victorian refugee health network

ACIR – Issues Arising

Briefing prepared by Immunisation Working Group

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Background

The implementation of No Jab No Pay has exposed a number of issues related to the Australian Childhood Immunisation Register (ACIR) that have direct impact on service providers and refugee-background communities.

This summary of issues has been prepared based on the June 2016 meeting of the Immunisation Working Group (IWG) as background for discussions with the Immunisation Section of the Department of Health, and is not intended for wider circulation.

Impact on families

1. **Families are losing Centrelink payments due to delays in ACIR information being registered** despite children being vaccinated and this information being notified to ACIR. This relates to the delays in registering overseas and historical vaccines as identified previously, and also due to providers faxing/posting information rather than entering historical records onto ACIR online (due to workforce pressures related to No Jab, No Pay).

   This occurs due to the need to update vaccination information for all children arriving or receiving catch-up vaccination in Australia over 7 years of age, understanding that prior to January 2016, the upper age limit for ACIR was 7 years. Providers report that there is no flexibility to expedite vaccine registration, and that the ACIR advice line will not take details of vaccination over the phone from providers (i.e. when vaccines given and notified) hence the delays caused by ACIR inefficiency have direct impact on families.

2. **The process for families to obtain their children's ACIR statements is complex**. Parents need to create a myGov account, link this to their Medicare, and obtain an immunisation statement from Medicare, OR download a mobile app, OR call the Immunisation Register to obtain their child's immunisation history statement. The myGov-Medicare instructions are provided in English; they require IT literacy and Internet access; and the details on obtaining an ACIR statement from Medicare are unclear. Providers report this process is not accessible for families with low English proficiency.

Technical issues

3. **No ability to bulk upload vaccine records to ACIR for children >7 years from existing software systems**, meaning providers have to enter individual records to ACIR. In Victoria,

local government areas (LGA) and a number of hospitals use ImPS (Immunisation Program System) to record vaccination information. The ability to upload historical ImPS data (or similar systems in other jurisdictions) would offer a mechanism to update ACIR at service level.

Given vaccination information could not previously be entered for older children, enabling upload of immunisation records maintained in other systems would allow a more accurate understanding of immunisation coverage.

4. **Batch rejection** - earlier in 2016, Primary Health Networks (PHN) reported that batches of vaccine records uploaded to ACIR were being rejected, affecting vaccination registration for multiple individuals. This appeared to be specific to the 'Genie' medical software used in general practice, and providers reported errors in one or more entries was resulting in the entire batch being rejected; although there was no automated notification this had occurred at the time, so providers needed to be alert to this possibility and check whether the batch had been successfully submitted. This issue highlights the importance of streamlining the interface between ACIR and commercial software.

5. **Pending codes** – providers reported a large number of new codes for pending vaccination registration since the beginning of 2016. Victorian Department of Health and Human Services (DHHS) staff provided a list of pending codes at the June meeting, it would be useful if this was available more broadly e.g. through the ACIR vaccine code website https://www.humanservices.gov.au/health-professionals/enablers/australian-childhood-immunisation-register-vaccine-code-formats.

6. '**Pending records' and the impact on vaccination registration** – there is complexity in catch-up vaccination not matching the routine National Immunisation Program Schedule (NIPS), and consequently many vaccination records remaining as 'pending'. Further, the mechanism to address this is inefficient; providers have to ring ACIR to request that the ACIR staff manually approved these records; increasing workload for both providers and ACIR.

   The most likely pending code involved is '107 = Dose administered at greater than recommended schedule age – PF18 to acknowledge warning'

   Providers report they are usually not aware that vaccination registration is pending until families return to the immunisation service because they are still receiving letters from Centrelink stating that their child is not up-to-date. When they call ACIR about pending codes, they are informed by ACIR staff that ACIR is awaiting clarification from the provider; and the providers (who entered the information in the first place) have to verify their provider status and confirm the vaccination was given. This is essentially double handling, and this duplication is a substantial inefficiency.

