

# The Biggest Problem in Immunization Registries Today: Recruiting Private Providers

Michael S. Garcia

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## Background

When looking at the evolution of Immunization Registries, it's easy to speak of the major barriers and issues registry implementers have had to overcome

In the early 1990's registry implementers were faced with defining and designing the basic data structure and system. Typically, "seed" money was available however there were many decisions to be made concerning hardware/software, data, and patient confidentiality.

The immunization registry community soon became a formalized and extremely effective vehicle in sharing solutions and experiences in initiating registries. Groups such as AKC provided forums for registry designers, implementers, and contractor to share this information. These issues were overcome in time. There were many lessons learned along the way however, the immunization registry community always shared these lessons and the barriers were quickly overcome and understood.

By the late 1990's and early 2000's many registry projects were well under way. Statewide, city or county based – there were even practice-based tracking programs. Some projects were able to proceed at a quicker pace of implementation and soon realized that though they had collected many data, the quality of the data was suspect. The federal dollars that were

used to kick start most registry projects had dried up significantly and registries were required to become more creative in assuring there would be adequate sustaining funding. And finally, though private providers were "involved" to the extent of enrolling and in some cases double entering data, they had not fully embraced the registry enough to allow for a true "population based" system. It quickly became evident to many of the registry implementers that a more seamless and less time-intensive solution would be required.

Once again, in time these problems were overcome – or at least understood. Solutions addressing duplicate patients were soon developed and refined. There are now tools that are available to, in real-time or off-line, identify and resolve identical duplicates or potential duplicates. Registry funding eventually came from state, some federal, and other less likely sources such as tobacco tax dollars, private sector participation, etc. Though it is still of concern, the sustainment of immunization registries is less of an issue to the probable integration with other Public Health systems in the future, thus leveraging the cost of maintaining these systems. The one issue that has yet to be addressed fully is integrating the registry fully with the private sector community. Across the nation, this remains the number one barrier in having many statewide registries achieve a true population-based immunization registry.

## Understanding the Problem

Though state demographics differ state to state, immunizations given in the private sector can range anywhere from 40% to 80% of states delivered immunizations. Based on these figures, it is clear that to have a true population based registry, the private sector needs to be fully engaged. Due to the privatization of health care, the amount of immunizations given in the private sector is actually rising in many areas nationwide. For this reason it is more critical that this issue is understood and addressed.

When looking at reason why the private sector does not participate fully in a registry – there are many but can be categorized in the following areas:

*Credibility issues* of Public health implementing and maintain a statewide system. Most public health department have not had a successful history in implementing systems in the private sector. To overcome this, the registry must have certain elements that portray a different “attitude”. This could mean having staff on the registry team that have private sector experience, understand the needs and requirements, a process of listening and responding to the private sector’s feedback. Too often the only requirements taken seriously are those within the public health system. For the registry to be taken seriously in the private sector, it must be apparent that their needs and requirements are taken seriously.

*Time intensive solutions.* The private sector is much more process-focused and obviously, financially focused than public health. For a registry to be a viable solution in the private sector, it must be as seamless as possible (though in reality, no registry can be totally seamless – some have more or less impact than others). The primary barrier in achieving this “seamless ness” is the lack of interfacing with a provider’s existing system. Almost all private doctors use some form of billing. A patient’s demographic and immunization information is entered into this system. Since the data is to be used for billing purposes, it doesn’t contain all the information registries would truly like to receive (i.e.: lot number), but it comes very close and is still quite adequate for populating shot records. The problem here is not a technical one – there are existing solutions, both on-line and using

“batch” file transfers. The problem is getting the billing system vendors to implement solutions.

There are two primary reasons why this hasn’t occurred. First, the question of who is going to pay for the vendor’s services quite often come to the forefront quickly. Though there exists a “many to one” relationship for most of the larger vendors (one vendor can service many different providers) there are still considerable cost associated with this. Secondly, the data format of the transfer is of large concern. Establishing standards for data transfer is a high priority from the federal level. The protocol or format of choice been driven by the CDC is HL7 (Health Level 7). Though the benefits of having one data protocol being used nationwide is obvious and HL7 has many advantages as a protocol, the reality is HL7 is not being readily accepted as a standard. Many maintainers of existing systems either do not have HL7 expertise or do not want to write the export in HL7. Those registries that have engaged with vendors who do want to write the export but not in HL7 are forced to use other protocols, much to the ire of the CDC.

