Updates and Alerts

- **Shortage of Pentacel and DAPTACEL Vaccines**
  Immunization manufacturer sanofi pasteur recently announced ordering restrictions on Pentacel and DAPTACEL. The shortage is expected to last through September 2012. For more information, visit the AAP Immunization Supply Page.

- **Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) issues provisional recommendation for those aged 65 and older to receive Tdap vaccine.**
  At their February meeting, the ACIP voted to recommend Tdap for adults aged 65 years and older. The provisional recommendations state that although only Boostrix is licensed for adults over 64, providers should not miss an opportunity to vaccinate. Adacel can be used if that is all that is available. Proper vaccination of all adults with Tdap vaccine helps to protect infants through “cocooning.” To view these recommendations, which include an update on the recommendations for all adults, visit: [http://www.cdc.gov/vaccines/recs/provisional/Tdap-feb2012.htm](http://www.cdc.gov/vaccines/recs/provisional/Tdap-feb2012.htm).

- **Outbreaks**
  **Pertussis Outbreak Continues**
  The Washington State Department of Health reported the number of pertussis (whooping cough) cases in 2012 is up to 640 in 23 counties as of March 31. Last year at this time, the number of cases was only 94. An outbreak continues in McHenry County, Illinois, as well. There, 300 cases have been reported across the county since August 2011. Remind patients to be immunized against this disease!

  **Measles Outbreak**
  According to the CDC, the number of measles cases in the U.S. in 2011 more than tripled from the approximately 60 cases per year between 2001 and 2010, to 222 cases in 31 states. Of these cases, 200 involved patients who caught the virus overseas or from someone who traveled abroad. The surge of measles cases was largely attributed to people who didn't receive the MMR vaccine, mostly children and teens who were exempted from vaccination requirements in school. For more information see the CDC’s [Morbidity and Mortality Weekly Report](http://www.cdc.gov/mmwr/).
Upcoming Events

➢ 10th National Conference on Immunization and Health Coalitions
  May 23-25, 2012
  JW Marriott Hotel New Orleans, New Orleans, LA
  To view the agenda for this meeting, visit:
  To register, visit:

➢ ACIP Meeting
  June 20-21, 2012
  CDC, Tom Harking Global Communication Center Building 19, Room 232, Atlanta, GA
  The role of the ACIP is to provide advice that will lead to a reduction in the incidence of vaccine-preventable diseases in the US, and an increase in the safe use of vaccines and related biological products. For more information or to register visit:
  http://www2a.cdc.gov/nip/ACIP/JuneRegistration.asp.

Recent Events

➢ AAP Cocooning Experts Meeting
  On March 23, 2012, the AAP gathered experts (including physicians, nurses, government officials, and other public health professionals) to discuss the community strategies for vaccinating adults against pertussis in order to “cocoon” infants. A final report will be available in mid-May.

Resources

➢ Immunization Action Coalition (IAC) sturdy, laminated 2012 Immunization Schedules
  These schedules, printed in color, are covered in a tough, washable covering making them durable for the entire year. The price ranges from $3.50 to $7.50, depending on how many are ordered. To order this resource for your office, visit:

➢ Tdap/Td and IPV Vaccine Information Statement (VIS) forms available in new translations
  The IAC has translated the Tdap/Td and IPV VIS into Armenian, Cambodian, Farsi (spoken in Bahrain, Iran, United Arab Emirates), Hmong, Korean, and Tagalog. To access these translations, along with several others, visit:
  • Tdap: http://www.immunize.org/vis/vis_td-tdap.asp
  • IPV: http://www.immunize.org/vis/vis_polio_ipv.asp

Call for Abstracts

➢ American Immunization Registry Association (AIRA) Call for Abstracts
  AIRA invites you to submit an abstract for an oral presentation at its 2012 IIS Meeting scheduled for September 19-20, 2012, in St. Paul, MN. The deadline to submit abstracts is Tuesday, May 15, by 11:59 p.m. EDT. Applicants will be notified of the status of their abstract's acceptance by June 14.

Please view the attachment at the end of this newsletter for the abstract submission guidelines. To submit your abstract, please use the following link:
In 2008, a slightly increased risk of febrile seizure was found in children (aged 12-23 months) who had received the MMRV (Measles, Mumps, Rubella, and Varicella) vaccine, compared to those children in the same age group who received the MMR (Measles, Mumps, Rubella) and Varicella vaccines separately. Until now, this effect had not been studied in children receiving a dose of MMRV, MMR or Varicella, or MMR + Varicella at the ages of 4-6.

