



Immunization Quality Improvement for Providers (IQIP)

2026 OPERATIONS GUIDE



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Abbreviations

Abbreviation	Definition
ACIP	Advisory Committee on Immunization Practices
CDC	Centers for Disease Control and Prevention
CoCASA	Comprehensive Clinic Assessment Software Application
EHR	Electronic Health Record
HBV	Hepatitis B Virus
HepB	Hepatitis B
HIPAA	Health Insurance Portability and Accountability Act
IIS	Immunization Information System
IOSB	Immunization Operations and Services Branch
IQIP	Immunization Quality Improvement for Providers
ISD	Immunization Services Division
LTFU	Lost to Follow-Up
mAb	Monoclonal antibody
NOFO	Notice of Funding Opportunity
PAIS	Patient Active/Inactive Status
PDSA	Plan-Do-Study-Act
PEAR	Provider Education Assessment and Reporting System
QI	Quality Improvement
REDCap	Research Electronic Data Capture
RSV	Respiratory syncytial virus
SAMS	Secure Access Management Services
VFC	Vaccines for Children
VPD	Vaccine-Preventable Disease

About This Guide

The Immunization Quality Improvement for Providers (IQIP) Operations Guide:

- Reflects current IQIP program processes and policies
- Defines IQIP requirements and outlines the components necessary to meet the requirements
- Communicates IQIP programmatic information to state, local, and territorial immunization programs

IQIP Program Resources

This guide mentions additional resources to assist jurisdictions implementing IQIP (called recipients). Many of these resources are available through CDC's Vaccines for Children Cooperative Agreement Management Platform (VFC CAMP). Immunization program managers may request access for IQIP staff through their assigned ISD Immunization Operations and Services Branch (IOSB) project officer.

Future Changes to the Guide

This document is designed to be an evergreen resource and will be updated regularly to maintain its accuracy and relevance, reflecting up-to-date information, evidence, and knowledge. Information and modules will be revised if information changes after the IQIP Operations Guide is published. CDC will notify recipients by e-mail anytime changes are made. As changes are made, they will be documented in the IQIP Operations Guide Change Control table on page 2.

Questions

Recipients with questions about the IQIP Operations Guide may contact their Immunization Operations Services Branch (IOSB) project officer or IQIP@cdc.gov.

Manual Overview

The IQIP Operations Guide details the requirements and standards for CDC's IQIP program. It is intended for use by CDC's immunization program recipients that receive Vaccines for Children (VFC) program funding under Section 317 of the Public Health Service Act. This funding supports the costs of prevention health services, and 317 priorities that include preserving immunization infrastructure, maintaining vaccine supply as a safety net for uninsured adults, and responding to vaccine-preventable disease (VPD) outbreaks.

Activities in this funding opportunity are included within the following five priority strategies:

- Strengthen Program Infrastructure and Management
- Increase Vaccine Access
- Improve Immunization Equity
- Promote Vaccine Confidence and Demand
- Enhance Data and Evaluation

Immunization program recipients are responsible for implementing the IQIP program and must ensure their IQIP operations comply with the standards outlined in this guide. This guide should serve as the

primary IQIP reference for developing or updating policies and procedures specific to their immunization program.

NOTE: CDC develops and administers the IQIP program. The quality improvement processes and strategies outlined as a part of IQIP may be used by unaffiliated parties. To avoid confusion, unaffiliated parties are encouraged to distinguish their initiative's name from CDC's IQIP program.

Terms Used in this Guide

Term	Definition
Assessment reports	Collectively refers to patient line lists and immunization coverage reports
Birth Hospital or Facility	A hospital with more than one birth during the past calendar year or ≥1 registered maternity bed
Immunization	The process of becoming immune or resistant to an infectious disease, typically by administering a vaccine. It implies that a person has had an immune response.
Immunization Coverage	The percentage of people in a defined cohort who have received specific vaccines. In the context of this guide, “coverage” does not refer to health insurance coverage.
Immunization Information System (IIS)	A confidential, population-based, computerized database that records all vaccine doses administered by participating providers to persons residing within a given geopolitical area
IQIP Awardee Performance Metrics (APM) Tool	Electronic tool used for annual and mid-year reports and target setting, hosted on the REDCap platform and accessible through the Secure Access Management Services (SAMS) portal
IQIP candidate provider locations	The subset of VFC-enrolled providers excluding specialty providers. CDC calculates the number of required IQIP visits from this subset instead of the total number of VFC-enrolled providers
IQIP Coordinator	Refers to the individual responsible for managing a recipient’s IQIP program
IQIP Consultant	Refers to the individual who conducts IQIP site visits, check-ins, or follow-ups or otherwise communicates with provider staff regarding IQIP efforts on behalf of an immunization program
IQIP Dashboard	Provides visualizations of IQIP data for monitoring program implementation, such as data quality, trends, and timeliness of site visits, check-ins, and follow-ups. The dashboard presents data from the IQIP Database on a PowerBI platform that is refreshed regularly.
IQIP Database	The electronic system for entering, monitoring, and exporting IQIP data. It is on the REDCap platform and is accessible via the Secure Access Management Services (SAMS) portal.
IQIP Database File Repository	A file sharing area in each IQIP Database that CDC uses to share IQIP program resources relevant to these systems with users. Each IQIP Database within REDCap has its own file repository.

Perinatal Hepatitis B Prevention Program (PHBPP)	The Perinatal Hepatitis B Prevention Program (PHBPP) within the immunization program identifies pregnant women with hepatitis B virus (HBV) and manages their infants to ensure they receive post-exposure prophylaxis (PEP) (hepatitis B (hepB) vaccine birth dose and hepatitis B immune globulin), complete the hepB vaccine series, and receive post-vaccination serologic testing
Prescriber	Provider staff responsible for prescribing vaccines (includes physicians, physician assistants, and nurse practitioners, as applicable)
Program or Recipient	Refers to state, local, and territorial immunization programs operating VFC programs that receive Vaccines for Children (VFC) funding under 317 of the Public Health Service Act and are conducting IQIP activities
Provider	Used inclusively in this guide to describe VFC-enrolled health care providers staff who deliver immunization services to patients aged 0–18 years (e.g., birthing hospitals, facilities, practices, or clinics)
Provider Education Assessment and Reporting System (PEAR)	An online Vaccines for Children (VFC) program oversight management tool for recipients and CDC. The system collects relevant VFC data, including VFC enrolled provider information, to support overall program activities
Secure Access Management Services (SAMS) Partner Portal	SAMS is a secure web site that allows public health partners and providers to access information and computer applications operated by the U.S. Centers for Disease Control and Prevention (CDC). The SAMS applications used for the IQIP program are PowerBI and REDCap.
Vaccines for Children (VFC) Program	An entitlement program for eligible children, ages 18 and younger that provides vaccine at no cost to VFC Program-eligible children through VFC Program enrolled public and private health care providers
VFC CAMP	Vaccines for Children Cooperative Agreement Management Platform, a centralized cloud-based system that combines cooperative agreement management resources, tools and processes into one unified system accessible to both internal and external users
VFC CAMP Knowledge Center	A resource repository in the VFC CAMP system with resources including user guides, technical assistance videos, FAQs and program implementation resources

Provider-Level Immunization Quality Improvement: Background and Overview

History of Provider-Level Coverage Assessment and Feedback

Since 2000, the [Community Preventive Services Task Force](#) (“Task Force”) has recommended provider assessment and feedback to increase immunization rates among people of all ages. This intervention evaluates provider performance in delivering one or more immunizations to a client population (assessment) and present providers with information about their performance (feedback) ([Increasing Appropriate Vaccination: Provider Assessment and Feedback](#)). CDC developed the Immunization Quality Improvement for Providers (IQIP) to provide a framework for state, local, city, and territorial immunization programs in conducting one-year immunization QI projects with providers enrolled in the Vaccines for Children (VFC) program to increase immunization coverage. Launched in 2019, the IQIP program combines provider assessment and feedback with evidence-based immunization QI strategies and best practices to support providers in improving immunization coverage among children aged 0 to 18. Presently, 63 recipients receive VFC Compliance and Quality Improvement funding.

The Office of the Inspector General (OIG) initiated an audit of the VFC program in December 2021 to determine whether CDC VFC recipients conducted site visits at enrolled and active VFC providers that administer childhood vaccines according to program requirements. Since the IQIP program is implemented using the same funds as the VFC program, it is included in the scope of the OIG’s oversight activities. Therefore, IQIP programs must observe the same level of diligence in assuring appropriate use of funds as the VFC program and ensure IQIP is implemented according to CDC program requirements.

Overview of Quality Improvement

Quality improvement (QI) is a structured, ongoing process focused on enhancing the effectiveness, efficiency, and overall quality of services, processes, or systems to achieve a better outcome. It involves identifying areas for improvement, collecting and analyzing data, implementing changes, and continuously monitoring and evaluating the impact of those changes ([Coughlin & Posencheg, 2023](#)).

Key Aspects of Quality Improvement

Data-driven: Quality improvement relies on data collection and analysis to understand current performance and identify areas for improvement.

Systematic: It involves a structured approach, often utilizing evidence-based methodologies

Continuous: Quality improvement is an ongoing process, not a one-time event, requiring regular monitoring and adjustments to maintain and improve performance.

Focus on outcomes: The goal of quality improvement is to achieve better patient outcomes, improved efficiency, reduced costs, and increased patient satisfaction.

Quality improvement within the primary care setting has been successful in initiating change in the provision of pediatric preventive services ([Rose et al., 2021](#); [Wells et al., 2018](#)) and previous investigations support practice-level quality improvement to improve pediatric immunization rates ([Rosen et al., 2025](#); [Harder et al., 2018](#); [Brewer et al., 2017](#)). States with policies that mandate immunization assessment as part of QI have higher immunization rates than states that do not have these policies in place, demonstrating that QI can make a difference in public health outcomes ([Collins et al., 2008](#)).

IQIP Program

IQIP is an immunization QI program for health care providers enrolled in the VFC program. The purpose of IQIP is to promote and support the implementation of provider-level strategies designed to increase immunization among children 0-18 years of age in adherence to the Advisory Committee on Immunization Practices (ACIP)-recommended immunization schedule.¹

The structure of IQIP is based on the Plan-Do-Study-Act (PDSA) cycle of quality improvement.² The PDSA cycle is a method used for quality improvement that involves **P**lanning a change, **I**mplementing the change (**D**o), **S**tudying the results, and **A**cting on what is learned to refine the approach. This cyclical approach helps in identifying and testing potential solutions to improve processes and the PDSA cycle has been demonstrated to improve immunization coverage rates in pediatric populations ([Stetson et al., 2019](#); [Bowden et al., 2017](#)).

To support provider-level QI, IQIP utilizes four evidence-based QI strategies to increase immunization coverage. These strategies offer providers opportunities to improve their processes (i.e. workflow, best practices, and education and training) and structure (i.e. use of technology and a coordinated, supportive approach to immunization). The four IQIP strategies are:

- Facilitate Return for Immunization
- Leverage the IIS, EHR or Other Electronic Systems to Improve Immunization Practice
- Give a Strong Immunization Recommendation
- Strengthen Immunization Communications to Address Vaccine Hesitancy

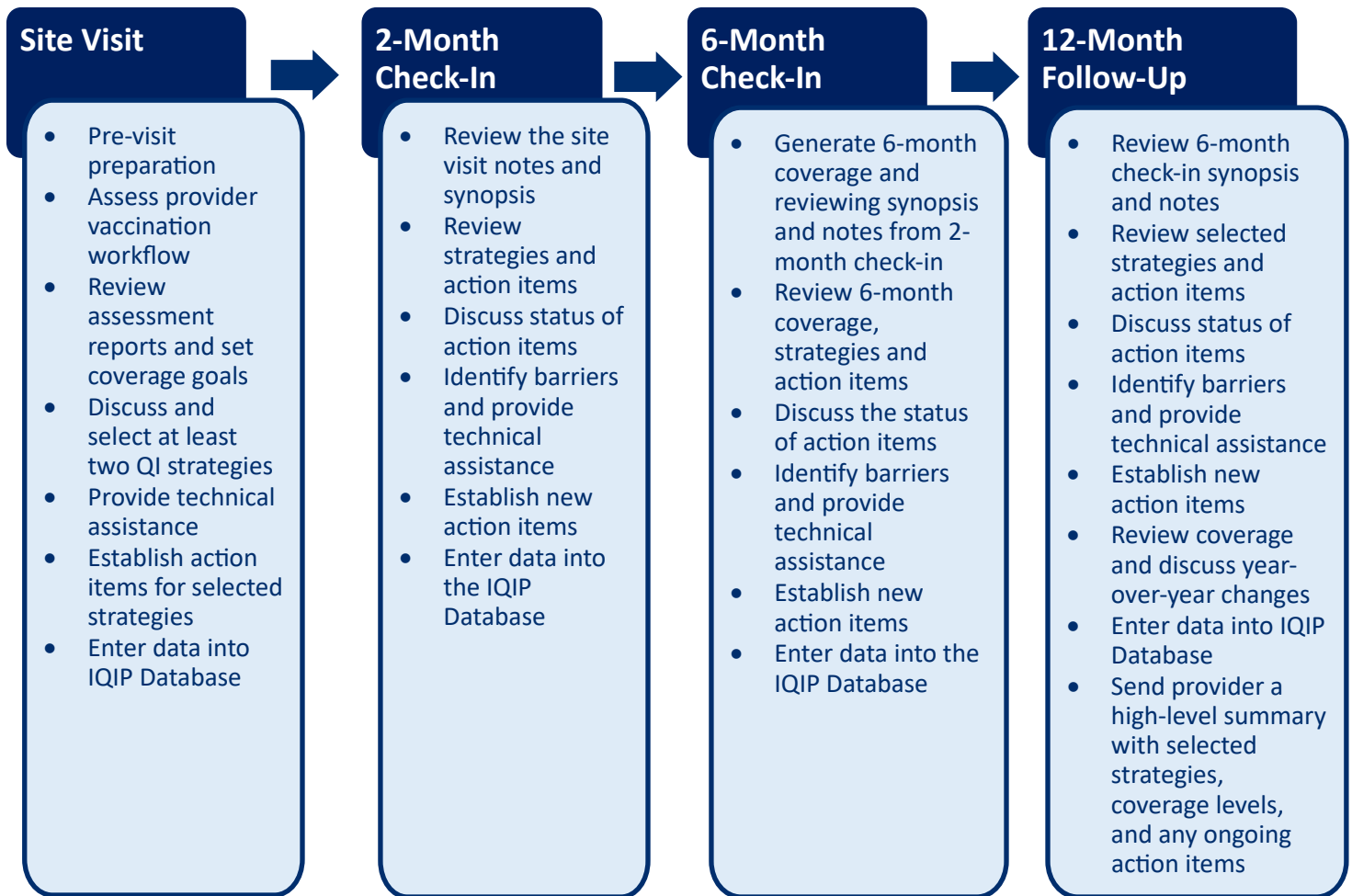
For a detailed overview of each IQIP strategy see Module 4 -- IQIP Core Strategies.

IQIP focuses on four age cohorts: birth, 2-year-olds, 13-year-olds, and 17-year-olds. IQIP specifies immunization coverage assessment parameters for each cohort, including the series and antigens to be measured for them throughout the IQIP cycle. See Module 2 for coverage parameters, and Module 6 for coverage goals.

¹ <https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html>

² <https://deming.org/explore/pdsa/>

The IQIP Cycle



Because the IQIP cycle spans 12 months, it is expected that the cycle will begin and end in different budget years. See the IQIP Timeline Examples resource for more information.

IQIP Program Staffing



NOFO Requirement: Recipients must designate an individual to serve as IQIP Coordinator.

Recipients should designate a staff person to serve as the program's IQIP coordinator. IQIP coordinators are responsible for overseeing the implementation and monitoring of the IQIP program activities, training IQIP staff according to CDC requirements, staying up to date on IQIP program CDC guidance, and more; refer to Table 1. While recipients may not have a staff position assigned full-time to the IQIP program coordinator role, there should be a clear understanding of who is responsible for the IQIP program.

Recipients must notify their IOSB project officer and IQIP@cdc.gov any time there is a change in the individual filling the IQIP coordinator role, including staff who may be in the role temporarily. Though

job titles may vary, the positions providing support to a recipient IQIP program ideally include those listed in Table 1.

