Assessing Key Factors to Pharmacy Enrollment in the Vaccines for Children Program

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section B

Submitted: 10/9/14

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Section B – Information Collection Procedures

1. Respondent Universe and Sampling Methods

Data will be collected from two types of state, tribal, local, and territorial (STLT) public health department staff: 10 coordinators of the Vaccines for Children (VFC) program and 10 VFC field staff who interact most closely with immunization providers, acting in their official capacity. Field staff, sometimes state employees and sometimes contractors to state health departments, conduct between 50-80 compliance visits to providers each year to ensure that these providers understand and meet the specific requirements of the VFC program. Through this role, they interact closely and frequently with all types of immunization providers, including pharmacists. The VFC Management Survey gives the aggregate number of pharmacies enrolled in each STLT program that is funded by CDC. The 20 VFC staff (one coordinator and one field staff member per state) would be drawn from 10 states with pharmacy enrollment in the VFC program as of 2013 (MN, NV, WA, WI, TX, CA, AZ, OR, MD, TN). These 10 states are a subset of the 64 states and territories that receive immunization funding through cooperative agreements with CDC.

Data also will be collected from pharmacists who have participated in the VFC program. They are considered delegates of public health agencies for the following reasons:

1) As per 0920-0879 Generic ICR language, "delegates are governmental or non-governmental agents (agency, function, office or individual) acting for a principal or submitted by another to represent or act on STLT government behalf".
2) Immunization services delivery, irrespective of venue, is part of Essential Public Health Services #7: "Link people to needed personal health services and assure the provision of health care when otherwise unavailable."
3) Pharmacists who participate in the VFC program are extensions of STLT health departments. Many state programs no longer provide direct immunization services and contract these services through their local health units. In order to participate in the state VFC program, all providers, including pharmacists, sign a Provider Agreement form and can then provide immunization services for VFC-eligible children and adolescents within that state based on their respective state laws. They can provide VFC-funded vaccine to VFC-eligible children and adolescents who would otherwise have to be immunized in health departments or provider offices, whose capacity can be limited in some locales and that are often less convenient for working parents due to restricted hours and wait times.
4) In many states, pharmacists provide access to immunizations for adolescents and adults who are less likely to see a health care provider on a routine basis, and thus would otherwise remain unimmunized.
5) Respondents will be identified in 10 states that have allowed pharmacy immunizations of children and adolescents and have successfully enrolled or sought to enroll pharmacists in the program. These states include those with pharmacy enrollment as of 2013 (MN, NV, WA, WI, TX, CA, AZ, OR, MD, and TN). Based on information in CDC's Provider Education Assessment and Reporting PEAR system, pharmacists practice and participate in the VFC program in the states listed above.

2. Procedures for the Collection of Information

Participants will receive via e-mail a project overview fact sheet (**Attachment D**) attached to an invitation to participate (**Attachment E**) from the Association for State and Territorial Health Officials (ASTHO), which is a partner with CDC in this data collection. This email will introduce the project and indicate that respondents will be able to select time slots that are convenient for them. To encourage participation among state immunization staff, state health officials will also receive an email communication from ASTHO (**Attachment F**). Those who do not respond within a week of the initial e-mail will receive a reminder e-mail (**Attachment G**) at that point. All communications will include a courtesy copy to the CDC Project Officer within the National Center for Immunization and Respiratory Diseases (NCIRD) and the Immunization Program Manager that works with the state being contacted.

As interviews are scheduled, participants will receive a confirmation e-mail (**Attachment H**) as well as an Outlook invitation that immediately feeds into their online calendars. Following the interview, respondents will receive a thank-you e-mail (**Attachment I**) expressing appreciation for the time they have taken to share their insights about key considerations for pharmacy participation in the VFC program.

Once the interviews are completed, the qualitative data from the interviews will be transcribed and imported into Dedoose® qualitative data analysis software (www.dedoose.com). The collected qualitative data will be coded and analyzed thematically, where data analysts will identify key themes that emerged across groups of interviews by segment or other characteristics. Frequency and intensity of discussions on a specific topic will be key indicators used for extracting main themes.

3. Methods to Maximize Response Rates and Deal with Nonresponse

Reminder and confirmation e-mails (**Attachments G and H**) will be the main method used to maximize response rates and follow up with non-responders. In addition, the data collection effort will be mentioned in an e-mail distributed to Immunization awardees in the 10 relevant states.

If a non-response appears to be the result of an incorrect e-mail address or respondent no longer serving in the same role, every effort will be made to identify the correct address and/or suitable replacement.

4. Test of Procedures or Methods to be Undertaken

The information collection instrument was pilot tested by 9 public health professionals that are Project Officers within CDC/NCIRD. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns and establish the estimated time required to complete the information collection instrument. In the pilot test, the average time to

complete the instrument — including time for reviewing instructions, gathering needed information and completing the instrument — was approximately 45 minutes. Based on these results, the estimated time range for actual respondents to complete the instrument is 30-45 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 45 minutes) is used.

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

The following individuals were consulted to provide advice about the design of these data collection activities:

Ericka McGowan, MS
Director, Infectious Disease Preparedness
Association of State and Territorial Health Officials (ASTHO)
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Elizabeth Ruebush
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CMT Consulting, LLC
404-377-4061
ctangum@mindspring.com

The following individuals are working on information collection, including instrument development, data collection, and data analysis:

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LIST OF ATTACHMENTS – Section B

D. VFC Project Overview
E. Participant Notification E-mail
F. SHO Notification Email
G. Reminder E-mail
H. Confirmation E-mail
I. Thank You E-mail