Researchers chose a cohort study and included children aged 48-83 months of age who received a dose of MMRV (86,750 children), a dose of MMR on the same day as a dose of Varicella injected separately (68,438 children), and children who received MMR alone (479,311 children) or Varicella alone (80,985 children). Authors defined a post-vaccine seizure as one that occurred for the first time within 42 days of vaccination, and a post-vaccine fever as one that occurred within the same time period. However, because the risk was found to be increased for a febrile seizure in children aged 12-23 months at 7-10 days past vaccination in previously published studies, the primary analysis was done using this time period.

Results showed that more fevers and seizures did occur in children who had received the MMRV vaccine, compared with children who had received MMR + Varicella, or MMR or Varicella separately, though this finding was not statistically significant. The study did not find any peak in seizure or fever activity in any of the study groups in the 7-10 post-vaccination period. The study also found that while there was a greater incidence of seizure in children who had received MMR + Varicella compared to those who had received MMR alone, this was also not statistically significant. Of the 4 febrile seizures observed in the 7 to 10 days in the post-vaccination period for children receiving MMRV, only one febrile seizure could be confirmed, resulting in authors claiming the rate of febrile seizure after MMRV to be 1 in 86,750 doses. Overall researchers found no increased risk of febrile seizures in any of the study groups within 6 weeks of vaccination.
The AAP is expanding its international child health work in support of global immunization priorities. Over 1 million infants and young children die every year from vaccine-preventable diseases. Vaccines are one of the most successful and cost-effective life-saving interventions. Unfortunately, one in five children globally does not have access to vaccines. Most of these children live in the poorest countries where multiple factors contribute to low coverage rates – including fragile or non-existent health services infrastructure, difficult geographical terrain, or armed conflict.

With support from two new grants from the Bill and Melinda Gates Foundation and the United Nations Foundation, the Academy is addressing important global immunization issues. The AAP’s role will center on fostering partnerships to support global immunization initiatives and programs. Specifically the AAP will provide pediatricians and other child health clinicians with tools and materials to be advocates locally for global immunization issues. The grants focus on increasing support of polio and measles/rubella eradication and funding for the Global Alliance for Vaccines and Immunization (GAVI) to increase access to new life-saving vaccines. Through the new grants, the AAP will also continue to work closely with the International Pediatric Association (IPA) on important global immunization issues.

GAVI was launched in 2000, with an initial grant of $750 million from the Bill and Melinda Gates Foundation to fund vaccines for children in the world’s 70 poorest countries when global immunization rates were desperately low. Their mission is to save children’s lives and to protect people’s health by increasing access to immunizations. GAVI was designed to bring together all the key players in vaccines including the World Health Organization (WHO), United Nations Children’s Fund (UNICEF), the World Bank, the Bill & Melinda Gates Foundation, donor governments, developing countries, international development and finance organizations and the pharmaceutical industry. As one of six founding country government donors, the US government has played a big role in GAVI’s commitments, but not to the level of other donor countries such as the United Kingdom and Norway. Only about 1% of the U.S. budget is allocated for foreign aid, and a tiny fraction of that goes for health initiatives to improve or save lives of children and families – we feel this should be at a higher level and one aim of the new grant is to support advocacy to increase funding to GAVI.

Additionally, through the grants, the AAP will focus on supporting and developing its leadership as global immunization champions in implementation of advocacy and education strategies; supporting and building capacity among pediatric leaders in selected donor countries for implementation of advocacy and education strategies; and supporting sustainability of advocacy efforts by enhancing linkages between pediatric leaders across donor countries, and between leaders in donor and affected countries.

Complementing the Gates Foundation grant, the AAP also received a grant from the UN Foundation, and is collaborating with ONE.
United Nations Foundation’s new Shot@Life campaign focuses on educating, connecting and empowering Americans to champion vaccines as one of the most cost-effective ways to save the lives of children in developing countries. By encouraging Americans to learn about, advocate for, and donate vaccines, the United Nations Foundation's Shot@Life campaign will decrease vaccine-preventable childhood deaths and give children a shot at a healthy life. The AAP is a founding partner in this campaign. As a partner, the AAP will help spread the message that all kids deserve a shot at life and will offer resources to help US based pediatricians advocate for global vaccine prevention programs. The Academy provides accurate technical information to the campaign along with also involving members to act as Shot@Life Champions in the grassroots effort. The AAP encourages you to visit the Shot@Life webpage to learn more at www.shotatlife.org.

The AAP is working with ONE on global immunization financing and delivery issues. ONE is an international advocacy organization co-founded by the musician Bono with more than 2.5 million members worldwide. The AAP’s commitment to the health of all children means that both the AAP and ONE are committed to preserving low-cost, high-impact programs that provide life-saving childhood vaccinations.