Table 1: IQIP Staff and Support

Immunization Program Manager	The immunization program manager oversees CDC-funded immunization services at the recipient level. The program manager is responsible for the immunization program's funding, staff, vaccine-preventable disease surveillance and control, communication, and reporting. They are also responsible for the IQIP program.
CDC Field Assignee	The CDC field assignee, often a public health advisor, may be responsible for activities that fall under any of the roles mentioned here, including ensuring the fulfillment of CDC reporting requirements.
IQIP Coordinator	The IQIP coordinator manages the jurisdiction's IQIP program. Responsibilities include: • Serve as the recipient's primary point of contact with CDC IQIP staff. • Participate in all CDC-led in-person IQIP meetings, all-recipient IQIP calls, workgroups, and webinars. • Develop and maintain a recipient-developed IQIP operations guide detailing jurisdictional IQIP program operations in alignment with the current CDC IQIP Operations Guide. • Direct consultant's work to support provider-level quality improvement according to CDC and recipient-specific IQIP requirements and operational standards. • Use available systems and tools (e.g., the IQIP Database and the IQIP Dashboard) to monitor and evaluate consultant activities and ensure program fidelity and data integrity according to CDC and recipient-specific IQIP requirements and operational standards. • Monitor the status of IQIP performance metrics compared to targets and take action to improve areas where metrics fall below established targets. Submit required mid-year and end-of-year IQIP performance metrics reports. • Assist the immunization program manager with planning IQIP program activities, setting program goals and performance metrics targets, provider selection and prioritization, and custom strategy development. • Conduct annual training for all IQIP consultants. • Conduct program orientation and initial IQIP training of all IQIP consultants including direct-hire, contract, or sub-recipient-level staff. This training must be completed before the new consultant conducts IQIP activities independently. • Observe recipient's IQIP consultant staff during at least one site visit annually. CDC recommends observing check-ins, and follow-ups as needed. • Collaborate with the recipient's IIS manager to support IQIP program activities using the IIS.
IQIP Consultants	IQIP consultants conduct IQIP activities with selected VFC providers on behalf of the recipient's IQIP program. Responsibilities include: • Conduct IQIP site visits with providers to ascertain the immunization workflow, identify opportunities for process improvement, and provide technical assistance and other resources to develop action items tailored to the individual provider. • Generate (or work with the provider to generate) provider-level immunization coverage assessment reports for baseline and follow-up progress measurements for the four IQIP cohorts. • Collaborate with provider staff through 2- and 6-month check-ins to support the selected QI strategies and related activities. • Conduct 12-month follow-ups to assess progress made on the selected QI strategies. • Ensure timely and accurate data entry into the CDC-developed IQIP Database for each stage of the IQIP cycle. • Identify and track providers conducting Alternate QI if program credit is desired.

Table 1: IQIP Staff and Support

IIS Manager	The IIS manager is responsible for the overall direction and technical management of a recipient's IIS. This includes IIS functions and operations that intersect with the IQIP program: • Support CDC's IIS functional standards, which specify the operations, data quality, and technology IISs need to support providers, immunization programs, and other immunization stakeholders. • Onboard providers for data exchange between individual provider EHRs and the IIS and national providers and the IIS to maintain interoperability, data quality and completeness and promote best practices in patient care. • Monitor and ensure high data quality in the IIS. • Deliver IIS training to stakeholders, such as IQIP staff and providers. • Work with the program manager and IQIP coordinator to support IQIP program data needs. These include immunization coverage assessment functionality according to the IQIP program's assessment specifications (cohorts, parameters, and doses) and patient lists (e.g., missed opportunities, patients due/overdue for immunization, invalid doses, etc.)
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Module 1 – Provider Selection



NOFO Requirement: Recipients are required to partner with a minimum of 25% of VFC-enrolled providers to implement the 12-month IQIP process to increase vaccine uptake.

Overview

Each budget year, recipients must initiate IQIP with a minimum of 25% of CDC-defined, VFC-enrolled providers. Additionally, recipients are required to complete the IQIP process with a minimum of 85% of VFC-enrolled providers who receive an IQIP site visit within 12 months. Before the start of the budget year, CDC calculates the number of required VFC providers participating in IQIP to meet the 25% for each recipient using VFC provider data in PEAR.

All VFC provider types are included in the calculation of total number of enrolled VFC providers. Specialty providers are not included in the total number of enrolled VFC providers used to calculate the 25% implementation requirement. Specialty providers may still participate in IQIP. Please refer to the [VFC Operations Guide](#) for more information about specialty providers.

The number of required visits does not change over the budget year, even if new providers enroll or existing providers unenroll from the VFC program. Providers must have at least one patient in one of the four IQIP age cohorts to be eligible for IQIP participation.

Recipients should set program priorities to assist in selecting the right provider for an IQIP visit. Recipients also have the latitude to change their selection and prioritization criteria from year to year to best support program priorities.

CDC encourages recipients to consider and use selection criteria that best apply to their jurisdictions but cautions against using convenience as criteria for provider selection. Selecting providers based on convenience may result in fewer opportunities to engage in immunization quality improvement work among VFC-enrolled providers serving groups with a higher risk of being under-immunized. Selection criteria may be applied individually or in combination; refer to Table 2.

Table 2: Example Provider Selection and Prioritization Criteria for IQIP

Selection Criteria	Benefit
Providers with large patient populations in any of the IQIP age cohorts	Maximizes the number of patients impacted by IQIP strategy implementation.
Providers located in areas with low immunization coverage	May focus on areas with low immunization coverage (National Immunization Survey or IIS data). However, coverage should be measured equally for all IQIP candidate providers at approximately the same selection time.
Lack of Immunization Information Systems (IIS) participation by provider	Selecting providers with minimal IIS proficiency or participation can help increase their familiarity with and use of the IIS, reduce the time it takes for clinical decision-making, and document vaccine administration data.
Time since the last IQIP cycle	Offers immunization QI support to providers the recipient has not visited in recent budget years.
Each provider participates in IQIP every 5 years	Ensures QI benefits all eligible providers within a jurisdiction and creates an opportunity to learn from high-performing providers.
Other	Additional criteria that recipients believe address the specific needs and challenges of their jurisdiction.

Module 2 – Assessment Report Generation

Overview



Program Requirement: Immunization coverage reports at the initial site visit, 6-month check-in, and 12-month follow-up

Different IQIP assessment reports inform recipients and providers when selecting QI strategies for implementation, compare progress, or evaluate year-over-year change; refer to Table 3. In addition to the immunization coverage reports required at the initial site visit, 6-month check-in, and 12-month follow-up, IQIP recommends that recipients review one or more patient line lists at the site visit. Examples include, but are not limited to:

- Patients who are missing immunizations
- Patients with missed opportunities for immunizations
- Patients with invalid doses

Table 3: Benefits of IQIP Assessment Reports		
Benefit	Report Type	
	Immunization Coverage (Required)	Patient Line Lists (Recommended)
Identify baseline coverage	✓	
Select coverage goals	✓	
Examine records of individual patients as examples of opportunities to improve performance		✓
Inform the development/delivery of technical assistance for the strategies selected	✓	✓
Compare progress at the 6-month check-in	✓	
Evaluate year-over-year coverage change	✓	

When no assessment data is available for a provider, consultants should focus on areas for improvement in their immunization workflow and completion of action items over the 12-month IQIP cycle.

Assessment Data Sources

IIS Data

IQIP consultants should generate assessment reports before the IQIP site visit and be familiar enough with the data to review it with the provider. Assessment reports should be generated using the IIS or with an assessment module integrated with the IIS. Recipients may use the provider's Electronic Health Record (EHR) if the IIS cannot generate assessment reports.

CDC recommends providers generate their own IQIP coverage assessments. Providers who generate coverage assessments regularly and share the information with staff are better equipped to measure improvement and success. If providers are not comfortable generating IIS-based assessment reports, IQIP consultants should provide technical assistance to teach them how to generate assessment reports independently. The goal is for providers to independently monitor coverage and patient line lists at regularly scheduled intervals rather than doing so only when selected for an IQIP visit.

Note on Confidentiality

Patient confidentiality is an important issue for providers. Providers may ask about state or federal regulations such as the Health Insurance Portability and Accountability Act (HIPAA).³ Consultants should be prepared to discuss provider's concerns. IQIP coordinators should address the issue of confidentiality with those conducting IQIP assessments by establishing policies and procedures for the distribution, handling, and disposal of confidential information. For example, programs can develop procedures to ensure staff protect confidentiality. Additionally, CDC has published information on the HIPPA privacy rule.⁴

Electronic Health Record (EHR) Data

EHR-based coverage data may be used for IQIP assessments when IIS data are unavailable or if the provider or birthing hospital prefers to use their EHR. IQIP consultants may assist providers in improving IIS data quality during the IQIP cycle. However, if used, the responsibility for generating EHR-based reports falls on the provider or hospital staff. The IQIP consultant is not responsible for using or delivering technical assistance for EHR software.

IQIP Without Electronic Data

CDC recognizes IIS or EHR data are not available for some providers. In those circumstances, a consultant may perform manual chart reviews to calculate coverage, but CDC discourages this practice because it is labor-intensive. While coverage assessments are beneficial, the benefits must be considered along with the costs, which include (a) time, (b) inconvenience to provider staff and use of provider space and resources, and (c) conflicting tasks (e.g., time devoted to chart pulls instead of

³ <https://aspe.hhs.gov/report/health-insurance-portability-and-accountability-act-1996>

⁴ <https://www.cdc.gov/mmwr/pdf/other/m2e411.pdf>

delivering technical assistance to the provider). When coverage assessments are not performed, the site visit, check-ins, and follow-up should be conducted as usual, but the focus will be solely on QI strategy action items, change in provider processes, and technical assistance without discussing coverage. CDC recommends providers select the “Leverage Electronic Systems” strategy and build capacity to calculate coverage with electronic data by the 12-Month Follow-Up. Consultants should brainstorm alternate data to assess change from IQIP participation (e.g., vaccine administration data) if available. If no alternate data is available, consultants should guide providers to think about other concrete outcomes to show change.



NOFO Requirement: Collaborate with IIS staff to ensure provider-level immunization coverage assessment capability for quality improvement projects.

IIS Data Selection and Management

IQIP consultants can assist providers in monitoring and supporting vaccine uptake by reviewing IIS-based assessment reports with providers. IQIP coordinators should work with their IIS staff to ensure IIS assessment reports comply with IQIP requirements, are easy to understand, and are available for providers to generate or reference.

Immunization coverage assessments are more accurate when excluding patients no longer active with the provider. It is tempting to inactivate patients to increase a provider’s coverage rate. However, recipients should ensure if a patient is inactivated, they are still assigned to a responsible party (e.g., district, city, county, or other local public health) within the geographic jurisdiction. This will ensure there is still a responsible party, or “safety net,” that will try to locate the patient and connect them with an immunization provider. For guidance on managing patient active/inactive status (PAIS) in the IIS, consult the [American Immunization Registry Association \(AIRA\)’s guidance document](#).

Interpretation of coverage assessments may be complicated by including inactive patients for whom the provider no longer holds responsibility for immunization. IQIP consultants should clarify how patients are included in the coverage assessment denominator and provide technical assistance on incorporating the IIS active and inactive status procedure for their IIS.

Patient active/inactive status links a patient to a provider for coverage assessment and reminder/recall efforts and identifies who is responsible for a patient’s immunization status. See [Patient Status in Immunization Information Systems](#) for guidance on managing PAIS in IIS, and Appendix E of the document [Template for Provider Guidance on Patient Status Management](#) for support when talking with providers about the management of their patients’ PAIS in the IIS.

Data quality improvements attributable to staff are not sustained if proper data management is not incorporated into the provider’s routine workflow. Consultants should:

- Avoid assigning tasks for provider staff to complete in advance of the IQIP site visit. Tasks assigned without context and explanation of the complete IQIP process provided during the site visit may deter the desire to participate in IQIP.
- Avoid cleaning IIS data for the provider to prevent engaging in time-consuming discussions about data validity, thus making the data the focus of the visit rather than process improvement

- Capitalize on the opportunity to teach the provider staff how to maintain their IIS data more effectively if the initial assessment reports include inactive patients

Assessment Specifications (Cohorts, Parameters, and Doses)

Recipients must select two cohorts in which the provider has active patients and for which IIS or EHR data are available. If a provider has patients in only one cohort, IQIP can proceed with a single cohort. If a provider does not have at least one patient in at least one of the four cohorts, they are ineligible to participate in IQIP.

The recommended age cohort for assessments at birth is 0-11 months; for childhood assessments it is 24–35 months; for adolescent assessments it is 13 years; and for older teen assessments it is 17 years; refer to Table 4. These parameters best facilitate evaluating immunization performance according to the ACIP-recommended immunization schedules.

Table 4: Recommended Parameters* for IQIP Coverage Assessments by Age Cohort				
	Birth[†]	Childhood	Adolescent	Older Teen
Patient age	0 years (0–11 months)	2 years (24–35 months)	13 years	17 years
Patient evaluated at/compliance by	Hospital discharge after birth	2nd birthday	13th birthday	17th birthday
Assessment “as of” date	Assessment date	Assessment date	Assessment date	Assessment date

*Variations are acceptable if assessment software cannot accommodate the recommended parameters

[†] IQIP assessment cohort added in Budget Year 1 as an allowable cohort.

CDC requires coverage assessment for certain immunizations by cohort; refer to Table 5.

Table 5: Coverage* to Report by Age Cohort

Reporting Condition	Birth [†]	Childhood	Adolescent	Older Teen
Required	HepB Birth dose	Combined 7-vaccine series [§] 4 DTaP 3 IPV 1 MMR UTD hepB 1 VAR	1 Tdap 1 MenACWY 1 HPV UTD HPV	1 Tdap 2 MenACWY UTD HPV 1 MenB
Optional	1 RSV	UTD Hib UTD PCV UTD RV 2 hepA UTD Influenza UTD COVID-19	UTD hepB 2 MMR 2 VAR 2 hepA UTD IPV UTD Influenza UTD COVID-19	UTD Influenza UTD COVID-19

* See [Healthcare Professionals: Child and Adolescent Immunization Schedule by Age | Vaccines & Immunizations | CDC](#) for more details on recommendations.

[†] For more information about the newly added birth cohort, see Module 11 – IQIP With Birthing Hospitals.

[§] Combined 7-vaccine series: 4:3:1:UTD:UTD:1:UTD

See Table 24 in Module 11: IQIP in Birthing Hospitals of this guide for more information on measuring hepB and RSV coverage for the birth cohort.

All providers benefit from periodic performance assessments, regardless of the size of the patient population. Recipients may deviate from recommended assessment parameters if the parameters cannot be accommodated by available assessment software. Recipients unable to produce the recommended IQIP coverage reports should evaluate their IIS and EHR functionality to determine the most suitable measures. Consultants should always use the same parameters for both the initial, 6-month, and the 12-month follow-up assessments.

Timing and Generation of Assessment Reports

Consultants must review initial, 6-month, and 12-month coverage reports with provider staff except in instances where IIS or EHR data are not available for assessment. Assessment reports should be generated within 1 week of the site visit, 6-month check-in, and 12-month follow-up to accurately reflect the provider's coverage at those times (i.e. refrain from running coverage reports in bulk for site visits that will be conducted at different times). If this is not possible (e.g., scheduling difficulties), reports must be run no earlier than 1 month prior. Coverage data must be reported in the IQIP Database within 10 days of each IQIP encounter. CDC encourages using patient line lists during the site visit to demonstrate examples in the provider's practice where immunization delivery processes could be improved. See Patient Line Lists in Module 6 – Site Visit for guidance on their use.

Assessment reports may be generated and analyzed more frequently than CDC requires, but this practice is discouraged unless there is ample capacity. In general, providers should run assessment reports at a frequency greater than that required by CDC only when they can generate—or are taught to generate—the assessment reports independently.

Module 3 – IQIP Data Systems

Overview

IQIP uses multiple data systems to collect, report, and visualize data. Recipients access and use these systems via the SAMS Partner Portal. Key systems include:

- **IQIP Database:** the system for entering, monitoring, and exporting IQIP data. It is built on the REDCap platform.
- **IQIP Dashboard:** the system that provides visualizations of IQIP data for monitoring IQIP program implementation, such as data quality, trends, and timeliness of site visits, check-ins, and follow-ups. The dashboard runs on a PowerBI platform and presents data from the IQIP Database and is refreshed regularly.
- **IQIP Awardee Performance Metrics (APM) Tool:** the tool for setting targets, mid-year, and end-year IQIP metrics reports. It is built on the REDCap platform. These reports are only available to IQIP coordinators or their designees.