7. **Issues related to specific antigens:**

   a) If MMR-V (Priorix-tetra®) entered for a child >3 years ACIR puts a pend on it, even though this is acceptable as the 1st dose of MMR and varicella immunisation for children aged 4-13 years.
   b) For children <4 years who are given MMR, ACIR will not record the child as up-to-date because they have not had their 18-month VV; even though the handbook recommends not using MMR-V as the first dose in children <4 years.
   c) If there is a dosing change in DT-containing formulations e.g. Infanrix-hexa® is entered as the first dose of that brand for the 18m schedule point (although it is the 4th dose of DT-containing vaccination), the entry is rejected because it should have been entered

as dose 4. This is similar to the issues arising when the NIP changed from 7vPCV to 13vPCV.

d) The current formulation of diphtheria and tetanus adsorbed vaccine dT-adsorbed (ADT equivalent) cannot be entered on ACIR – providers need to enter as split antigens (generic diphtheria and generic tetanus separately). Providers at the Royal Children's Hospital report that they are recording this vaccination as an ADT dose.

e) **If the first dose of catch-up vaccinations is registered as DTPa-IPV dose 4 and MMR dose 2 (regardless of previous history) this will record the child as up-to-date and facilitate continuous Centrelink payments.** This occurs because the 'fully immunised' status at 12-<15m; 24-<27m and 60-<63m are considered independently and not cumulatively. This offers providers a pragmatic and time-efficient solution to ensure Centrelink payments for families, and while catch-up can still be delivered, this will compromise immunisation coverage data, as there is no straightforward mechanism to update/correct ACIR once this has occurred.

8. **Future proofing -** all medical software that links with ACIR will need to be re-configured to include all vaccines, at all ages, when ACIR is extended to become the Australian Immunisation Register (AIR). The short timelines for AIR (November 2016) and the Australian School Vaccination Register (ASVR; January 2017) mean this will be a major issue in the next months. While No Jab No Pay has highlighted early childhood immunisations, considering the NIPS across the lifespan is important going forwards.

Data entry issues

9. **Extending the ACIR to become a whole-of-life register offers an opportunity to enhance demographic information related to migration status.** Identifying people from refugee and asylum seeker backgrounds in administrative datasets is essential to monitoring coverage, evaluating policy impact and understanding outcomes/service usage patterns in these communities. We recommend the collection of 'country of birth' and 'year of arrival' as minimum data items, but would also suggest consideration be given to interpreter requirement and refugee/asylum seeker on entry to Australia.

10. **Extending the ACIR to become a whole-of-life register offers an opportunity to indicate whether immunisations are part of a specified catch-up plan.** ACIR does not include a mechanism to indicate whether immunisations are part of a specified catch-up plan (and then whether this is completed). This information would significantly enhance monitoring of catch-up immunisation.

11. **Naming conventions** - ACIR functionality allows providers to search for a patient's record using either their Medicare number, or their name AND date of birth. IWG members have identified several difficulties for our client group. Many databases do not support the entry of single name or multi-syllable named persons. For example, many Karen (Burmese) people have only one name, often written in a number of syllables when transliterated from Karen e.g.: La Ka Paw, Ku Sah Wah. Inconsistent approaches are used to enter these naming conventions into databases, leading to difficulties matching and/or recalling entries. Many people seeking asylum do not have access to Medicare, hence name and DOB is an important mechanism in this group.

Interface between ACIR and Centrelink

12. **There appear to be discrepancies between Centrelink and ACIR reporting.** Providers were aware of several cases where families had been sent Centrelink letters stating their children were not up-to-date with immunisation, despite ACIR recording the children as fully immunised. This may be due to Centrelink not having the child's Medicare number, or ACIR

not having the child's Centrelink Customer Reference Number, leading to difficulties in matching records. It appears that the onus falls on families to resolve discrepancies between ACIR and Centrelink, and they lose payments in the interim.