*No value* to the private sector. Clearly, any solution presented to a user base needs to show value or it will not be accepted. Regardless if the private sector believes that using the registry is the “right thing to do” or there is a mandatory reporting law, this ideal holds true with implementing a registry in the private sector. A registry designed solely for public health, satisfying only public health requirements, will not be accepted in the private sector. Providing reminder notices seems to be almost a basic capability in most registries, though this is a critical capability, it is not the only one – by far. Providers, to include health plans, are increasingly looking for the registry to provide assessment capabilities such as CASA and HEDIS. The registry can also provide quality assurance in terms of billing and duplicate records. Analysis tools tailored for practices, health plans, or individual providers can also be provided by the registry. These include Pocket’s of Need analysis’ using Geographic Information Systems (GIS). There are a myriad of capabilities that can be designed and implemented for the private sector – all showing value and also showing the commitment and resolve to understand and satisfy their requirements.

## Strategies to Recruit the Private Sector

Before employing a private provider recruiting strategy, a registry implementer should first conduct two analyses.

### Legislation Analysis

Typically there are one or two pieces of legislation that either define the existence of the registry and/or define the particulars. Legislation has much more of an impact on the private sector than the public sector and can wither help or hinder the registry. Some states have put much effort into either creating clear, solid legislation that provides a framework for implementing a registry. These states typically have involved the private sector (or outside entities that understand the private sector needs and requirements) in developing their law. Other states have legislation that actually impedes the progress of the registry and are in the process of modifying the law by rule, policy, or having it changed. Or in the worse case, doing nothing and letting the law impede the registries value and progress. The primary legislation elements, in order of having most impact are:

1. Consent (general versus specific written)
2. Data elements that can be collected
3. Liability relief
4. Mandatory reporting
5. Other Laws

*Consent:* The primary difference between gaining consent to participate in a registry is in how that consent is gathered. Specific written consent typically requires a specific form or statement that allows for the participation in the registry that needs to be signed by the patient's parent or guardian and stored by the provider. General consent typically means that the record can generally be shared with other health information systems. An existing consent form signed by the patient's parents or guardian usually satisfies this. Specific written consent places a large burden on the provider (or the state, depending on who is managing the consent process). Forms need to be created or re-written, training of clerical staff to ensure the "correct message" is conveyed needs to occur, systems need to be implemented that ensure "opted out" records do not get entered into the registry, etc. One of the primary negative effects of requiring specific written consent is no historical data can

be loaded into the registry. This results in very few complete or near complete records in the registry and requires much data entry to enter those records into the database. Thus the value of the registry will not be attained for a much longer period. This fact will not escape the private sector. Of all the legislative elements, requiring specific written consent has the most negative impact on the immunization registry.

*Data Elements:* Restricting what data elements can be collected can also have a serious effect on the registry. Since the data is collected from many different sources, immunization registry data is typically very "bad". Even with the sophisticated deduplication tools that exist today, with very few data elements, it's very difficult to, in an automated fashion, identify and resolve duplicate patient records. Thus, having as many elements at the disposal of the tools will provide the highest probability of identifying duplicates. The quality of the data in the registry is directly related to the value of the system. If providers consistently view duplicate records, the credibility and thus the value, of the system is at risk.

*Liability Relief:* Providing liability relief to the private sector is key in relieving the concern of electronically sending data to registry. In many states, public health typically has not provided or required the private sector to send and store data to their systems. Private doctors are much more apt to engage when they are relieved of any liability that may occur once the record has been sent to the state, county, or city.

*Mandatory Reporting:* It may be surprising that this element is not considered to be the most critical. However, it has been our experience that those state that have mandatory reporting included in the registry legislation can still have problems in receiving private sector data. The bottom line is even with the mandatory law in place; a registry needs to be very careful in how they implement it. Public health should be providing systems that take the private sector different needs and requirements into consideration rather than forcing them to send data. If a private doctor is forced to send data, there are negative side effects to this. The impression that the private sector's needs are not considered, they can report by paper rather than electronically, and worse of all, the impression of the registry being "just another public health system" will start to form. All of this impact the

value of the registry and the impetus of having the private sector fully engage in the registry. Most private doctors will agree that the registry is a “good thing” and will participate regardless if there’s a law mandating reporting or not – providing their needs and requirements are addressed in the system.

