinated children from school during outbreaks of vaccine-preventable diseases. In addition, ISDH was tasked with regularly updating the required immunization list.
- ISDH turned to Indiana’s school nurses and health department nurses for assistance in implementing the new requirements. The nurses were instrumental in the program’s success, as they monitored immunization status and worked together to administer any needed vaccines through school clinics. These clinics were funded with H1N1 preparedness funds and were aided by an ISDH-trained team of contract nurses (a “strike team”). These providers were able to offer all vaccines required for school attendance in addition to the H1N1 vaccine.
- ISDH also worked with the school nurses to enter all new and existing immunization data into CHIRP and organize additional after-school clinics using community volunteers.
- When school requirements inevitably increased vaccine demand, Indiana initially did not have the infrastructure to keep up. Also, most local health departments didn’t have the billing systems to provide vaccines for residents with health insurance. In addition, many private providers had stopped providing immunizations due to the upfront costs of purchasing vaccine

- Meningococcal disease cases were reduced 76% between 2009 and 2012.¹
- As other states saw surges of pertussis in 2011 and 2012, Indiana’s cases remained stable.
- Indiana’s teen Tdap, MCV4, and varicella immunization rates more than doubled between 2009 and 2013.
and the financial risk of vaccine loss during power outages or equipment failure. Several Indiana counties lacked providers who could vaccinate Hoosiers with insurance.

- In response to the above issues, ISDH began working with the Indiana Pharmacist Alliance on a scope of practice bill for pharmacists to administer vaccines. ISDH staff also met with leadership from the Indiana chapters of the American Academy of Pediatrics and the American Academy of Family Physicians to discuss their concerns for a new scope of practice bill.
- Eventually, ISDH was able to find a compromise between the Indiana Pharmacist Alliance and the physician groups. The final 2013 scope of practice bill allowed pharmacists to administer vaccines to patients over the age of 10, on the condition that the pharmacies entered the immunization data into CHIRP.
- Finally, Indiana passed a 2013 bill requiring all providers to enter specified data into CHIRP for all immunizations administered to persons under nineteen years of age.

Results:

- Beginning in 2016, school nurses, pharmacists, and physicians will all enter data into CHIRP, reducing duplicative vaccines and providing ISDH with a comprehensive and accurate picture of state immunization rates.

- Immunization rates for the adolescent vaccines newly- or recently-required for school entry—tetanus, diphtheria, and pertussis (Tdap), meningococcal conjugate vaccine (MCV4), and varicella—more than doubled between 2009 and 2013.

- Between 2009 and 2012, disease case rates have remained stable or decreased despite the recent resurgence of pertussis. This is likely due to increased immunization rates and ISDH and local health department enforcement of school exclusion of unvaccinated children during outbreaks.

- Pharmacies have become incredibly valuable places to advertise vaccines due to their billboards and neighborhood proximity. This option may particularly impact adolescents that need to complete the HPV series of vaccines or seniors with Medicare seeking pneumococcal vaccines. ISDH monitors incoming data to ensure that pharmacies are complying with the requirement to enter data into CHIRP.

- ISDH now has a mandate to revisit and approve vaccines required for school entry. This provides ISDH with the flexibility to adjust future school standards based on CDC guidelines. The agency also worked with local health departments and school organizations to enforce immunization mandates, developed a uniform process for religious and medical exemptions, and built a coalition of statewide vaccine advocates.

Lessons Learned:

- ISDH credits stakeholder partnerships for the successful passage of its three immunization bills. It was necessary to meet with different providers and discuss concerns to pass the bills. However, the opportunity to bring results back to these partners allowed ISDH to build trust and continued participation for program implementation.

- ISDH had to remain mindful of how statewide mandates could affect providers on the ground. Disagreements about certain provisions in the legislation delayed some of the bills by a year and had to be resolved through open discussion and compromise.
Potential collaborators shouldn’t be limited to clinicians. Buy-in from the Indiana Department of Education and individual school districts was essential to this program’s implementation and success.

When drafting legislation, ISDH considered models used by other states to increase vaccination rates, but remained pragmatic about how Indiana’s landscape could differ in application.

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