13. **Centrelink letters about ACIR are confusing for families and providers** - Families frequently receive letters from Centrelink with different options for actions to clarify their children's immunisation status. These letters are confusing, especially those with low English language proficiency. Please see examples attached as appendix 2. Letters for children aged 10 years and older are often assumed to refer to adolescent vaccination, and providers report specific issues related to Centrelink letters requesting the CRN for ACIR (where Centrelink clearly have this information).

Inconsistent ACIR advice

14. **Advice provided by the ACIR and Immunise Australia enquiries lines has been inconsistent.** Examples include:

    a) **How Centrelink registers a catch-up plan being in place** - calls to Immunise Australia and ACIR in February and March 2016 to request information generated conflicting advice. Advice from Immunise Australia in February was that the only way for a child to be considered on a recognised catch-up schedule and have their payments reinstated was for the child to have all overdue vaccines at a schedule point and for the vaccine encounters to be reported to ACIR. In March 2016, ACIR general enquiries staff advised that in addition to reporting the vaccine encounters to ACIR, a GP or recognised immunisation provider could call or send a letter (on letterhead) to ACIR and advise that they have organised to commence a child on a catch-up schedule, in order for families' Centrelink payments to be reinstated. Subsequent practice has suggested that ACIR registration is the trigger for stopping/restarting Centrelink payments.

    b) **Catch-up incentive payments** – we have had inconsistent advice (February 2016 and 23/6/16) from the Immunise Australia, ACIR general enquiries line, and ACIR policy line about:

        i. If the additional catch-up incentive payments are for children over or under 7 years (Immunise Australia and ACIR policy line said it was for children <7 years, ACIR general enquiries line said children >7 years),

        ii. If providers get both ACIR notification payments and catch-up incentive payments (told yes, but not for same schedule point, which would indicate no).

        iii. If there is complexity to the administration of catch-up payments (i.e. where payment for one vaccine may depend on the administration of another (different) vaccine) similar to the ACIR notification payments.

    Consistent information is important, and there is no clear written information on these areas.

    c) **Paediatrician registration with ACIR** - we have had inconsistent advice about whether paediatricians are automatically recognised as vaccination providers by ACIR. We have received three versions: i) no paediatricians are registered, ii) all paediatricians are automatically registered, but that they need to activate their registration and more recently (ACIR general inquiries line 15/6/16) that iii) some, but not all, paediatricians are automatically recognised as immunisation providers

with ACIR. The ACIR staff member was not certain about criteria; and/or why some paediatricians may be automatically recognised, but suggested that if the person worked in a public hospital, they may have been allocated a provider number that triggered ACIR registration. Clarification is essential, as paediatricians are an important workforce in childhood immunisation.