IQIP Database

The IQIP Database is a data entry system built on the REDCap platform. IQIP consultants record provider-level data and notes at each step of the IQIP cycle. The IQIP Database is designed to:

- Offer simple navigation and data management
- Assist with scheduling and planning visits, check-ins, and follow-ups by offering calendar functionality
- Facilitate the delivery of technical assistance customized to each provider using narrative data entry fields
- Generate editable reports to share with providers
- Provide a dashboard to monitor visit status throughout the IQIP cycle
- Simplify retrieval of data and reports for review and analysis
- Reduce unnecessary data entry

Database Access and Questions

Immunization program managers should submit requests for new staff to gain access to the IQIP Database to their CDC IOSB project officer.

Recipients with questions about the IQIP Database should first consult the IQIP Database User Guide. Any questions that remain after consulting these documents should be sent to IQIPDatabase@cdc.gov.

- Record data for providers engaged in IQIP or an alternate QI program; see Module 10.

IQIP Database User Guide and Training Resources

The IQIP Database is an essential part of conducting IQIP activities. IQIP coordinators and consultants should be knowledgeable and comfortable using its various features. For an outline of the resources, recipient IQIP staff should review, refer to Table 6.

Table 6: IQIP Database Resources		
Resource	Description	Location
IQIP Database User Guide	Provides an overview and screenshots of IQIP Database features; a step-by-step tutorial for data entry and monitoring for the entire IQIP cycle; and guidance for working with data reports	IQIP Database File Repository VFC CAMP Knowledge Center
IQIP Consultant Training Packet – Session 3: IQIP Database	Provides an overview of the IQIP Database, including its purpose, features, and applications. This training session includes an adaptable PowerPoint slide deck and training activity.	VFC CAMP Knowledge Center

The IQIP Dashboard

Data entered in the IQIP Database is visualized through the IQIP dashboard. IQIP coordinators can request access to the IQIP dashboard for consultants. For more information on the IQIP dashboard, see Module 12 – Program Management and Oversight.

Module 4 – IQIP Core Strategies

Overview

IQIP supports the implementation of ongoing improvement of four provider-level QI strategies – facilitate return; leverage electronic systems; strong recommendation; and strengthen immunization communication – to increase immunization coverage. Provider assessment and feedback is also a best practice recommended by the Community Guide ([Guide to Community Preventive Services, 2015](#)). The relationship between an IQIP consultant and the VFC provider is designed to support the assessment and feedback process. This module presents the four IQIP core strategies and provides a strategy overview, rationale, and examples of best practice implementation.

IQIP Core Strategies	
Facilitate Return 	Leverage Electronic Systems 
Strong Recommendation 	Strengthen Immunization Communication 

NOFO Requirement: Collaborate with providers to implement at least two quality improvement (QI) strategies, selecting at least one of the following: Strengthen Immunization Communications to Address Vaccine Hesitancy or Give a Strong Immunization Recommendation.

Implementing Multiple Strategies Amplifies Impact

While many strategies have been shown to increase immunization coverage, the most effective efforts implement multiple strategies simultaneously ([Cataldi et al., 2020](#)). The Community Preventive Services Task Force recommends combining interventions targeting different areas for improvement ([Guide to Community Preventive Services, 2015](#)). Consequently, IQIP requires that providers select two core strategies.



Facilitate Return for Immunization

Strategy Overview and Rationale

This core strategy focuses on implementing processes that support making and keeping immunization appointments and addressing barriers to patients returning for timely immunizations. Providers can improve access to immunizations by ensuring the next appointment is scheduled before the patient leaves the office, expanding practice hours or locations, allowing walk-in immunization-only appointments, and removing barriers to immunization. Multiple studies have evaluated the positive impact of facilitating patient return for immunization including:

- Distance to and referral outside of primary care providers to receive immunizations are two key barriers to accessing immunization services, especially in rural areas according to a systematic review ([Albers et al., 2022](#)).
- Standing orders and nurse only visits are recommended by The Community Guide. An implementation study conducted in 2021 found the number of immunizations administered to pediatric patients doubled after the introduction of standing orders to allow immunization at any visit ([Dorn & Knudson, 2021](#)).
- In a 2023 study workflow changes successfully removed barriers to immunization for children with developmental disabilities or phobias ([McDonald et al., 2024](#)).

Best Practices for Strategy Implementation

The following list of activities serve as examples of best practices for implementation:

- Use effective scheduling protocols to schedule the next appointment before the patient leaves the office, either in the exam room or during check-out
- Use presumptive language when scheduling the next appointment instead of asking the patient or caregiver if they want to schedule the next appointment
- Build out clinic schedules into the future to prevent caregivers from needing to remember to call back once the schedule opens
- Allow online self-scheduling tools to reduce barriers to scheduling among patients or caregivers who prefer contact-less options
- Inform parents of future vaccine dates by giving parents a copy of their child's current immunization record and a list of future recommended vaccines with precise due dates
- Prevent missed opportunities by screening and offering immunizations at each visit regardless of the type of visit (e.g., well-child, sports physicals)
- Increase access to immunizations by offering various types of appointments and expanding hours or locations:

- Create standing orders for nurse-only appointments
- Expand clinic hours to accommodate working families
- Offer immunizations at satellite locations or community events for easy access
- Address barriers to immunization by accommodating patients with special needs to reduce patient stress. Accommodations could include low stimulus clinic environments, longer appointment times, or in-car immunizations.

Leverage Immunization Information Systems (IISs), Electronic Health Records (EHRs), or Electronic Systems to Improve Immunization Practices

Strategy Overview and Rationale

On-time immunization depends on tracking patient immunization status and being aware of which vaccines a patient is due for. Providers can use their IIS or EHR to maintain patient immunization information, determine patient immunization status, and effectiveness. During the IQIP cycle, consultants should help providers understand the importance of ensuring patient IIS data are accurate, timely, and complete. Reminder and recall lists, vaccine forecasts, and coverage assessments can reveal valuable information on improving immunization, identifying missed opportunities, and monitoring overall performance.

Many studies describe the advantages EHR and IIS offer providers in their immunization practice:

- Reminder/Recall is a way to remind someone to get vaccinated or to recall them to come back and receive another immunization. This is an established best practice across age groups for improving immunization delivery as supported by a Cochrane review of 75 studies ([Vann et al., 2018](#)) and 2021 review ([Kempe et al., 2021](#)).
- A study examining the feasibility of using e-mail for seasonal influenza immunization reminders to parents of adolescents found practice-based email reminders are feasible and can increase influenza immunization coverage rates among adolescents ([Dombkowski et al., 2017](#)).
- Text message reminders improved compliance with routine childhood immunizations among 0-2 year olds in a 2025 study ([Rosen et al., 2025](#)).
- A 2021 study found that EHR-based provider reminders (also called Best Practice Alerts) enhanced with IIS-based clinical decision support resulted in a significant increase in completion of the primary immunization series in both well-child and acute care visits among most age groups and several immunization types ([Stephens et al., 2021](#)).

Best Practices for Strategy Implementation

The following activities serve as examples of best practices for implementing this strategy. Although not an exhaustive list, these are standards that providers should strive to meet and may adapt:

- Use reminder and recall systems to communicate with patients' parents/guardians about appointments (e.g., future well-child, immunization-only, and follow-up acute appointments).
- If automated reminder and recall systems are not available, generate patient line lists routinely to identify patients who are not up-to-date and schedule appointments.
- Use best practice alerts to assess immunization status, prompt providers to offer all immunizations that a patient needs at every patient encounter.

Capacity Building

Capacity building is crucial for increasing immunization coverage and strengthening public health systems. It involves developing and enhancing the skills, resources, and infrastructure needed for effective immunization delivery and management.

The below action items alone do not lead to increased immunization coverage. However, they are necessary to build capacity.

- Assess practice performance and generate practice-level coverage reports at regularly scheduled intervals for single vaccine and combination series for various age cohorts.
- Keep records up to date by:
 - Monitoring electronic data submissions to the IIS to leverage the full benefit of complete immunization records and vaccine recommendations supported by CDC's [Clinical Decision Support for Immunization \(CDSi\)](#) specifications.
 - Maintaining accurate patient contact information by verifying and updating patient contact information at each appointment.
- Report all historical and administered immunization data routinely to support complete patient records and more accurate immunization forecasting.



Give a Strong Immunization Recommendation

Strategy Overview and Rationale

Immunization depends on parents choosing to vaccinate their children, and providers play a critical role in increasing parents' vaccine confidence. Parents consider their child's healthcare professional one of the most trusted immunization information sources. This "Give a Strong Immunization Recommendation" strategy covers how the provider introduces the topic of immunization, presents immunization recommendations to parents, and addresses their concerns.

All verbal or interpersonal communications between the provider staff and the caregiver/patient falls under this strategy, which focuses on helping the provider adopt or improve upon making a strong Immunization Quality Improvement for Providers (IQIP) Operation Guide | Updated | 7/1/2025

vaccine recommendation. Implementing this strategy will support providers in addressing gaps in coverage that may exist due to vaccine hesitancy. This strategy is not exclusive to the prescriber; all provider staff who communicate with patients can be part of this strategy.

Several studies have linked making a strong immunization recommendation to increased vaccine confidence and acceptance, thus increasing immunization coverage.

- Adolescents in a 2022 study were more likely to receive HPV immunization if their child's doctor provided consistent messaging on cancer prevention ([Bernstein et al., 2022](#)).
- Providers trained to use the presumptive announcement approach for HPV immunization saw more significant increases in HPV immunization coverage among their patients relative to coverage among control clinics in a 2017 randomized clinical trial ([Brewer et al., 2017](#)).
- One 2018 study showed that vaccine-hesitant parents and caregivers were more likely to accept immunizations when their child's provider used presumptive immunization language ([Opel et al., 2018](#)).
- A 2022 study found that motivational interviewing to address vaccine hesitancy was associated with significantly higher immunization coverage rates among patients aged 0 to 6 years ([Cole et al., 2022](#)).

Best Practices for Strategy Implementation

The following list details examples of best practices for implementation:

- Use effective communication approaches when recommending immunizations including presumptive language, motivational interviewing, the bundling approach, and sandwiching recommendations
- Listen to parents and seek to understand the concerns behind parents' questions before responding. Willingness to listen and acknowledge parents' concerns plays a role in building trust
- Train providers to recognize and acknowledge the reason(s) that some parents are hesitant about immunizations



Strengthen Immunization Communication to Address Vaccine Hesitancy

Strategy Overview and Rationale

Confidence in vaccines is built through conversations between parents, doctors, nurses, pharmacists, and community members. Everyone is essential in supporting immunization, from the front desk to the exam room to checkout.

The Strengthen Immunization Communications strategy covers both internal communications (e.g., staff meetings), non-verbal external communications (e.g. websites, social media), internal staff

training, and building a coordinated, supportive approach to immunizations. It also includes other approaches to immunization messaging, including displaying immunization posters in the waiting room and examination rooms and providing immunization-related content in e-mails, mailings, website content, and social media posts.

Studies have linked web-based educational content to improved vaccine acceptance:

- A 2020 study identified that primary care practices with the greatest gains in identifying missed opportunities were those that built multi-disciplinary teams, including medical directors and front desk staff ([Cataldi et al., 2020](#)).
- A 2017 study found increased on-time immunization among infants whose parents were provided with web-based content about immunizations, including social media options while pregnant ([Glanz et al., 2017](#)).
- Participants in a 2018 HPV communication intervention that produced a significant reduction in missed opportunities for immunization reported that communication training and fact sheets were the most used and useful components ([Dempsey et al., 2018](#)).
- Tailoring messaging to your target audience and using clear language are both especially important ([Lama et al., 2021](#)).
- A 2019 study identified several common facilitators to implementing an effective HPV immunization promotion program ([Escoffery et al., 2019](#)):
 - Designating an Immunization Champion to encourage program objectives, reinforce immunization as a priority, and ensure that education and messaging spread consistently among clinic staff
 - Training and education for staff increased their confidence in immunizations and their ability to talk with patients and caregivers. Training was important for all staff including frontline workers and medical assistants.
 - Ensure availability of tools and resources to prompt a discussion on immunizations. Posters in waiting rooms and patient rooms help patients to start thinking about immunizations before the provider walks into the room.
- A 2020 study interviewed primary care practices that achieved a 20 or more-percentage point improvement in missed opportunities for HPV immunization. Researchers found that these practices' QI projects had common characteristics of leadership support, multidisciplinary teams, a collaborative atmosphere, and practice champions. In addition, the teams in these practices "often had broader representation, including the practices' medical director and/or practice administrator, the chief medical officer (if part of a health system), or front desk staff" ([Rand et al., 2020](#)).

Best Practices for Strategy Implementation

The following list of activities serves as examples of some of the best practices for implementing this strategy.

- Educate patients and parents by including educational material on immunizations (e.g., one-pagers, posters) in welcome packets for new patients, waiting rooms, and exam rooms
 - Facilitate access to reliable online information about immunization by incorporating immunization-related content and links on provider websites and ensure the content is routinely updated
- Foster a coordinated, supportive approach to immunization by making immunization education and promotion a team effort:
 - Appoint an immunization champion to help the provider team maintain focus on their IQIP coverage goals. Champions can create enthusiasm and a sense of cohesion among staff as well as serve as an internal advocate for implementing IQIP strategies.
 - Develop a multidisciplinary and collaborative team to implement, monitor, and support immunization initiatives
- Provide routine training about vaccine preventable diseases, recommended vaccines, and the ACIP schedule to all staff

Available Resources to Support IQIP Core Strategy Implementation

Additional resources for IQIP program coordinators and consultants such as program guidance, job aids, checklists, and templates are available in VFC CAMP Knowledge Center. Immunization program managers may request access for IQIP staff through their assigned ISD Immunization Operations and Services Branch (IOSB) project officer.

Module 5 – Pre-Site Visit

Overview

The IQIP site visit has several components which include reviewing the provider’s immunization workflow, discussing the provider’s initial assessment reports, and collaborating with the provider to review and select quality improvement strategies. To complete all components, consultants must prepare for the site visit. Efficient planning will result in a smooth, coordinated site visit that allows the provider staff to be fully engaged.

Recipients will find CDC’s site visit preparation steps for consultants in the IQIP Preparation Checklists resource in VFC CAMP Knowledge Center. Recipients may develop additional tools to assist with consultant preparation.

NOTE: Consultants should confirm that each provider is in the IQIP Database before the site visit to support timely data entry and notes.

CDC suggests conducting IQIP site visits independently from VFC compliance visits when possible. When recipients must perform combined visits, enough time must be allotted to observe provider workflow fully and engage appropriate staff in a discussion of QI strategy implementation.

Planning an IQIP Site Visit

When planning an IQIP site visit, consultants should consider:

- How and when to initiate contact with the provider
- What content to include in the communication sent to the provider staff prior to the visit
- Which assessment reports should be run prior to the visit
- What additional provider is needed prior to the visit (e.g., previous visits, VFC issues, etc.)
- What materials and resources to have at the visit
- What materials to leave with the provider staff after the visit is completed

Arranging an IQIP Site Visit

Scheduling procedures should include the following:

- Determine if the site visit will be in-person or tele-IQIP. If the site visit will be done via tele-IQIP, see the “IQIP Tips” resource for tele-IQIP best practices in the VFC CAMP Knowledge Center.
- Identify a contact person at the provider to discuss logistics (physical space, virtual platform, staff in attendance, etc.). Confirm their job title, e-mail address, and phone number. Remember that the appropriate contact for IQIP may not be the VFC primary or backup coordinator. Confirm that the contact person is knowledgeable, can discuss immunization workflow, and can support the implementation of strategies at the provider.
- Explain the purpose and goals of participation in IQIP. This is an appropriate time to determine if the provider is actively engaged in immunization QI projects and is available to participate in an IQIP cycle. If the provider is already engaging in a different QI activity, the consultant should notify the IQIP coordinator to determine if the QI program should be submitted to CDC for alternate QI program credit for the provider (see Module 10 – Alternate QI Program Credit.).
- Discuss with the contact person the estimated time needed for the site visit. Site visits typically take 1-2 hours to complete.
- Discuss with the contact person the importance of physicians and other immunization prescribers participating, along with the immunization champion (see The Role of the Immunization Champion resource in the VFC CAMP Knowledge Center), QI coordinator, nursing, and office management staff, being present during the site visit. This is important because any workflow, policy, or procedure changes require their buy-in and approval. If conducting a combination VFC/IQIP visit, participation is needed from more than the VFC coordinator alone.
- Confirm provider information (e.g., address, safety protocols, entry requirements).
- Confirm the cohorts served by the provider.
- Outline any consultant on-site needs (e.g., meeting space, workstation, or power source).
- Send a confirmation letter or e-mail (see IQIP Site Visit Confirmation Letter template in the IQIP Library) to the contact person that includes:
 - Date and time of site visit
 - The benefits of implementing immunization QI at the provider level
 - What to expect during the site visit, check-ins, and 12-month follow-up. Consider including the IQIP At-A-Glance for Providers resource in the VFC CAMP Knowledge Center.
 - IQIP consultant contact information
- Confirm the site visit 2-3 working days before the appointment.