Many AAP members have already become involved in both of these campaigns and have been a part of advocacy days on Capitol Hill. The AAP is looking to engage more pediatricians in advocacy and campaign events.

Opportunities for you to engage:

**Call for Chapter Global Immunization Champions.** The AAP would like each chapter to identify at least one global immunization champion who can work together with new advocacy tools to advocate at different levels in their communities. With AAP support, champions will help keep chapter leadership and members, and elected officials, educated and informed about global immunization issues.

**Call to Action for Child Health advocacy event.** In June 2012, the AAP will host a special event on the Hill to educate and advocate Congress on global immunization issues.

**Shot at Life Campaign.** You can become active in the Shot at Life Campaign in various ways. Go to the website to learn more and get involved – www.shotatlife.org.

Please take the time to visit the AAP’s new and continually expanding global immunizations webpage at http://www2.aap.org/immunization/about/globalpartnerships.html. Check back often, as more information and tools will be added in the coming months. Please feel free to contact the Program Manager at AAP if you want to be more involved or if your chapter is interested in learning more about global immunizations. For more information or to sign up as a chapter champion, please contact Terrell Carter at globalvaccines@aap.org or 847/434-4319.
In February 2012, CISP asked its IZNews Listserv ® to respond to the following questions based on the National Vaccine Advisory Committee Standards. Below are the results.

<table>
<thead>
<tr>
<th>NVAC Standard # 5: How does your practice staff communicate with parents about vaccines, in a way that informs them, while also building their trust in the pediatrician?</th>
<th>Best Practice:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice risk communication with the parents. Some techniques include the CASE model (<a href="http://www2.aap.org/immunization/pediatricians/riskcommunicationvideos.html">http://www2.aap.org/immunization/pediatricians/riskcommunicationvideos.html</a>), and motivational interviewing (<a href="http://www.motivationalinterview.net/clinical/whatismi.html">http://www.motivationalinterview.net/clinical/whatismi.html</a>).</td>
<td>What your peers are doing:</td>
</tr>
<tr>
<td>Our office has found that the key is to engage in motivational interviewing-type skills. Don’t own the patient’s decision. Listen to their concerns. Ask the family if they would like information (that others found useful) in deciding what to do about vaccinating.</td>
<td></td>
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<td>Distribute Vaccine Information Statements (VIS).</td>
<td>We use the Vaccine Information Statements (VIS) as educational tools for all parents and use face to face Questions &amp; Answers (Q&amp;A) during all well-child visits.</td>
</tr>
<tr>
<td>Expect to have conversations with parents about vaccines. Don’t rush through them; be open and understanding towards parents’ concerns. Use handouts to help in these discussions, and to answer further questions.</td>
<td>We discuss all vaccines at each visit, we talk about benefits of being vaccinated, the diseases that they prevent, and side effects. We also have handouts, open discussions and address concerns specifically.</td>
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<tr>
<td>Distribute educational information to parents before the visit on which immunizations will be given</td>
<td>We have an immunization packet that has a letter from the pediatrician encouraging immunizations, another paper stating why you should vaccinate your child, a schedule of when immunizations are due, and the VIS sheets for each vaccine. We give the packet to the parents at the baby’s first visit telling them that this is their homework. We talk about starting immunizations when baby is 2 months old. We discuss immunizations again when we take the patient into exam room for the 2 month visit. The doctor then goes over them again during the visit. When we go to administer the immunizations, we ask if there are any more questions and review what to watch for regarding vaccine reactions.</td>
</tr>
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Got an idea about a topic you’d like us to cover? Contact us at cispimmunize@aap.org
**NVAC Standard #9:** What steps are taken to ensure accurate recording of all aspects of vaccine administration (date, manufacturer, lot number, signature of the vaccine administrator, location it was given, etc.)?