Other concerns

15. **PHNs advise that ACIR reports for general practice are not user-friendly** – GPs can generate 10A reports through the ACIR secure site, but the information is provided in multiple files that need to be combined. This is reported to reduce useability, and has resulted in limited uptake and use of practice-based reporting. There is currently work underway to provide a 'webinar' resource for practices to generate to 10A reports, given the complexity. In contrast, providers report the previous system (quarterly 20A reports communicated to practices from ACIR as part of the GP Immunisation Incentive scheme) as a useful/useable format. PHN staff report the previous 30A reports provided for GP divisions (when they were in operation) were a useful resource, and note the lack of equivalent reporting at PHN level.
16. **Delays in registering as an immunisation provider/activating registration for ACIR** appear to be an issue. Despite ACIR general enquiries staff advice (15/06/2016) that it should take no longer than 10 business days for providers to receive this information., examples raised by the IWG include:
    a. It took 8 weeks for a paediatrician whose provider number was already recognised as a vaccination provider by ACIR to receive details to access the secure site
    b. The Asylum Seeker Resource Centre is still waiting for their provider number 4 months after submitting an application to register as an organisational vaccination provider
    c. North West Melbourne PHN is still waiting for their provider number 6 weeks after submitting an application to register as an organisational vaccination provider
17. **Medical exemptions** – as previously discussed
18. **The application of due and overdue rules[1] for hepatitis B vaccine is not clear in relation to catch-up immunisation.** Hepatitis B vaccine becomes overdue at 3 months after dose 2, however, by the Immunisation Handbook, the dosing interval for hepatitis B catch-up vaccination specifies that the interval between dose 2 and 3 must be 2 months, ***and***, the dosing interval between dose 1 and 3 must be 4 months. Therefore, a minimum dosing interval for hepatitis B catch-up vaccination is 0, 1 and 4 months – i.e. 3 months between dose 2 and 3, so the vaccine becomes overdue at the point it can first be given.
19. **Catch-up incentive payments do not support best practice catch-up immunisation,** and payments are higher for sub-optimal catch-up vaccination with longer intervals between dosing. Catch-up incentive payments are only available for children <7 years, for vaccines given after 1/1/16, that are more than 2 months overdue; thus if an immunisation provider gives the first dose of a catch-up schedule and recalls the child for the next dose of catch-up vaccines 1 month later (which is the minimum interval and best practice), the second dose does not trigger a catch-up incentive payment, as it is not considered overdue in relation to the first.

[1] https://www.humanservices.gov.au/sites/default/files/.../acir-**due-overdue-rules**.docx

Appendix 1. Immunisation Working Group members

Name	Position	Organisation
Dr Georgia Paxton	(Chair) Head Immigrant Health, Paediatrician	The Royal Children's Hospital and Murdoch Children's Research Institute
Dr Karen Kiang	Paediatric Refugee Health Fellow	The Royal Children's Hospital
Dr Sophie Oldfield	Paediatric Refugee Health Fellow	The Royal Children's Hospital
Dr Margie Danchin	Paediatrician & Senior Research Fellow, Infection & Immunity	The Royal Children's Hospital and Murdoch Children's Research Institute
Kate Russo	Immunisation Nurse & Immunisation Program Consultant	Networking Health Victoria
Lindy Marlow	Statewide Facilitator, Refugee Health Program	coHealth
Merilyn Spratling	Refugee Health Nurse Practitioner	EACH Social and Community Health
Sahema Saberi	Project Officer, Refugee & Asylum Seeker Health	South Eastern Melbourne Primary Health Network
Sandra Lonergan	Project Officer, Immunisation	South Eastern Melbourne Primary Health Network
Wendy Reid	Program Officer, Immunisation & Quality Improvement Support	North West Melbourne Primary Health Network
Samantha Milford	Program Officer, Refugee & Asylum Seeker Health	North West Melbourne Primary Health Network
Angela Dunn	Immunisation Team Leader	Hume City Council
Lisa Beck	Immunisation Coordinator	City of Greater Dandenong
Lynda Marburg	Immunisation Coordinator	Wyndham City Council
Stephen Pellissier	Manager, Immunisation Section	Department of Health and Human Services
Megan Beasley	Senior Project Officer, Immunisation Section	Department of Health and Human Services
Rosemary Morey	Immunisation Nurse, Immunisation Section	Department of Health and Human Services
Crystal Russell	Senior Policy Adviser, Refugee & Asylum Seeker Health	Department of Health and Human Services
Zoe Smith	Public Health Officer, Western Area	Department of Health and Human Services
Toni Bloodworth	Manager Health Advice and Policy	Department of Education and Training
Sheenagh McShane	Health Program Manager	Asylum Seeker Resource Centre
Victoria Fisher	Settlement Team Leader North West	AMES
Sue Casey	Manager, Sector Development & Partnerships	Foundation House
Lauren Tyrrell	Sector Development & Policy Advisor (secretariat support)	Victorian Refugee Health Network