Preparing for the IQIP Site Visit

Effective planning for the site visit is critical to ensure the consultant has all the information and resources needed to conduct the site visit. Consultants should consider the information required to optimize their time with the provider. Types of helpful information include:

- General knowledge about the patient population served by the provider (e.g., race/ethnicity, socioeconomic status, insurance status, languages spoken, rural or urban setting)
- Additional immunization services in the community (e.g., immunization providers in areas with few immunization providers)
- Cohorts served by the provider
- Staffing information, including an immunization champion, a lead physician, and additional staff with decision-making authority
- Any immunization-related content (e.g., links to trusted immunization resources, etc.) on the provider's communication platforms (e.g., websites, social media, etc.)
- Data and information from previous QI visits
- IIS reporting method (e.g., bi-directional query, HL7, direct data entry, batch transfers, etc.)
- IIS reporting status (e.g., potential data quality issues, submission frequency, generation of recall or reminder messages, vaccine inventory, etc.)
- Assessment reports (if generated before the site visit, see Module 2 – Assessment Report Generation)

Consultants should also prepare and collect materials and resources to support discussions with the provider. The support tools include but are not limited to:

- Tools for documenting site visit information:
 - Laptop/tablet with internet access, or
 - Paper copy of the IQIP Site Visit Form. For a hard copy of the IQIP Site Visit Form, download and print a PDF of the instrument from the IQIP Database.
- Recipient-specific IQIP Operations Guide and other recipient-developed materials.
- Items from VFC CAMP Knowledge Center (e.g. material related to QI strategies, samples of parent-focused educational material, and provider-focused training material)
- Assessment reports (if generated before the site visit, see Module 2 – Assessment Report)

Module 6 – Site Visit



NOFO Requirement: Partner with a minimum of 25% of VFC-enrolled providers to implement the 12-month IQIP process to increase vaccine uptake.

Overview

The IQIP site visit sets the foundation for the rest of the IQIP cycle. Through observation, discussion, and collaboration, the provider and IQIP consultant identify areas for improvement with the goal of increasing immunization coverage. This is accomplished through a review of the provider's immunization workflow and an optional review of assessment reports (i.e. initial immunization coverage data and patient line lists) in relation to IQIP core strategies. The consultant and provider staff then collaborate to set 12-month coverage goals, select strategies, and develop action items to reach those goals. The consultant also provides or arranges for any technical assistance needed to help the provider implement the selected QI strategies.

The site visit should proceed in the following order (also see the IQIP Site Visit Process Diagram in the VFC CAMP Knowledge Center):

1. Start the site visit with introductions, the purpose of the visit, and an overview of the IQIP process.
2. Conduct the immunization workflow assessment.
3. Review the findings of the provider's immunization workflow assessment in combination with the provider's assessment reports to identify gaps and potential strategies.
4. Select at least two IQIP strategies (one of the strategies must be a communication strategy).
5. Develop action items for both strategies.
6. Set 12-month coverage goals.
7. Provide or arrange for technical assistance as needed.
8. Wrap up by discussing next steps and establishing check-in and follow-up dates.

NOTE: If the appropriate staff (i.e. practice manager, nurse manager, prescriber) is absent, plan with provider staff for how they will be included in IQIP discussions and action items.

Tele-IQIP Option

CDC recommends that site visits are conducted in-person, but recipients are permitted to conduct site visits virtually. This site visit method is called “Tele-IQIP.” If recipients allow consultants to conduct tele-IQIP visits, they must ensure that the following criteria are met:

- IQIP consultants must use a virtual platform with screen sharing functionality (to ensure effective presentation of documents and demonstration of software) and video conferencing (to increase engagement and allow for visual cues).
 - The virtual platform should be able to be used continuously for the duration of the site visit.
 - The virtual platform must be HIPAA-compliant to provide patient privacy protection.
 - Consultants must be proficient and confident using the recipient’s chosen video-conferencing application.
- The visit must adhere to existing IQIP guidance for site visits and documentation, which includes participation by prescribers and other decision-makers.
- The visit must include a verbal or video walkthrough of the provider’s workflow for patients receiving immunization services.

For site visits that will be done via tele-IQIP, see the “IQIP Tips” resource for tele-IQIP best practices in the VFC CAMP Knowledge Center.

Note-Taking and Data Collection During the Site Visit



NOFO Requirement: Requirement: Documentation of the site visit in the IQIP Database is required within 10 business days after the site visit.

The IQIP consultant should make the site visit as engaging and interactive as possible while at the same time recording the notes and data necessary to (a) provide meaningful technical assistance and monitoring during the IQIP cycle and (b) record visit information accurately in the IQIP Database. CDC encourages the IQIP consultant to take notes and collect data using the most comfortable and least distracting method during the visit. Available options include:

- Entering notes and data directly into the IQIP Database. This is the most efficient option from a data entry perspective when internet connectivity is available.
- Using electronic notes or a blank printed of the CDC IQIP Site Visit Form. For a hard copy of the IQIP Site Visit Form, download and print a PDF of the instrument from the IQIP Database.

NOTE: Recipients may create their own site visit form tailored to their IQIP program for consultant use. However, any recipient-designed form must consist of all CDC-required documentation elements.

Starting the Site Visit

It is essential to familiarize both the consultant and provider participants with the names and roles of those in attendance, what to expect during the site visit, and to preview the remaining steps of the IQIP cycle. Starting the site visit should include the following:

- **Introductions**—The consultant introduces themselves and asks those in attendance to state their name and role in the office regarding immunization.
- **Purpose of the Site Visit** – The consultant explains the purpose of the site visit as the first step in a 12-month collaborative QI project where participating staff:
 - Describe their immunization workflow
 - Identify opportunities for improvement
 - Select strategies to address those opportunities
 - Create action items to implement selected strategies
 - Identify any technical assistance needed
- **Overview of the IQIP cycle** – The consultant explains the IQIP process, including a description of what will happen during the site visit, the 2- and 6-month check-ins, and the 12-month follow-up.

The Role of the Immunization Champion

The immunization champion is a staff member who reinforces immunization as a priority within the clinic. Their role can include monitoring the practice's immunization coverage or ensuring all staff are trained in their role in immunization delivery and patient education. An immunization champion can be a key facilitator and help support IQIP activities. For examples of how an immunization champion can promote immunization in the clinic, see “The Role of the Immunization Champion” in the VFC CAMP Knowledge Center.

Immunization Workflow Assessment



IQIP Program Requirement: Awardees should assess the provider's immunization workflow prior to discussing coverage assessment data.

When assessing a provider's immunization workflow, an IQIP consultant is conducting a gap analysis that compares a provider's current immunization-related activities to best practices. The consultant and the provider then use this information in combination with the IQIP assessment reports to select QI strategies and plan the 12-month IQIP cycle. Because workflow assessment findings should drive IQIP strategy selection and action item development, any discussion of immunization coverage should occur after the workflow assessment is completed.

For guidance on communication strategies for leading the workflow assessment discussion, see “Effective Communications Strategies for Consultants” in the VFC CAMP Knowledge Center.

First Workflow Point: Practice Management

Staff in practice management roles oversee and coordinate the administrative and operational aspects of medical practices. In this capacity, they have influence over resources and systems needed to support immunization practice, including policies and procedures (i.e. operational workflow), patient record management (e.g., electronic health record (EHR) system), training and education, and staffing.

The purpose of the immunization workflow assessment is to identify opportunities for providers to improve their immunization performance by taking steps to implement or improve upon immunization best practices. While specific best practices may be implemented at subsequent workflow points, practice management plays a key role in the planning and preparation necessary for them to be implemented. For example:

- To implement nurse-only immunization appointments, standing orders must also be adopted. This task requires new policies, education and training.
- To implement best practice prompts in the EHR, a system enhancement or technical support from the vendor may be necessary.
- To implement use of motivational interviewing for immunization counseling, providers must first receive education and training.
- To more fully promote immunizations to their parents and patients, educational resources must be created or acquired along with a system for distributing and maintaining them.

While selecting strategies and developing action items to implement IQIP strategies, consultants should be aware that some action steps may need to be performed by practice management staff to set the stage for implementation by other staff. Table 7 below lists the IQIP core strategies and best practices related to practice management.

Table 7: IQIP Strategies and Best Practices, Practice Management	
Strategy	Best Practice
Facilitate Return	• Standing orders and nurse-only appointments • Expanded clinic hours • Community Events • Build schedules further into the future • Allow patients to self-schedule appointments
Leverage Electronic Systems	• EHR best practice alerts/immunization prompts • Routine reporting of historical and administered immunizations to IIS • Routine generation of coverage assessments • Routine review and update of patient active/inactive status in IIS (pair with reminder/recall)
Strong Recommendation	• Presumptive language training • Immunization recommendation trainings • Motivational interviewing training

Strengthen Immunization Communications	• Immunization champion • Create a coordinated, supportive approach to immunization • Routine immunization education and training • Immunization education resources throughout office • Incorporate immunization content into website and social media
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Second Workflow Point: Front Desk

Front desk staff organize patient information for upcoming appointments and help immunization tasks proceed smoothly by ensuring that patient records are accurate and complete. They are also the first point of provider interaction and play a crucial role in making patients feel welcome and supported during their visit.

When leading the discussion about front desk staff activities, the consultant should gain a complete understanding of the provider's routine check-in processes for scheduled and unscheduled appointments and their impact on the quality of patient information, immunization recommendations, and patient/family confidence in immunizations. The consultant's assessment identifies any missing processes that may lead to inaccurate immunization records or recommendations, returned immunization recall notices. Table 8 lists the IQIP core strategies and best practices related to this workflow point.

Table 8: IQIP Strategies and Best Practices, Front Desk	
Strategy	Best Practice
Facilitate Return	• Verify and update contact information at every visit
Leverage Electronic Systems	• Prepare immunization history • Immunization screening at every visit (e.g. well-child, sports physicals, sick visits) • Update patient status in the IIS • Issue reminders for upcoming appointments • Recall patients overdue
Strong Recommendation	• Positive immunization messaging • Answer/refer immunization questions
Strengthen Immunization Communications	• Provide immunization education resources in new patient packets

Third Workflow Point: Prescriber Discussion and Exam

At this point in the workflow, the prescriber (e.g., physician, nurse practitioner) identifies and recommends all eligible immunizations due and answers any questions. When discussing this workflow point, the consultant should gain an understanding of

- How the prescriber determines the immunizations the patient is due to receive,
- If they recommend all immunizations the patient is eligible for at every visit,

- How they make their immunization recommendation, and
- How they respond to questions or hesitancy.

When discussing how the provider determines which immunizations the patient is eligible to receive, the consultant identifies the source of the immunization recommendations and identifies available options for leveraging available electronic systems to improve the accuracy of their recommendation. When discussing how the provider makes their immunization recommendation, the consultant assesses whether the provider could improve their recommendation further by updating their communications strategy. Table 9 lists the IQIP core strategies and best practices related to this workflow point.

Table 9: IQIP Strategies and Best Practices, Prescriber Discussion and Exam	
Strategy	Best Practice
Leverage Electronic Systems	• EHR best practice alerts/immunization prompts
Strong Recommendation	• Recommend eligible immunizations at every visit (e.g., well-child, sports physicals, sick visits) • Strong recommendation • Presumptive language • Sandwiching recommended immunizations • Listen to parents and answer questions • Motivational interviewing

Fourth Workflow Point: Immunization

At this workflow point, clinical staff administers and documents immunizations in the patient's medical record. In addition, staff can use presumptive language and other communications strategies to create a future commitment to vaccinate and schedule the next appointment. When discussing this workflow point, the consultant develops a complete understanding of how future immunization are discussed and scheduled. Table 10 lists the IQIP core strategies and best practices related to this workflow point.

Table 10: IQIP Strategies and Best Practices, Immunization	
Strategy	Best Practice
Facilitate Return	• Schedule next immunization appointment
Strong Recommendation	• Use effective communication approaches including presumptive language • Listen to parents and seek to understand their concerns before responding

Fifth Workflow Point: Patient Check-Out

During patient check-out, provider staff schedule patients’ return appointments and provide a visit summary with immunizations administered and the date of their next appointment. This is also the final workflow step and the last opportunity for provider staff to interact with parents and patients before they leave the office. When discussing this workflow point, IQIP consultants develop a complete understanding of how the provider ensures the patient has a date and time at which they will return for future immunization, understands the importance of keeping that appointment, and expects future communications. The consultant’s assessment identifies any opportunities for staff to leverage electronic systems, use presumptive language or other immunization communications strategies to support the patient’s return to receive their next immunization. Table 11 lists the IQIP core strategies and best practices related to this workflow point.

Table 11: IQIP Strategies and Best Practices, Check-Out	
Strategy	Best Practice
Facilitate Return	• Schedule next immunization appointment • Copy of immunization record • After-visit summary with list of future recommended immunizations and clear on-or-after dates
Leverage Electronic Systems	• Offer/set up appointment reminders
Strong Recommendation	• Presumptive language

Review Assessment Reports and Data with Providers

Discussion of assessment reports and data during the site visit help the IQIP consultant and provider staff identify performance gaps, select appropriate QI strategies, and tailor action items and technical assistance to areas of greatest need. Consultants should review coverage assessment reports for all assessed vaccines with provider staff (e.g., coverage for the combined 7-series should be reviewed, as well as the coverage of each vaccine in that series) as well as available patient lists. Assessment reports should be discussed after the provider’s immunization workflow assessment is complete. Assessment report specifications (i.e. coverage and patient lists) are described in Module 2-Assessment Report Generation.

Immunization Coverage

Initial coverage data for series and individual immunizations provide a baseline indicator of the provider’s immunization performance. Nearly all providers have room to increase immunization coverage for their practice. Baseline coverage for some doses may be lower than others. In cases where data are unavailable, the provider’s current level of strategy implementation can guide future

activities.

Interpretation of coverage assessments and patient lists may be complicated when inactive patients for whom the provider no longer holds responsibility for immunization are included in the provider's population. If this situation arises during the assessment report discussion, the consultant should explain IIS active and inactive status, that there is a way in their IIS to remove the patient from the list, which can be discussed along with other technical assistance after strategies have been selected. For more information on managing patient active/inactive status (PAIS), see Module 2 – Assessment Report Generation.

Patient Lists

Patient line lists provide the opportunity to examine provider immunization performance at the individual patient or patient visit level. They can aid in identifying the root causes of missed opportunities or other lapses in immunization workflow. Types of patient lists, demonstrations that the consultant can provide, and how the information can be translated into QI strategy selection are below.

Missed Opportunities List

A missed opportunities list identifies immunizations that patients were eligible to receive but did not. Comparing the missed opportunities list and the provider's medical records can identify errors in reporting to the IIS or process issues such as inaccurate assessment of a patient's immunization status or lack of familiarity with the ACIP schedule. Once the root cause of the missed opportunity is found, the consultant should suggest an IQIP strategy that would help prevent similar missed opportunities in the future. While sharing this report with the provider, the consultant should invite them to choose a patient from the list, look up their visit record, and compare it to the information on the missed opportunities list.

- If there are immunizations in the medical record that are not on the IIS missed opportunities list, then the consultant should determine why the immunization was not in the IIS.
- If the immunizations in the medical record and on the missed opportunities report match, then the consultant should investigate why the patient did not receive the immunization for which they were eligible.

Invalid Doses List

An invalid doses list identifies immunization doses administered that were either too early or too late according to the dosing intervals indicated on the ACIP schedule. Comparing the invalid doses list and the provider's medical records can identify errors in reporting to the IIS or process issues such as a scheduling error, lack of familiarity with the ACIP schedule, or low vaccine confidence. Once the root cause of the invalid dose is found, the consultant should suggest an IQIP strategy that would help prevent similar errors in the future. As with the missed opportunities list, the consultant should invite the provider to choose a patient from the list, look up their visit record, and compare it to the information on the invalid doses list.

- If there are doses in medical record that are not on the invalid doses list that are within the

recommended dosing interval, then the consultant should determine why the immunization was not in the IIS.

- If the immunizations in medical record and on the invalid doses list match, then the consultant should investigate why the patient did not receive the immunization at the recommended dosing interval.