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<th>Best Practice:</th>
<th>What your peers are doing:</th>
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| Use your Electronic Medical Record (EMR) or registry, as it may help prompt you to record all information. | Our EMR has a form built in for that. We use the immunization registry with as many items defaulted as possible to avoid possible data entry error.  
- Vaccines received are entered into registry’s inventory module including lot number, manufacturer, expiration date, etc., and when the specific lot is selected by the user, all necessary information defaults with it.  
- The date on which the vaccination is given defaults to date of data entry (however may be overridden by user if necessary to document vaccines given a day later in the event of catch up after a mass flu clinic).  
- The user who logs into application defaults as the vaccinator (however again may be overridden if necessary).  
- The VIS form & date defaults to the most current version. Centralized immunization program offices communicate with all sites when VIS are updated and give a 2-week window to update their clinic copies before changing the default in the registry. |
| Record information in as many places as needed. | We chart all vaccine information (lot number, expiration, brand) on the chart note, vaccine record, and state immunization network. |
| Do quality assurance tests by checking charts daily. | We conduct daily checks of our records for accuracy, count doses, and ensure lots and standardization of documentation. |
| Develop a form, either for paper charts, or for your EMR, or both, which prompts you for all the information that needs to be documented. | We use a paper form that contains all the needed information. Parents are able to sign this form, confirming that they received the VIS statements. Also, we peel off the label on the single dose syringes and attach them to the form. After all the information is put onto the form, the form is scanned into the electronic medical record.  
We have 2 places where we have to enter the immunizations that are given, our EMR and the immunization registry. We have a single sheet of paper with all the vaccines that we give, with the name of the vaccine, manufacturer, lot number, expiration, dose and site of injection, and route, signature/initials of giver, and VIS dates. At the bottom of the page the vaccines are listed and we circle the ones being given for that day. We have a line below that to write in the patient’s name and birth date and registry number. When we draw up the immunizations we double check the vaccine information on the vials, making sure it matches our sheet. We have the parent check that it is the vaccines that they were expecting to receive that day and have them sign the sheet. We use this sheet to enter all info whenever we have time following the appointment. It has worked very well for us. I keep the copies filed by month and they have come in very helpful if a question arises regarding immunizations given. |
| Have a specific procedure that is clear to all staff. | After all vaccination clinics, a vaccine administration record is completed for all clients. It contains, name of vaccine, dose given (#1 of series, etc.), Vaccine manufacturer, lot number, expiration date, signature of administrator, and that a VIS form was given. This procedure is reviewed with all staff, and is part of immunization policy and procedure. |
SUBMIT ABSTRACTS FOR ORAL PRESENTATION UNDER THE FOLLOWING CATEGORIES:

- Data Quality: Accuracy/Timeliness/Completeness, including Patient De-duplication, Vaccine De-duplication, IIS Assessments and Performance Improvement
- Data Exchange/Real-time/Bi-directional, including HL7 Standards, Transport Layers, Interstate Data Exchange, Continuity of Care Documents (CCD)
- Working with Health Information Exchanges
- Vaccine Accountability including VTrckS ExIS and Vaccine Ordering, Vaccine Inventory, VFC Eligibility in the IIS - Dose Level
- Meaningful Use
- Forecasting Algorithms/Clinical Decision Support
- Funding Opportunities and Sustainability
- Privacy/Security/Confidentiality/Consent
- Transitioning to New IIS Platforms
- Strategies for Non-Traditional Immunizers (e.g., pharmacies/retail health clinics; school located vaccination clinics)
- Parent/Consumer Access
- Linkages/Integration with other Child Health Programs
- Other

ABSTRACT SUBMISSION GUIDELINES

- Abstracts should not exceed 300 words, excluding title and authors. The abstract should clearly and concisely describe the material to be presented at the meeting.
- The deadline for submission of abstracts is Tuesday, May 15, 2012, 11:59 p.m. EDT
- Submit abstracts online at www.surveymonkey.com/s/airacallforabstracts
- Additional meeting information is at www.immregistries.org

ABSTRACT FORMAT

- We are not soliciting poster presentations for this meeting.
- Title: Be as brief and explicit as possible. Do not use abbreviations or acronyms in the title.
- Contact Information: Please include your full mailing address, telephone, and email address.
- Name(s) of Presenter(s):
  - Presenter
  - Co-Presenter(s)
  Please provide the email address and affiliation(s) of the presenter(s) (organization, city, state, country). A maximum of three affiliations is permitted for each co-presenter.
- Abstract Text: Please follow the structured format. Always define abbreviations and acronyms including standard measures. Place special or unusual abbreviations in parentheses after the full word the first time it appears.

There are three main parts of your abstract:
- 30 Word Abstract Summary: Sell your abstract to reviewers and potential conference attendees if your work is selected. Please make sure this 30 word summary effectively describes the main goal of your abstract.
- 300 Word Abstract Body: Describe in detail the information that you plan to present if your abstract is selected for the conference. Be as specific as possible.
- Learning Objectives: Provide potential session attendees with actionable descriptions of what they will learn attending your session. Your learning objectives should start with an active, observable and measurable verb (ex. Explore the benefits of ExIS implementation; Establish guidelines for data exchange).

- Each abstract must include all information necessary for its comprehension and not refer to another text.

ABSTRACTS WILL BE PEER-REVIEWED

QUESTIONS? CONTACT: Jennifer Bank, AIRA Executive Assistant
jbank@immregistries.org • (202) 527-7000 • Fax: (202) 833-3636