**Other Laws:** There are typically other pieces of legislation that can have either a positive or negative impact on the registry. Schools/day care legislation, other data sharing laws that affect public health,

### **Private Sector Analysis**

Depending on a states particular private provider environment, there are different strategies that can be employed to reach the private sector. It must be noted first that a formalized private sector analysis should be completed before determining what strategy or combination of strategies should be employed. The analysis should focus on the following areas:

- Volume of immunizations delivered (VFC and non-VFC)
- Computer infrastructure at the practice (network, hardware, knowledge, etc.)
- Existing information systems (physician management systems, hospital systems, billing systems, etc.)
- Willingness to participate and reasons why not

### **Private Sector Strategies**

*Provider Oriented:* This is the “grass roots” approach. This strategy focuses on the individual private doctor or practice. It’s geared towards proving the value of the registry to the individual and letting them fight the upcoming internal “battles”. Typically, the person you will be dealing with will be an office manager, someone who is extremely familiar with the business processes within the practice. If they are adequately convinced, they can eventually even convince their management that paying for their billing vendor’s services are worth the effort. This strategy requires certain elements:

-Capabilities that show the value to the practice – this makes for much easier sell.

-Using the Private Sector Analysis, group the providers in terms immunization volume. Start with the highest and work you way down the list -Registry staff that can “carry the registry flag” and do it convincingly. This might require outside sources or training, but typically you’ll only get one chance with a practice, you need to have the highest probability of success.

*Managed Care / Health Plan Oriented:* For those states that have Managed Care, focusing on health Plans can be a very successful strategy for gaining private sector support. If a Health Plan uses the registry, they will want their members to use it also, some to the point of writing it in their contract. The strategy is geared towards using registry data and tools to assist the Health Plans in conducting HEDIS assessments. Most registries contain the basic data to perform this, however there are additional capabilities that must be implemented such as a “batch query”, etc. In this strategy, it is even more critical that your registry team includes managed care or health plan expertise. Since this strategy directly impacts the Health Plans bottom line (conducting HEDIS assessments is a financially significant), the probability of success is high if you have the staff that can market/sell it to the plans and your registry has the tools to accommodate it.

*Vendor Oriented:* Of all the strategies, this is probably the least successful. Using the Private Sector Analysis, group providers by the vendor of their billing system. Then group the vendors by volume themselves. Similar to the Provider Oriented strategy, the registry team can then target the “high volume” vendors and attempt to have them write exports. This strategy requires a totally different type of approach – in speaking with the vendors, you wont be selling the value of the registry, but rather the discussion will focus on the business decision of the vendor writing the export for free or determining how much it will cost.

### **Private Sector Marketing**

Whatever strategy is chosen, marketing to the private sector is critical. A formalized marketing plan complete with literature, presentations, speaking engagements, partnerships, etc needs to be implemented as early as possible. Implementing the registry in the private sector will take much longer than in the public sector – marketing campaigns need to start early as possible. There needs to be an element on the

registry team that can consistently present the “the registry message” to the private sector in terms that they can relate too and see value in. Public Health typically doesn’t have the skills so they must be gained either from the outside or training. Every user base or stakeholder in the registry seems to have some formalized group or association. There are many registry marketing opportunities within these groups or associations: doctor associations, pediatric association, family practice associations, state and local coalitions, the list is truly very long. Many of these may also allow newsletter submittals. The marketing plan that defines a registry’s campaign needs to be tailored specifically for the state (or county, city) since each has different demographics, level of managed care, culture, etc.

### **Summary of Private Sector Involvement**

Population based immunization registries require all to participate if success is to be achieved. Public health systems that support only public health and do not include the private sector when this is a user requirement will become antiquated. The barriers faced are not typically technological but legislative, financial, and “mind set” oriented. There are solutions for every barrier to involve the private sector, but the initial move must be to change the public health mentality – place the private sectors needs and requirements on an equal level with those of public health and address them.

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### **Scientific Technologies Corporation**

4400 E. Broadway, Suite 705

Tucson, Arizona 85711

[www.stchome.com](http://www.stchome.com)