Patients Overdue List

A patients overdue list identifies patients seen by the provider that are overdue for one or more immunizations. This exercise can identify lapses such as scheduling errors, lack of follow-up on no-shows, lack of familiarity with the ACIP schedule, or low vaccine confidence. Once the root cause of the overdue patient is found, the consultant should suggest an IQIP strategy that would help prevent similar errors, in the future and help the provider develop action items to implement the strategy. As with the previous lists, the consultant should invite the provider to choose a patient from the list, look up their visit record, and compare it to the information on the patients overdue list.

- If there are doses in the patient’s medical record that are not in the IIS, then the consultant should determine why the immunization was not in the IIS.
- If the immunizations in the medical record and on the overdue list match and the patient is truly overdue for immunizations, then the consultant should ask if the patient missed an appointment or perhaps wasn’t scheduled for their next immunization appointment.

NOTE: Patient line lists should be used as demonstrations if needed. Some jurisdictions generate patient line lists and encourage providers to schedule immunization appointments for all patients on those lists as an intervention measure. However, CDC does not recommend this approach unless the practice will be adopted and performed by provider staff at regularly scheduled intervals. For more information on this topic, see the “Developing Action Items that Increase Immunization Uptake” section below.

Setting 12-Month Coverage Goals

After reviewing coverage, the consultant and provider staff collaborate to set ambitious but attainable coverage goals to work toward during the 12-month IQIP cycle. IQIP requires coverage goals that vary by cohort. Refer to Tables 12 through 16 for details.

Table 12: Required and Optional IQIP Coverage Goals by age Cohort				
Coverage Goals	Birth [†]	Childhood	Adolescent	Older Teen
# of Goals Required	1	2	2	2

Required	HepB birth dose	Combined 7-series* & one additional vaccine	1 HPV & one additional vaccine	1 MenB & one additional vaccine
Additional Vaccines to Consider	RSV	4 DTaP 3 IPV 1 MMR UTD hepB 1 VAR UTD Hib UTD PCV UTD RV 2 hepA UTD Influenza UTD COVID-19	1 Tdap 1 MenACWY UTD HPV 1 MenB UTD hepB 2 MMR 2 VAR 2 hepA UTD IPV UTD Influenza UTD COVID-19	1 Tdap 2 MenACWY UTD HPV UTD Influenza UTD COVID-19

* IQIP assessment cohort added in Budget Year 1 as an allowable cohort.

*Combined 7-vaccine series refers to the 4:3:1:UTD:UTD:1:UTD series.

A good coverage goal is possible to reach but not met too quickly. The patient population size also plays a role in coverage goal selection. For example, if a provider has ten patients in a cohort and has immunization coverage of 50%, then a 10-percentage-point increase would only equate to the immunization of one additional patient. A coverage goal increase of 30 or 40 percentage points might be more appropriate for this hypothetical provider with few patients. For larger providers, a 30- or 40-percentage point increase would often be unrealistic.

Birth Cohort Coverage Goals

If the birth cohort is selected, **one coverage goal is required**, but two coverage goals is highly encouraged. The hepB birth dose is a required coverage goal, and RSV immunization product is highly encouraged for goal setting. Consultants should manually set coverage goals in the IQIP Database using the logic in the Table 13 or other goals agreed upon during the site visit.

Table 13: Suggested 12-Month Birth Cohort Coverage Goals	
Initial Coverage	Suggested 12-Month Coverage Goal
0% to less than 70%	Increase by 10 percentage points
70% to less than 75%	Increase to 80%
75% to less than 90%	Increase by 5 percentage points
90% to less than 95%	Increase to 95%
95% to 99%	Increase by 1%

Childhood Coverage Goals

If the childhood cohort is selected, **two coverage goals are required**. The IQIP Database autogenerates and prepopulates a suggested 12-month coverage goal for the combined 7 vaccine-series. The consultant and provider staff may edit this value if a different goal is preferred. The provider must pick a second childhood series to target during the IQIP cycle. This may be any of the required or optional series. Consultants should manually set coverage goals in the IQIP Database for this second childhood vaccine or vaccine series (e.g., 4 DTaP, 1 MMR, etc.) using the logic in Table 14, or other goals agreed upon during the site visit.

Table 14: Suggested 12-Month Childhood Coverage Goals	
Initial Coverage	Suggested 12-Month Coverage Goal
0% to less than 80%	Increase by 10 percentage points
80% to less than 90%	Increase by 5 percentage points
90% to less than 95%	Increase to 95%
95% to 99%	Increase by 1%

Adolescent Coverage Goals

If the adolescent cohort is selected, **two coverage goals are required**. The IQIP Database autogenerates and prepopulates suggested 12-month coverage goals for 1 HPV. The IQIP consultant and provider staff may edit these values if different goals are preferred. The provider must pick a second adolescent immunization or vaccine series to target during the IQIP cycle. Consultants should manually set adolescent coverage goals in the IQIP Database using the logic in Table 15, or other goals agreed upon during the site visit.

Table 15: Suggested 12-Month Adolescent Coverage Goals	
Initial Coverage	Suggested 12-Month Coverage Goal
0% to less than 70%	Increase by 10 percentage points
70% to less than 75%	Increase to 80%
75% to less than 90%	Increase by 5 percentage points
90% to less than 95%	Increase to 95%
95% to 99%	Increase by 1%

Older Teen Coverage Goals

If the older teen cohort is selected, two coverage goals are required. The IQIP Database autogenerates and prepopulates suggested 12-month coverage goals for 1 MenB. The IQIP consultant and provider staff may edit these values if different goals are preferred. The provider must pick a second older teen immunization or vaccine series to target during the IQIP cycle. Consultants should manually set older teen coverage goals in the IQIP Database using the logic in Table 16, or other goals agreed upon during the site visit.

Table 16: Suggested 12-Month Older Teen Coverage Goals	
Initial Coverage	Suggested 12-Month Coverage Goal
0% to less than 70%	Increase by 10 percentage points
70% to less than 75%	Increase to 80%
75% to less than 90%	Increase by 5 percentage points
90% to less than 95%	Increase to 95%
95% to 99%	Increase by 1%

Discussing, Selecting, and Documenting Quality Improvement Strategies



Requirement: Jurisdictions must ensure each provider receiving an IQIP visit selects at least two QI strategies for implementation or improvement, one of which must be Strengthen Immunization Communications to Address Vaccine Hesitancy or Provide a Strong Immunization Recommendation.

To help the provider determine which strategies to select, the IQIP consultant should review baseline status and implementation options for each IQIP core strategy in combination with the immunization workflow assessment. This will also help the consultant determine what technical assistance the provider needs.

The provider must select at least two QI strategies for implementation or improvement. However, one of the selected strategies must focus on immunization communications: Strengthen Immunization Communications to Address Immunization Hesitancy or Provide a Strong Immunization Recommendation.

Technical Assistance

Technical assistance is the delivery of education or training to providers to help them implement their selected IQIP strategies. It is critical to successful strategy implementation and should be provided as needed throughout the IQIP cycle. Consultants should be prepared to offer various technical assistance options for each IQIP core strategy and adapt the technical assistance to the specific needs of the provider. Technical assistance options include but are not limited to:

- Role-playing how staff discuss scheduling the next appointment with parents/patients
- Demonstrating presumptive vs. non-presumptive language or role-playing prescriber-parent interactions when recommending immunizations
- Demonstrating IIS functions and reports and involving jurisdictional IIS technical assistance if needed
- Reviewing current, applicable immunization education materials, explaining their use and what makes the source relevant and trustworthy

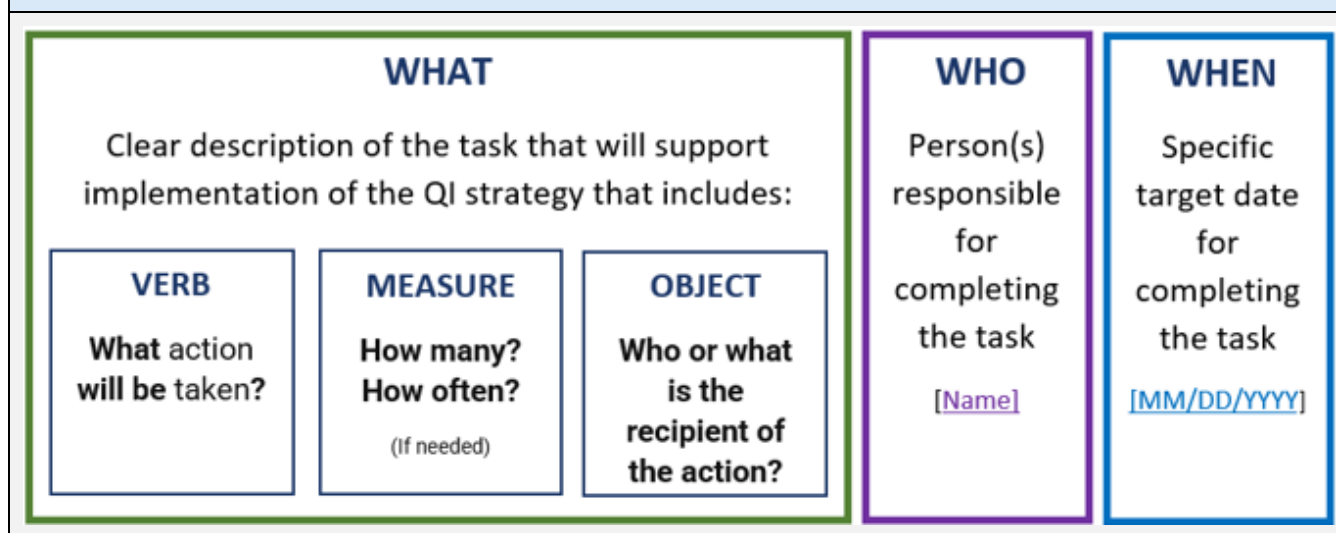
Action Items

Once the provider selects their QI strategies, the IQIP consultant then works with them to develop action items to implement them. Well-written action items will lead the provider toward improved immunization workflow processes that will increase immunization uptake. Therefore, the creation and completion of action items are the driving force within the IQIP program and how the actual work of process improvement takes place.

Action items must be written in a manner that supports measurement and should include:

- WHAT activity is starting, stopping, or changing,
- WHO is tasked with the activity, and
- WHEN to start or complete the activity.

Figure 1: Three Essential Components of An Action Item



NOTE: While most action items will be assigned to provider staff, there may be times when it is also appropriate to assign some to the consultant. For instance, the consultant may create an action item to provide resources, demonstrations, or technical assistance. See the Action Items Overview resource in the VFC CAMP Knowledge Center for more guidance.

Developing Action Items That Increase Immunization Uptake

When developing action items, the consultant should make sure they will build towards an increase in the number of immunizations administered. Providers may first need to build capacity for meaningful QI, such as improve data quality or research options for strategy implementation. However, while these steps might be necessary, they should be followed with additional action items will make a measurable impact on immunization uptake.

For example, inactivating patients in the IIS should not be the only action item assigned to a provider during IQIP. It increases provider capacity for QI because it cleans the provider's IIS data and improves the accuracy of their immunization coverage assessment. However, it does not directly lead to more immunizations being administered. If needed, inactivating patients in the IIS can and should be assigned as an action item but it should then be followed by conducting reminder/recall. When paired together, these action items will lead to more robust strategy implementation and immunization delivery.

Table 17 provides more detailed examples. The left-hand column lists action items that will only improve provider capacity. The right-hand column lists the same action items from the left column but has additional action items in bolded text that move the provider from preparation into action.

Table 17: Ensuring Action Items are Building Towards a Complete Strategy to Increase Immunization

IQIP Strategy: Leverage Electronic Systems	
Action items that only build capacity	Action items that build capacity and lead to increased immunization
1) Demo using screen-sharing how to use IIS to inactivate clients during the 2-month check-in [Jane Smith (IQIP consultant): 4/15/2025] 2) Dedicate 2 hours each month over the next 12 months to review the active pt list to identify pts in need of inactivation [Mary: 6/12/2025] 3) Use report functionality in IIS to mass inactivate identified pts in a second round of inactivation [Mary: 9/12/2025] Outcome: Coverage rates are more accurate	1) Demo using screen-sharing how to use IIS to inactivate clients during the 2-month check-in [Jane Smith (IQIP consultant): 4/15/2025] 2) Dedicate 2 hours each month over the next 12 months to review the active pt list to identify pts in need of inactivation [Mary: 6/12/2025] 3) Run an overdue patient line list and send a reminder text nudging the patients to come in [Mary: 6/16/25] 4) Use report functionality in IIS to mass inactivate identified pts in a second round of inactivation [Mary: 9/12/2025] 5) Begin recall/reminder efforts on the first of every month [John & Mary: 10/1/25] Outcome: Coverage rates are more accurate <u>and</u> additional patients are more likely to be vaccinated.
IQIP Strategy: Strengthen Immunization Communications	
Action items that only build capacity	Action items that build capacity <i>and</i> lead to increased immunization

1) Evaluate content to be shared on social media [Kayla: 3/13/2025] Outcome: There is internal progress towards development of social media content and a immunization policy.	1) Evaluate content to be shared on social media [Kayla: 3/13/2025] 2) Post social media content on Monday and Wednesday each week starting April 1st and reassess after 1 month [Kayla and Angie: 4/30/25] 3) Print posters of written immunization policy and display in each exam room and the front desk [Angie, 6/1/2025] Outcome: Social media content was developed and implemented. More parents and patients are receiving positive immunization messaging through social media and through visual cues when visiting the provider.
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Successful implementation of each IQIP strategy may require the completion of a series of action items.

Site Visit Wrap-Up

Identify Dates for Check-Ins and Follow-Up

The final step of the site visit is to collaborate with provider staff to schedule dates for the check-ins and follow-up. These dates should be as close to the IQIP timeline as possible. See the On-Time Date Range Tool for assistance scheduling check-ins and follow-ups. Scheduling complications may arise, however, and CDC considers modest deviations from intended time intervals acceptable; refer to Table 18.

Table 18: Scheduling Guidelines for IQIP Check-Ins and Follow-Up			
IQIP Step	Intended Interval	Minimum Acceptable Interval from the Site Visit	Maximum Acceptable Interval from the Site Visit
2-Month Check-In	2 months	1 month	3 months
6-Month Check-In	6 months	5 months	7 months
12-Month Follow-Up	12 months	11 months	13 months

Entering Site Visit Data into the IQIP Database

IQIP consultants must document the site visit in the IQIP Database within 10 business days after the site visit. When entering site visit data into the IQIP Database, the IQIP consultant must:

1. Record baseline status information concisely in the IQIP Database for the two selected strategies on the Site Visit page
2. Complete the following two fields for each strategy selected:
 - Describe any technical assistance provided for the strategy during the site visit (e.g., resources shared, demonstrations, role-playing, etc.).
 - Describe action items agreed upon for the strategy using the recommended format for each item.
3. Record action items for each strategy with due date, point of contact, and text describing the action item.

Strong Recommendation Action #1	
POC	LATERIKA CASSEY CMA
Due Date	04-13-2026  Today M-D-Y
Action Note Plans to focus on waiting room, having educational materials available. Place children's books in the waiting area.	
Expand	

Once action items for each selected strategy are recorded and saved on the Site Visit page of the IQIP Database, they are automatically collated under the heading “Summary,” located on the Synopsis page. This summary also includes provider contact information, baseline coverage, coverage goals, and planned dates for check-ins and follow-up.

Follow-Up Correspondence

Consultants should send the provider a written summary within two business days after the site visit. It should include a visit summary or Synopsis page from the IQIP Database (see above), links to online resources, and planned dates for check-ins and follow-ups.

Module 7 – 2-Month and 6-Month Check-Ins



Program Requirement: The 2- and 6-month check-ins are not optional and must be conducted according to IQIP scheduling guidelines.

Overview

The purpose of the 2- and 6-month check-ins is to communicate with provider staff as they implement their QI strategies. These contacts enable consultants to identify progress made by the provider with strategy implementation, provide additional training and technical assistance with action items, and deliver clear direction and support to the provider staff. Check-ins should be conducted either by phone or virtually. For the best use of resources and provider time, check-ins are not intended to be conducted face-to-face.

The 2-month check-in is intended to be a brief update on progress and a chance for the provider staff to identify additional needs for technical assistance. The 6-month check-in is a much lengthier visit and includes a review of coverage data.

Preparing for Check-Ins

When preparing for the check-ins, consultants should contact the provider in writing before the 2- and 6-month check-ins to:

- Confirm the selected date and time for the check-in
- Reiterate the purpose and goals of the call
- Ensure the appropriate staff participates

CDC has developed 2- and 6-month check-in checklists for consultants (see the IQIP Preparation Checklists in the VFC CAMP Knowledge Center) to assist in preparing for the calls. Recipients may also develop their job aids to help with consultant preparation.

Gather and Review Relevant Information Before the Check-In

This process will reacquaint the consultant with the provider and support the efficient use of time during the check-in. Helpful information to review before the check-ins can include:

- Notes and data in the IQIP Database from the site visit or previous check-in
- Relevant information regarding VFC compliance issues since the IQIP site visit and previous check-in

- Status of any technical assistance (e.g., IIS-related issues) the consultant agreed to arrange or provide
- Technical assistance was previously provided to prepare any new or updated materials to support the provider in implementing or improving the selected strategies and working towards completing the pending action items

Providers Who Want to Change Strategies During 2-Month or 6-Month Check-Ins

While additional action items can be added at the 6-month check-in, IQIP strategies should not be changed during the IQIP cycle. If a provider wants to change strategies or make extensive edits to their action items at the 2-month check-in, the consultant should stop the 2-month check-in and restart the site visit. Restarting the site visit will require update the dates and the coverage data. Then the IQIP cycle timeline will restart to allow a full 12 months for the chosen strategies to be implemented.

2-Month Check-Ins by Email

Recipients may conduct 2-month check-ins via email. All the data fields required in the IQIP Database will still be required. The 2-month check-in date is the date that the provider replied with all the required information.

Assessing Coverage During 6-Month Check-In

Coverage reports are required at the 6-month check-in. The purpose of reviewing coverage at the 6-month check-in is to serve as a mid-point check to see if coverage has changed since the site visit. The 12-month follow-up will provide the opportunity to discuss year-over-year coverage change and the sustained impact of the strategy implementation and improvement.

Conducting Check-Ins

At the beginning of a check-in, confirm that the immunization champion and other appropriate staff are in attendance, review the IQIP cycle and the goal of check-ins, and outline the topics that will be covered.

Review Strategy Implementation

Next, review the strategies selected and understand any changes to their implementation status since the site visit. Also, review the status of action items for each strategy.

Check-ins provide the opportunity for tracking implementation progress. These interactions should be used to measure the quality of implementation progress and determine the effectiveness of the methods used by the provider. Consultants should communicate to provider staff that check-ins are an opportunity to decide if they are advancing their strategy implementation plan and if mid-course corrections are needed. When discussing progress on action items, the consultant should ask:

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Is the scope of the action item(s) narrow enough, or should it be refined?

- Vague or broad action items can be demotivating when there's no ability to view incremental change.

Are you where you expected to be at this point? If not, why not?

- The provider staff may need to adjust their activities/ methods to get back on track for their 12-month targets.

Are the action items still relevant?

- Were there obstacles or developments that suggest a change in direction is needed to implement the strategy?

Do you have the right team/ person?

- Is there someone who can help move things along better or more smoothly?

If the provider cannot complete an action item, the consultant should explore why. Consultants should use effective communication methods during these conversations; see Table 19. Also see Effective Communication for IQIP Consultants in the VFC CAMP Knowledge Center. Using open-ended and probing questions will help reveal new opportunities for advancing the strategy. The consultant should work with the provider to adjust action items as necessary

Tailored technical assistance is a critical component of an effective check-in. Consultants should come prepared with resources and training opportunities to advance the selected strategies. Consultants should not limit technical assistance to providing additional handouts; valuable activities may include live demonstrations, role play, training, etc. If there are time constraints during the check-in, technical assistance can be scheduled for a later date.

Table 19: Examples of Effective Communication Techniques

Open-ended questions	“What happened when you tried running reports from the IIS?” “What concerns did parents have that you were not able to address?”
Reflective listening	“It sounds like the reports you are running include patients that aren’t yours. Is that correct?” “I understand that you have new social media accounts but may need help with content related to immunizations?” “Okay, so staff are still unclear on the immunization messaging they are asked to deliver to parents and patients?”
Ask probing questions to find the root cause	“Why do you think that is happening?” “Why do you think that follow-up appointments are not being scheduled routinely by all staff?”
Solicit and consider all ideas for overcoming the barrier	“What we came up with at first doesn’t seem to be working. What other ways do you think we can approach this?” “What would help you that you don’t currently have?”

Wrap-Up and Next Steps

At the end of the check-in, confirm the date and time for the next scheduled contact. After the call, consultants should send the provider a written summary within two business days. The note should include the updated summary, links to online resources, and a reminder of the following contact's date. Timely follow-up is critical to sustaining the momentum gained during the check-in.

Documenting the 2- and 6-Month Check-Ins in the IQIP Database



NOFO Requirement: Report all IQIP program data to CDC within 10 days of every provider-level encounter.

When entering 2- and 6-month check-in information into the IQIP Database, the consultant must concisely summarize the current implementation status, existing gaps/limitations, opportunities for improvement, technical assistance was given, and action items were assigned. Please remember that the 2-month check-in should be brief and the 6-month check-in should take more time.

Provider Lost to Follow-Up and Scheduling Challenges

Consultants should be prepared for potential scheduling issues. Obstacles may include staffing changes, regional health concerns or other changes at the practice. Anticipating these challenges will help consultants keep the IQIP cycle on schedule. There may be an instance where the provider is no longer able or willing to participate in the IQIP cycle. In this case, consultants can designate a provider as lost to follow-up (LTFU).

Criteria for Designating a Provider as Lost to Follow-Up

Barriers may arise that prevent a consultant from completing an IQIP cycle with a provider. If those barriers meet certain conditions, the consultant can designate a provider as “lost to follow-up” (LTFU), after which the IQIP cycle is terminated for that provider.

A consultant may designate a provider as LTFU **only** if any of the following conditions are met at the time of the 2- or 6-month check-in or the 12-month follow-up:

- The provider has permanently closed
- The provider has merged with another provider, and the VFC PIN has changed to the merged provider
- The provider no longer participates in the VFC program
- The consultant has made four documented attempts to contact the provider by phone and e-mail over a four-week period and received no response
- The provider has opted out of further IQIP engagement

To document issues with completing check-ins or follow-ups because of other criteria, contact the IQIP program (IQIP@cdc.gov) for assistance.

Other Considerations When Determining a Provider’s Lost to Follow-Up Status

Before designating a provider as lost to follow-up, a consultant should consider the following:

- A consultant should designate a provider as LTFU in the IQIP Database only if they are sure there is no chance the provider will resume the IQIP cycle.
- Once a provider is designated as LTFU, the IQIP cycle is terminated for that provider.
- It is possible to reset the record if the provider re-engages with IQIP after being designated LTFU. However, it is a multi-step process that requires erasing previously entered IQIP Database responses.

If you need assistance resetting a provider record in the IQIP Database, contact your recipient’s IQIP coordinator or the CDC IQIP program at IQIP@cdc.gov.

LTFU Designation and IQIP Performance Metrics

Recipients should be aware that once a provider's status is designated as LTFU, data for the provider

will no longer be included in calculations for the IQIP performance metrics for any future check-in or follow-up. However, previously entered data for the provider (e.g., use of IIS data for coverage assessment) will be included in the recipient’s performance metrics calculations. LTFU is entered and tracked in the IQIP Database. It is also visualized on the IQIP dashboard.

How to Find Information About Providers Designated as LTFU in the IQIP Dashboards

- On the **"Overview"** page, the “Check-In & Follow-Up Status” table includes a column titled "LTFU," which states the number of providers that are LTFU at that stage in the IQIP cycle.
- On the **"Metrics"** page, an LTFU percentage is included in the “Other IQIP Metrics” table.

The right-hand menu filters include 2-Mo. Status, 6-Mo. Status, and 12-Mo. Status, which allows users to filter for lost follow-up at each stage.



Other IQIP Metrics ⓘ	
Metric	Value
IQIP-only site visit	100%
Lost to follow-up	0%

Module 8 – 12-Month Follow-Up



Program Requirement: Recipients must complete 12-month follow-ups with a minimum of 85% of IQIP providers.

Overview

The 12-month follow-up allows consultants to assess QI strategy implementation status, review year-over-year change in coverage, work with the provider to address challenges, and encourage continued implementation. The follow-up should be conducted virtually or by phone. Conducting a 12-month follow-up by e-mail is not allowed.

Preparing for the 12-Month Follow-Up

Confirm with Provider

When preparing for the 12-month follow-up, consultants should contact the provider beforehand to:

- Confirm the selected date and time for the follow-up.
- Reiterate the purpose and goals of the follow-up.
- Ensure appropriate staff participates.
- Agree upon a method for sharing assessment reports to be discussed during the follow-up (e.g., secured e-mail attachments, Microsoft Teams, IIS, etc.).

The consultant may also offer the provider the option of continuing IQIP for a second consecutive year if the recipient's program priorities and resources will accommodate a second IQIP cycle. See the "Conducting IQIP with the Same Provider Over Two Consecutive Budget Years" section below for detailed guidance.

Job Aid: CDC offers 12-month follow-up checklist for consultants (see the "IQIP Preparation Checklist" in the VFC CAMP Knowledge Center) to assist recipients in their preparations. Recipients may also develop their own job aids for this purpose.

Gather and Review Relevant Information

To make the most efficient use of time during the 12-month follow-up, the consultant should review available information about the provider's IQIP process to date. This information includes:

- Notes and data from the IQIP site visit and check-ins.
- Initial, 6-month, and 12-month assessment reports.
- Status of any technical assistance the recipient's immunization program agreed to provide.
- Relevant information regarding any IIS or VFC program issues.

Follow-Up Assessment Reports



Program Requirement: The 12-month follow-up coverage assessments must be run using the same parameters used for the initial coverage assessment.

A follow-up coverage assessment at 12 months is required if it is possible without a manual chart review. The 12-month coverage assessment:

- must be run using the same parameters used for the initial coverage assessment, and
- the assessment or "as of" date should be as close as possible to 12 months from the date of the initial coverage assessment.

NOTE: Following these guidelines is essential for accurately interrupting year-over-year change.

Understanding Patient Inclusion by Age in Coverage Assessments

IQIP coverage assessment parameters are designed to assess groups of patients up to date as of a specific birthday. The initial assessment and the 12-month assessment both measure coverage of 2-year-olds as of their second birthday. However, these assessments are done 1 year apart. As illustrated in Table 20, the 2-year-olds included in the initial assessment turned 3 years old by the time of the 12-month assessment and aged out of the 2-year-old cohort, and the 2-year-olds included in the 12-month assessment were 1-year-olds at the time of the initial assessment and have aged into the 2-year-old cohort.

Table 20: Childhood Patients Included in Coverage Assessment for Sunshine Pediatrics, Assessed as of patient 2nd Birthday (IQIP Site Visit Date: 8/8/2025)

Patients by DOB	Initial Coverage (Run: 8/1/2025)	6-Month Coverage (Run: 2/1/2026)	12-Month Coverage (Run: 8/2/2026)
Anthony, DOB: 8/23/2022	Included		
Ben, DOB: 10/12/2022	Included		
Caspian, DOB: 1/28/2023	Included		
Dolores, DOB: 4/19/2023	Included	Included	
Edgar, DOB: 6/2/2023	Included	Included	
Frances, DOB: 8/10/2023		Included	Included
George, DOB: 9/30/2023		Included	Included
Hugo, DOB: 11/27/2023		Included	Included
Isla, DOB: 1/21/2024		Included	Included
Jacob, DOB: 2/9/2024			Included
Katherine, DOB: 3/4/2024			Included
Lucy, DOB: 6/6/2024			Included
Michael, DOB: 7/28/2024			Included

Measuring Immunization Uptake by Comparing Initial and 12-Month Coverage

IQIP designed this method for initial and 12-month coverage assessments because it creates a control group (patients included in the initial assessment) and an intervention group (patients included in the 12-month coverage assessment).

Childhood Cohort Example

Control Group (Patients included in the initial assessment):

- Turned two years old while their provider was following their customary immunization workflow processes.
- If seen by the provider prior to the IQIP cycle, were subject to missed opportunities and other gaps in immunization workflow.

Intervention Group (Patients included in the 12-month assessment):

- Turned 2 years old while their provider implemented their selected immunization QI strategies.
- If seen by the provider during the IQIP cycle, were subject to improved immunization best practices (i.e. reminders, recalls, strong recommendation, improved scheduling and immunization communications).

Ideally, after QI strategy implementation, a higher percentage of children have received all immunizations for which they are eligible. Repeating a coverage assessment for groups of patients at the same age before and after IQIP helps capture the impact of the selected strategies as reflected in the provider's immunization coverage rate.

Conducting the 12-Month Follow-Up

At the beginning of the 12-month follow-up, the consultant should confirm the appropriate staff is in attendance and give a brief outline of the topics that will be covered to focus the discussion. Next, they should review the provider's progress in implementing or improving the selected strategies and as reflected by changes in coverage.

Reviewing Strategy Implementation

To assess strategy implementation status, effectiveness, and sustainability, consultants should:

- Determine if the workflow or operational changes agreed upon during the IQIP cycle were successfully implemented and are currently followed.
- Identify the barriers encountered if workflow or operational changes were not implemented as intended.
- Discuss ways to overcome these barriers and provide any technical assistance needed.
- Discuss how the provider can sustain strategy implementation.
- Discuss how the provider could continue working on existing action items or develop new ones to continue strategy implementation.

Reviewing and Interpreting Year-Over-Year Coverage

The consultant and provider should review changes in year-over-year coverage to assess strategy impact and areas for continued focus. To determine how successful the QI strategies were in increasing immunization, consultants must consider more than just the coverage rate. They must also consider other dynamics such as the cohort size, the number of patients up to date, and PAIS updates. The examples below illustrate how these factors can lead to insights in provider performance.

Provider A

Table 21: Provider “A” – No Change in Denominator with Increase in Coverage						
Variable	Site Visit		12-Month Follow-Up		YOY Change	
Assessment Info						
As of	8/8/2023		8/11/2024		12.1 mo.	
# Patients	114		114		0%	
	Coverage %	# Patients UTD	Coverage %	# Patients UTD	% Point Increase in Coverage	% Decrease in Pts UTD
Vaccine A	83%	95	91%	104	+8 ppt	+9%
Vaccine B	64%	73	82%	93	+18 ppt	+27%
Vaccine C	85%	97	94%	107	+9 ppt	+10%

As illustrated, Provider A:

- Has the same number of patients (N=114) in the assessment cohort for the initial and 12-month assessment, and
- Has 12-month coverage much higher compared to their initial coverage

Therefore, IQIP strategies may have contributed to this increase.

Provider B

Table 22: Provider “B” – Decrease in Denominator with Increase in Coverage						
Variable	Site Visit		12-Month Follow-Up		YOY Change	
Assessment Info						
As of	8/8/2023		8/11/2024		12.1 mo.	
# Patients	114		83		-27%	
	Coverage %	# Patients	Coverage %	# Patients	% Point Increase in	% Decrease in Pts

		UTD		UTD	Coverage	UTD
Vaccine A	83%	95	91%	76	+8 ppt	-20%
Vaccine B	64%	73	82%	68	+18 ppt	-7%
Vaccine C	85%	97	94%	78	+9 ppt	-20%

Like Provider A, Provider B

- Also has a 12-month coverage that is higher compared to their initial coverage, and
- Has the same coverage rate for each vaccine, BUT:
- Has fewer patients in the assessment cohort (N=114 at site visit and N=83 at 12-month follow-up)
- Has fewer total patients UTD compared to their initial coverage
- Began conducting routine PAIS updates in the IIS during the IQIP cycle

Therefore, it is likely that the increased coverage rate is partly due to improvements in documentation (i.e. updating PAIS), instead of an actual increase in the number of immunizations administered.

Provider C

Table 23: Provider “C” – Decrease in Denominator with Increase in Number of Patients Immunized						
Variable	Site Visit		12-Month Follow-Up		YOY Change	
Assessment Info						
As of	8/8/2023		8/11/2024		12.1 mo.	
# Patients	114		102		-11%	
	Coverage %	# Patients UTD	Coverage %	# Patients UTD	% Point Increase in Coverage	% Increase in Pts UTD
Vaccine A	83%	95	93%	100	+15 ppt	+5%
Vaccine B	64%	73	83%	73	+19 ppt	+16%
Vaccine C	85%	97	99%	97	+14 ppt	+4%

Provider C finished IQIP with a lower denominator and higher coverage as did Providers A and B. As with Provider B, inactivating patients from the IIS lowers the number of patients included in the assessment, which can result in an increase in the coverage rate even if *actual* vaccine uptake did not increase.

However, while Provider C:

- Had fewer patients in the assessment cohort (N=114 at site visit and N=102 at 12-month follow-up, and
- Increased coverage rates for all vaccines, they also;
- Had more total patients up to date.

Inactivating patients in the IIS cannot cause the year-over-year increase in *number* of vaccinated patients seen for Provider C. Provider C increased uptake of all immunizations despite its decrease in patient numbers.

Discussing Year-Over-Year Change and Interpreting the Effect of QI Strategies on Immunization Uptake

To gain insight about how the workflow changes affected immunization uptake, the consultant should discuss changes in coverage in combination with the level of strategy implementation during the 12-month follow-up.

For example, a provider's positive year-over-year change in coverage for 1 HPV may indicate the provider successfully increased their HPV initiation. Referencing the notes from the site visit and check-ins, the consultant points to their adoption of the best practice of bundling their HPV immunization recommendation with their recommendation for Tdap and MenACWY immunizations. Noting this, the consultant can share this insight with the provider and encourage sustained adherence to this best practice.

However, if the provider's year-over-year change indicated no positive increase in HPV initiation despite adoption of the best practice of bundling their HPV immunization recommendation with Tdap and MenACWY immunizations, the consultant should ask the provider to reflect on their implementation. For example:

- When did the bundling practice begin during the IQIP cycle?
- Was it fully implemented by all prescribers?
- If not, what were the challenges to implementation?

If the answers to those questions indicate barriers to implementation, the consultant and provider can discuss ways to refine their implementation. If the answers to those questions indicate full implementation, then the consultant and the provider can discuss potential barriers and other options to boost HPV immunization uptake moving forward.

Concluding the IQIP Cycle

The consultant concludes the IQIP cycle by summarizing insights from the 12-month follow-up discussion. The consultants should also encourage the provider to sustain successful best practices and connect the provider to available technical assistance resources if needed.



Requirement: Documentation of the 12-month follow-up in the IQIP Database is required within 10 business days after the follow-up.

Documenting the 12-Month Follow-Up in the IQIP Database

When entering 12-month follow-up information into the IQIP Database, the consultant must concisely

summarize the current implementation status, existing challenges and opportunities for improvement, technical assistance provided, and action items, if assigned.

Closing Out the IQIP Cycle

The consultant should close out the IQIP process by sending a full synopsis to the provider, acknowledging their participation, and encouraging them to maintain any progress achieved. The consultant should include a full summary of the strategies selected, implementation progress, any action items, coverage data showing year-over-year change, and contact information for follow-up questions. Recipients may also choose to provide a certificate of appreciation from the immunization program to the provider after their participation in the IQIP program to recognize their efforts.

Conducting IQIP with the Same Provider Over Two Consecutive Budget Years

Providers may repeat IQIP for a second consecutive year. If the 12-month follow-up will double as the site visit for a new IQIP cycle, then it must be conducted in person or via Tele-IQIP. Because the consultant may not know prior to the 12-month follow-up that the provider wants to continue IQIP for another 12 months, it may be necessary to schedule the site visit for the second budget year on a later date than the 12-month follow-up for the first budget year.

The second IQIP cycle must complete the usual steps for conducting a site visit. A second immunization workflow assessment and site visit discussion must be conducted during the site visit for the second IQIP cycle to ensure that strategy selection and action items are based on the most current workflow processes. If the date of the site visit for the second IQIP cycle is more than 1 week after the 12-month follow-up, then the consultant should generate a new coverage assessment for the second IQIP cycle's site visit.

Module 9 – IQIP with Multisite Providers

Overview

Recipients may conduct IQIP activities collectively with providers from the same multisite provider group/organization. Each provider must be enrolled in the VFC program, have patients in at least one of the IQIP age cohorts, and provide routine immunization services.

The site visit must be conducted with at least one representative from each provider. The consultant may conduct the site visit, 2-month and 6-month check-ins, and 12-month follow-up with all representatives simultaneously or divide them into subsets.

Conducting a joint IQIP site visit has several benefits.

- The provider group's manager(s), who oversee facility procedures, can drive the adoption of the selected QI strategies at a corporate level, improving the odds of successful implementation.
- Staff across participating sites can collaborate on strategy selection, policy and procedural changes, and workflow improvement.
- Recipients save time and resources on travel to and from multiple providers.
- Recipients may count each participating provider with a separate VFC pin toward meeting their 25% requirement.

CDC IQIP staff will review data in the IQIP Database and contact recipients if there is no representation from each location or if other data entered is inconsistent with CDC guidance.

IQIP operational guidance in previous modules applies when working with multisite provider groups, with some exceptions and additions. This module only addresses these variations. See the IQIP Tips resource in the VFC CAMP Knowledge Center for best practices when conducting IQIP with multisite providers.

Modifications to IQIP Operations When Working with Multisite Providers



Program Requirement: Representatives from each provider must participate in multisite site visits and check-ins and follow-up.

Coverage Assessments

immunization coverage assessment reports must be generated and entered the IQIP Database for each provider in the group, both for the site visit, the 6-month check-in, and the 12-month follow-up. Assessment results (immunization coverage and denominators) should not be identical for each site.

Pre-Site Visit Activities

Along with the activities outlined in Module 5 – Pre-Site Visit Activities, consider the following when arranging a multisite visit:

- Meeting space logistics (physical space vs virtual platform)
- Attendance of at least one representative from each of the VFC-participating sites and appropriate representatives from the provider group's management
- Identify the best point of contact within the health system's leadership to ensure buy-in and awareness
- Consider including individuals who work in quality improvement. Example job titles include:
 - Chief for Innovation and Strategy
 - Chief Quality Officer
 - Medical Director for Performance Excellence
 - Director of Clinical Quality
- The consultant should confirm that each provider is in the IQIP Database before the site visit to support timely data entry and notes. If any VFC providers are not represented in the IQIP Database, contact IQIPDatabase@cdc.gov.

Site Visit

Due to the difference in setting and the participation of multiple representatives, group dynamics can introduce challenges for the consultant. Consultants may need additional facilitation skills and techniques to build rapport, create a collaborative atmosphere, and involve participants in making changes.

In relation to the activities in Module 6 – Site Visit:

- Representatives from each provider should describe their immunization workflow.
- Coverage goals must be set individually for each participating provider.
- Individual providers may select the same or different QI strategies for implementation at their locations.
- Consultants should develop a summary for each site with action items specific to each site.

Check-Ins and Follow-Up

In relation to the activities outlined in Module 7 - 2-Month and 6-Month Check-Ins and Module 8 - 12-Month Follow-Up:

- The 2- and 6-month check-ins and the 12-month follow-up must be conducted with representatives from each provider.
- Check-ins may be conducted individually, in subsets, or aggregately
- Assessment reports must be generated individually for each provider in the group.
- Share a summary of the multisite visit and check-ins with health system contacts and the individual provider staff.

Training Staff to Conduct Multisite Visits

In relation to the activities outlined in Module 12 - IQIP Program Management and Oversight:

- New consultants should be trained on the variations required for multisite visits.
- New consultants should shadow a multisite visit, including the pre-site visit activities, before doing one on their own.
- IQIP coordinators should observe and provide feedback to consultants on multisite visits in addition to single-provider site visits.

Data Collection and Reporting

- Consultants must document IQIP data and notes separately for each provider in the IQIP Database.
- There are unique data fields for multisite visits. Consultants must select that the visit includes multiple providers, state the number of locations represented, and list the health system's name.
- The data entered for the site visit participation questions should be specific to each provider.

Module 10 – Alternate QI Program Credit

Overview

CDC recognizes the existence of non-IQIP QI programs with goals that serve the purpose of IQIP. CDC allows recipients to claim credit for up to 20% of their required IQIP site visits by documenting providers engaged in alternate QI programs. To be eligible for IQIP credit:

- The provider must be engaged in the alternate QI program during the current BY (i.e. July 1, 20XX–June 30, 20XX).
- The alternate QI program must focus on one or more immunizations and must target patients 18 years of age or younger.
- The intervention must be conducted by the VFC provider.

Receipt of IQIP credit for a provider engaged in an alternate QI program does not require a site visit. IQIP coordinator or IQIP consultant participation in Alt QI activities is not required.

NOTE: Alternate QI programs featuring short term interventions or single day events do not meet the criteria.

Submission and Review Process

A recipient seeking IQIP credit for provider participation in an existing QI program must complete CDC's Alternate QI Program Credit Submission Form, located in the VFC CAMP Knowledge Center.

- Completion of the form requires:
 - Descriptive information explaining how the alternate QI program fulfills the IQIP purpose. CDC is looking for QI programs that are comparable to IQIP in intensity.
 - Any available supporting materials (e.g., worksheets, presentations, URLs, or handouts) used or distributed by the alternate QI program
 - Documentation of approval by the recipient's program manager
- The recipient should complete one form per QI program (not one per provider).
- The recipient should send the completed form and relevant supporting materials to IQIP@cdc.gov with the recipient's name and "Alternate QI Request" in the subject line.

CDC will review the form and supporting materials and decide on the QI program's suitability for IQIP credit. CDC will respond to submissions within two weeks of the date received. The response will state the submission status and next steps for the recipient. If the submission is not approved, the response will provide an explanation and instructions for the next steps if the recipient would like to resubmit.

Recording Data in IQIP Database

Once CDC approves the alternate QI program, the recipient may enter data for providers participating in the program into the IQIP Database. Participation by these providers will count toward IQIP requirements for up to 20% of the required visits and will count only if reported in the IQIP Database. The following data must be documented in the IQIP Database:

- The name of the alternate QI program as it appears on the submission form.
- Descriptive information about the alternate QI program (a subset of the information reported on the Alternate QI Program Submission Form)
- Recipients are encouraged but not required to enter coverage data.

The “IQIP Database User Guide,” located in the VFC CAMP Knowledge Center and the IQIP Database File Repository, includes specific instructions for reporting alternate QI program data in the IQIP Database. Alternate QI programs reported in the IQIP Database that are not included on CDC’s list of approved programs will not be credited for IQIP.

Renewing Alternate QI Program Approval

Recipients may resubmit an alternate QI program for which they received approval during the previous budget year. All other criteria for claiming for provider alternate QI program credit still apply. The resubmission must have an updated date and the program manager's signature. A recipient may claim alternate QI credit for providers participating in the program after renewed approval.

Module 11 - IQIP in Birthing Hospitals

Overview

Approximately 3,667,758 births occur in the United States each year. Birthing hospitals, defined as a facility with >1 birth within a year OR ≥ 1 registered maternity bed, are the most common place for births, with 98.4% and 0.52% of births taking place in a hospital or freestanding birth center, respectively.

Birthing hospitals play a critical role in providing early immunizations to protect newborns against hepatitis B and respiratory syncytial virus (RSV). The ACIP recommends hepB vaccine for newborns; and RSV immunization for infants aged <8 months born during or entering their first RSV season (e.g., October-November), or within a baby's first week of life if born October through March (ideally during the birth hospitalization). Birthing hospitals provide a safety net and ensure access to immunizations for uninsured and underinsured infants. Approximately 1 in 8 commercially insured and 1 in 4 Medicaid-covered infants do not have an outpatient office visit within 5 days of discharge from the birth hospitalization and 308,000 infants miss their first outpatient visit entirely, often because of transportation and cost concerns – underscoring the importance of administering hepB and RSV during the birth hospitalization to ensure access.

Among the 2,817 birthing hospitals in the United States, 1,012 (36.2%) are enrolled in the Vaccines for Children (VFC) program and are eligible to participate in IQIP. To improve perinatal hepB and RSV immunization rates among newborns in birthing hospitals, a multidisciplinary QI approach can focus on educating both providers and patients about the importance of hepB and RSV immunizations, implementing standing orders for immunization administration, establishing readily available access to immunizations, consistent provider and patient reminders, and addressing potential barriers to vaccination through targeted outreach and communication; all while closely monitoring immunization rates and identifying areas for further improvement.

Implementing IQIP's Core Strategies in Birthing Hospitals

IQIP's four core strategies can be implemented into birthing hospitals utilizing a multidisciplinary approach to increase immunization coverage rates.



Facilitate Immunization

In birthing hospitals, this core strategy focuses on implementing processes to facilitate newborn immunizations prior to discharge from the birth hospitalization.

Strategy Overview and Rationale

- Evidence shows that standing orders are an effective means of increasing immunization rates in the hospital setting ([Patel et al., 2021](#)). One study found that implementing standardized orders in a birthing hospital increased hepB birth dose coverage from 44% to 84% ([Sarathy et al., 2021](#)). Example standing orders can be found [here](#) and [here](#).
- Approximately 1 in 8 commercially insured and 1 in 4 Medicaid-covered infants do not have an outpatient office visit within 5 days of discharge from birth hospitalization and 308,000 infants miss their first outpatient well-child visit entirely, often because of transportation and cost concerns ([Nelson et al., 2023](#)).

Best Practices for Strategy Implementation

- **Link the newborn to care.** Prior to discharge **ensure infants are scheduled for their first well child visit.** If the infant did not receive the perinatal hepB birth dose or RSV immunization, implement a process to ensure the newborn's pediatrician is aware the newborn needs these immunizations during the first well child visit.
- **Standing orders:** Standing orders for immunization enable non-physician personnel such as nurses to administer immunizations using an approved protocol without the direct involvement of a physician. Implement standing orders for administering the birth dose of hepB within 24 hours of birth and RSV before hospital discharge, respectively, ensuring all eligible newborns are automatically offered the vaccine.

 **Leverage Immunization Information Systems (IISs), Electronic Health Records (EHRs), or Electronic Systems to Improve Immunization Practices**

Strategy Overview and Rationale

Standardized systems and processes in birthing hospitals are important for improving quality and outcomes for both mother and newborn. Specifically, standardizing immunization systems and processes can improve on-time delivery of immunizations to newborns prior to discharge from the birthing hospital.

Studies have linked the use of standardized systems and processes to increased immunization coverage in birthing hospitals.

- A 2021 qualitative improvement project demonstrated that using an electronic medical record (EMR) embedded best practice alert (BPA) in a birthing hospital improved compliance with the CDC guidelines for the administration of the birth dose of the hepB vaccine within 24 hours of birth ([Kirschhoffer, 2021](#)).

- To facilitate perinatal hepB vaccination, a birthing hospital created an individualized immunization order set and updated administration instructions to reflect new perinatal hepB administration guidelines. This strategy was part of a multidisciplinary approach which led to an increase from a baseline of 45% to 80% of infants receiving hepB vaccine before discharge. ([Hayashi et al., 2021](#))

During the initial site visit, the consultant should learn about any current systems, processes or standing orders that facilitate hepB and RSV immunizations in the birthing hospital, this could include, but is not limited to, reviewing how standing orders, electronic medical records systems, and immunization information systems (IIS) are utilized to improve immunizations. Once the current systems and processes are understood, this strategy should focus on either a) strengthening current systems or processes or b) implementing new systems or processes to improve immunizations.

Best Practices for Strategy Implementation

The following list of activities serves as examples of best practices for implementation:

- **Electronic Medical Record (EMR) alert:** Include alerts on electronic medical records to improve immunization workflows and support patient care by providing timely reminders and warnings to healthcare providers.
- **Order set:** Incorporate immunizations into an immunization order set to facilitate administration
- **Clinical documentation:** Standardize documentation processes to accurately track the birth dose of perinatal hepB and RSV immunization and identify gaps in vaccination rates. Standardized documentation should include documenting immunization doses in the immunization information system (IIS), also referred to as the immunization registry.



Strengthen Immunization Communication to Address Vaccine Hesitancy

Communication is a key component of a multifaceted approach to increase newborn immunizations in birthing hospitals. Strategies to improve communication between providers and parents/caregivers of newborns have been shown to significantly impact immunization coverage rates by hospital discharge.

Strategy Overview and Rationale

- Nurse-led interventions, including the ability to obtain consent, were significant contributors to improvement in the timeliness of hepB vaccine administration in a 2021 study examining strategies improving timeliness of hepB vaccine birth dose administration ([Sarathy et al., 2021](#)).

Best Practices for Strategy Implementation

- Incorporate information about immunizations into hospital registration forms, brochures, and information.
- **Develop patient education materials in multiple languages**, including information about the risks of perinatal HepB and RSV infection for newborns.

- **Utilize various communication channels** such as posters, brochures, and website information.
- **Provide information to parents and caregivers** who decide not to immunize their newborn before discharge and ensure they have a plan to follow-up on immunizations.



Give a Strong Immunization Recommendation

A strong, clear immunization recommendation from a healthcare provider is a major factor in determining whether a parent/caregiver gets their newborn immunized. When healthcare providers strongly advise parents/caregivers to get immunized to protect their infant against serious disease, it can significantly influence decision making.

Strategy Overview and Rationale

This “Give a Strong Immunization Recommendation” strategy covers all verbal or interpersonal communications between the provider staff and the caregiver/patient falls under this strategy, which focuses on helping the provider adopt or improve upon making a strong immunization recommendation. This strategy is not exclusive to the prescriber; all provider staff who communicate with patients can be part of this strategy.

- A multidisciplinary approach including standardizing the process of offering hepB vaccine via scripting and timing, engaging and educating parents, and educating physicians and nurses regarding the importance of hepB vaccination and strategies to discuss hepB vaccination with vaccine-hesitant parents resulted in increased and sustained hepB vaccination rates by hospital discharge from a baseline of 52.4% to 72.5% ([Bradshaw et al., 2020](#)).

Best Practices for Strategy Implementation

Patient-centered

- **Train staff to talk about immunizations early:** Train L&D and post-partum staff to actively ask about immunizations. Additionally, train and encourage obstetricians to discuss hepB and RSV vaccination during prenatal visits.
- **Counsel parents and caregivers** on which immunizations the infant received or did not receive while at the birthing hospital. Make a strong recommendation for the infant to receive immunizations during their first well child visit, if they did not receive them at the birthing hospital.

Healthcare Provider-centered

- **Train providers on making a strong recommendation.**

Initial Site Visit

Workflow Assessment

To assess immunization workflow in a birthing hospital, partner with key stakeholders to map the current process, identify bottlenecks and inefficiencies, and collaborate to propose improvements to streamline the process and ensure all newborns receive the birth dose of hepB within 24 hours of birth

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and RSV immunization prior to discharge. The workflow assessment should include individuals from, but may not be limited to, pharmacy, the labor and delivery (L&D) unit, postpartum unit, and neonatal intensive care unit (NICU).

During the initial site visit, the consultant should learn which immunizations are offered at the birthing hospital; where immunizations are stored; where immunizations are administered; when newborn immunizations are offered to parents/caregivers; who talks to parents and caregivers about immunizations and identify where the workflow process is documented.

The consultant should identify key steps:

From the moment a mother is admitted to the hospital:

- **Maternal hepB status and RSV immunization history:** How is this information gathered and documented?
- **Newborn Assessment and Eligibility:** How is a) the newborn's risk for exposure to hepB established and documented and b) eligibility for RSV immunization determined?
- **Immunization Access:** Where are immunizations stored and how is administration coordinated across units?
- **Documentation and Record Keeping:** How are immunizations documented and where are records stored?
- **Discharge Planning:** How is immunization information communicated to the parents/caregiver and included in the discharge summary? How are newborns who are not vaccinated before discharge linked to care?

Use visual tools:

- **Create flowcharts or diagrams** to illustrate the process, highlighting each step and the individuals involved.

Coverage Assessments

The ACIP recommends 1) hepatitis B vaccination for all newborns and 2) respiratory syncytial virus (RSV) immunization with a monoclonal antibody (RSV mAb) for infants younger than 8 months who are born during or entering their first RSV season. For infants born during the RSV season, RSV mAb should be given within the first week of life, ideally during the birth hospitalization, if the mother did not receive RSV vaccination during pregnancy. Jurisdictions implementing IQIP in birthing hospitals are required to examine coverage for the birth dose of hepB. For the purposes of the IQIP program, hepB birth dose coverage should be measured as receipt of the dose within 1 calendar day of birth.⁵ Coverage assessments for RSV immunizations are optional and should be considered based on seasonality. However, RSV immunization coverage assessments coupled with hepB will provide a more complete representation of immunizations provided in the birthing hospital and the impact of quality improvement strategies. In addition to coverage assessments, jurisdictions may choose to examine the

⁵ This coverage guidance is different from operational guidance for the Perinatal Hepatitis B Prevention Program (PHBPP), which requires administration of hepB within 12 hours of birth for infants born to an infected mother, and within 24 hours of birth to an HBV negative mother.

number of doses administered at various time points; percent of newborn immunizations reported to the Immunization Information System (IIS) and other metrics (Table 24). EHR-based coverage may be used for IQIP assessments when IIS data are unavailable or if the birthing hospital prefers to use their EHR. However, if used, the responsibility for generating EHR-based reports falls on the hospital staff. As with other IQIP cohorts, coverage assessments for the 2- and 6-month check-ins and the 12-month follow-up should be run using the same parameters used for the initial coverage assessment.

For birthing hospitals, jurisdictions are only required to assess coverage at the site visit and the 12-month follow-up. Assessing coverage at the 2-month and 6-month check-in is optional. The 2-month and 6-month check-in should be used to identify barriers and challenges to QI implementation, reexamine workflow, and identify additional training, education, and resources that may be helpful to the birthing hospital.

Table 24: Overview of IQIP Site Visits in Birthing Hospitals

IQIP Cycle			
Site Visit	2-month (optional)	6-month	12-month
- Baseline coverage for hepB birth dose (RSV immunization optional and depends on seasonality) - Select IQIP strategies	- Examine change in coverage since site visit - Examine change in coverage for same period in previous year	- Examine immunization coverage since: - Site visit 2-month check-in* - Compare coverage to same period in previous year	- Examine change in coverage since: - Site visit 2-month check-in* 6-month check-in* - Compare coverage to same period in previous year
Additional Assessments (Optional)			
Site Visit	2-month (optional)	6-month	12-month
- Number of doses administered % of hepB birth doses reported into IIS within 1 month of receipt % of infants receiving hepB vaccination within 1 calendar day of birth (baseline)*	% of hepB birth doses reported into IIS within 1 month of receipt % of hepB birth doses reported into IIS since site visit - Compare coverage of infants receiving hepB vaccination within 1 calendar day of birth to site visit*	% of hepB birth doses reported into IIS within 1 week/month of receipt % of hepB birth doses reported into IIS since - Site visit 2-month check-in* - Compare hepB vaccination within 1 calendar day of birth to - Site visit 2-month check-in*	% of hepB birth doses reported into IIS within 1 week/month of receipt % of hepB birth doses reported into IIS since - Site visit 2-month check-in* 6-month check-in* % of hepB birth doses reported into IIS within 1 month (previous year) compared to current year - Compare coverage of infants receiving hepB vaccination within 1 calendar day of birth to - Site visit 2-month check-in* 6-month check-in*

*If applicable

2-Month and 6-Month Check-Ins

The 2-month and 6-month check-ins are an opportunity to assess IQIP implementation and identify any barriers/challenges and address them early. For birthing hospitals, coverage data does not have to be collected at either check-in and the 2-month check-in itself is optional. However, collecting coverage data at the 2- and 6-month check-in provides an opportunity for the Immunization Program and the hospital to work together to identify barriers/challenges, reexamine workflow, and identify additional training, education, and resources. Please refer to Module 7 and Table 19 for additional guidance on the 2- and 6-month check-ins in birthing hospitals.

12-Month Follow-Up

The 12-month follow-up is intended to capture challenges and successes of the IQIP cycle. It also includes opportunities to plan for future improvements and sustainability. Comparing change in data over time can be helpful in assessing change. Even if data has not improved, it is important to consider other outcomes including capacity building among the provider staff. Please refer to Module 8 for additional guidance on the 12-month site visit.

Getting Started in Birthing Hospitals

If you are considering initiating IQIP in birthing hospitals, we recommend you connect with your jurisdiction's Perinatal Hepatitis B Prevention Program Coordinator. You can find contact information [here](#).

CDC recognizes that IQIP in Birthing Hospitals includes unique challenges. Please reach out to us if we can assist in anyway by emailing us at IQIP@cdc.gov.

Module 12 – IQIP Program Management and Oversight

Overview

Proper program management and oversight is essential to effective IQIP program implementation. Program management involves assuring that the necessary resources (e.g., staff, materials, guidance) are available so that the program can be implemented, whereas oversight entails maintaining awareness of implementation status and identifying and handling problems as they arise.

IQIP program management tasks include:

- Developing and maintaining a recipient IQIP operations guide
- Developing and implementing a custom immunization QI strategy (optional)
- Setting performance standards and targets
- Conducting IQIP consultant training
- Providing IQIP consultants with job aids and immunization education resources

IQIP program oversight tasks include:

- Monitoring implementation status and performance
- Monitoring qualitative data
- Assessing provider satisfaction

IQIP Program Management

Recipient Operations Guide



Program Requirement: Recipients must develop and maintain an IQIP operations guide tailored specifically for their IQIP program. The guide must align with CDC requirements, recommendations, and operational guidelines.

A recipient's IQIP operations guide should be specific and detailed enough so new hires can easily follow jurisdiction-specific protocols with minimal supervision or clarification. The immunization program manager, in collaboration with the IQIP program coordinator, must conduct annual reviews of the recipient's IQIP operations guide to verify the current policies and procedures align with CDC requirements and recommendations.

At a minimum, the content of the recipient's IQIP operations guide must include the definition of the IQIP program and its purpose and describe procedures for:

- Provider selection (see Module 1 – Provider Selection)
- Generating assessment reports according to the data source (e.g., IIS or EHR). Details must address the coverage assessment parameters, timing of coverage assessment in relation to the site visit and follow-up, and patient lists (e.g., missed opportunities) to be discussed with the provider (see Module 2 – Assessment Report Generation).
- Collecting and reporting IQIP data, including obtaining access to the IQIP Database, training on data entry, quality standards, and available reports (see Module 3 - Data Collection and Reporting)
- Overview, rationale, and implementation examples for IQIP core strategies (see Module 4 – IQIP Core Strategies), and recipient custom strategy, if applicable (see Module 12 – IQIP Program Management and Oversight)
- Arranging a site visit, including scheduling, confirmation, and preparation (see Module 5 – Pre-Site Visit Activities)
- Reviewing, interpreting, and discussing assessment reports with providers, including training on coverage assessment reports for both single immunization and series coverage (see Module 6 – Site Visit and Module 7 – 2- and 6-Month Check-Ins)
- Reviewing, interpreting, and discussing patient lists with providers as applicable, including identification of root causes for missed opportunities, invalid doses, and patients not up to date (see Module 6 – Site Visit)
- Conducting an IQIP site visit, including the purpose, timing, preparation, logistics, participants, implementation, documentation, associated correspondence, and list of educational materials to leave with a provider after a site visit. If different procedures are used for various situations (e.g., other provider types), each situation should be described and included in the recipient's IQIP operations guide (see Module 6 – Site Visit)
- Conducting 2- and 6-month check-ins, including the purpose, timing, preparation, logistics, participants, implementation, discussion of coverage at the 6-month check-in, documentation, and any associated correspondence (see Module 7 – 2-Month and 6-Month Check-Ins)
- Conducting the 12-month follow-up, including the purpose, timing, preparation, logistics, participants, implementation, discussion of year-over-year coverage, and documentation (see Module 8 – 12-Month Follow-Up)
- Informing other immunization program staff when discovering immunization program issues that are outside the scope of IQIP (e.g., informing VFC staff if a provider is having difficulty with vaccine inventory management)
- Conducting IQIP with multisite providers (see Module 9 – IQIP with Multisite Providers)
- Identifying, completing and submitting the Alternate QI Program Credit submission form to request IQIP site visit credit for providers engaged in another immunization QI program (see Module 10 – Alternate QI Program Credit)
- Managing and overseeing IQIP activities and data, including annual observation of IQIP consultants as they conduct site visits, check-ins, and follow-ups, as well as quality assurance checks on data entered in the IQIP Database (see Module 12 – IQIP Program Management and Oversight)
- Training IQIP staff, including curriculum for training new employees and providing periodic training updates for existing employees (see Module 12 – IQIP Program Management and Oversight)

Custom QI Strategy



Program Requirement: Recipients must complete and send a custom strategy submission form to CDC for approval prior to offering it as an IQIP strategy. A custom strategy must not be entered into the IQIP Database prior to receiving CDC approval.

Recipients have the option to expand their IQIP program and offer a custom strategy to providers along with the four core IQIP strategies. Only one custom strategy per recipient may be provided per budget year. The custom strategy:

- May be new or based on an existing immunization QI strategy that is not already a component of one of the four IQIP core strategies
- May focus on one or more immunizations
- Must be based on available evidence or sound rationale
- Must target a cohort of patients 18 years or younger
- Must be presented as a strategy option to all providers with patients in the targeted age cohort

Recipients may develop a novel strategy or adopt an existing evidence-based immunization QI strategy. In either case, strategies should be based on evidence and sound rationale. The [Community Guide](#) lists several approaches for increasing immunization coverage. Recipients may review the information available for each approach to determine which intervention suits their needs. Factors to consider during selection are:

- Has the intervention been documented as successful for your target patient population?
- Do you have the capacity (i.e. resources and expertise) to implement the strategy (i.e. provide technical assistance, job aids, educational resources)?
- Is the strategy scalable and feasible for provider implementation during the 12-month IQIP cycle?

Once the strategy is developed, the recipient must complete and submit a Custom Strategy Submission Form to CDC for approval before offering it as an option. A fillable Word version of this form is in the VFC CAMP Knowledge Center. The submission should include:

- Name of the strategy
- How the strategy aligns with the IQIP purpose
- Any available evidence to support the strategy
- Description of delivery method and technical assistance (e.g., discussion, handouts, demos, role-playing, etc.)
- Description of resources that will be used to support the strategy

Send custom strategy proposals to IQIP@cdc.gov with the recipient's name and "Custom Strategy Proposal" in the subject line. CDC will review the proposal and determine the eligibility of the strategy within 2 weeks of the date received. The response will state the submission status and describe any next steps for the recipient. If the submission is not approved, instructions for the next steps if the recipient would like to resubmit.

Once the custom strategy has been approved, recipients must develop the training and strategy resources needed to support implementation. CDC recommends using job aids for the custom strategy to ensure consistency among IQIP consultants. Recipients may adapt existing IQIP job aids to their custom strategies. Recipients may use available CDC and partner resources found on CDC’s [Communication and Print Resources for Public Health](#) and [Vaccine Communication Resources for Healthcare Providers](#) web pages and are encouraged to share the educational materials and job aids they create for their custom strategies. **A custom strategy must not be offered to providers or entered into the IQIP Database before receiving CDC approval.**

NOTE: CDC also encourages recipients to collaborate and share ideas on strategy development

Renewing Custom Strategy Approval

If a recipient wishes to offer their custom strategy during the next budget year, they must resubmit that strategy to renew their approval using the Custom Strategy Submission Form. If the strategy has not changed, the language from the previously approved submission form may be reused. However, the resubmission must have an updated date and the program manager's signature. A recipient may begin offering the custom strategy to providers only after receiving renewed approval from CDC.

IQIP Program Performance Standards and Targets

CDC-Required IQIP Program Performance Metrics

Recipients are required to set targets, describe relevant IQIP program oversight activities, and measure progress on performance metrics selected and defined by CDC. The metrics chosen by CDC are those associated with meeting program requirements regarding site visit completion (implementation status), IIS-based coverage assessment, and timely completion of 2- and 6-month check-ins and 12-month follow-ups. These metrics are calculated for each recipient using data submitted to the IQIP Database and visualized in the IQIP Dashboard. To access the dashboard, see the IQIP Dashboard – How to Access resource in the VFC CAMP Knowledge Center. The required performance metrics are listed below in Table 25.

Table 25: CDC-Required IQIP Performance Metrics			
Metric #	Metric Name	Description	Target
1	Implementation Status	Percentage of required providers participating in IQIP in the current budget year. (Includes Alternate QI credits)	Mid-Year: 50% End-Year: 100%
2	IIS-Based Coverage Assessment	The percentage of providers with initial coverage assessed using IIS data (among providers who completed an IQIP site visit)	Recipient-set
3	Timely 2-Month	The percentage of 2-month check-ins completed 1-3 months after the site visit (among providers	Recipient-set

	Check-Ins	who completed an IQIP site visit)	
4	Timely 6-Month Check-Ins	The percentage of 6-month check-ins completed 5-7 months after the site visit (among providers who completed an IQIP site visit)	Recipient-set
5	Timely 12-Month Follow-Ups	The percentage of 12-month follow-ups completed 11-13 months after the site visit (among providers who completed an IQIP site visit)	85%

Recipient-set targets for metrics 2, 3, and 4 are submitted to CDC in the Awardee Performance Metrics Tool in REDCap. Targets for metrics 1 and 5 were set by CDC for all recipients. The target for metric 1, implementation status, is set at 50% by the mid-year point and at 100% by the end of the year. The target for metric 5, timely 12-month follow-ups, is set at 85%. Recipients can monitor status for all required performance metrics by using the IQIP Dashboard. Recipients must submit mid- and end-year reports and action plans to address any metric values below targets in the IQIP Awardee Performance Metrics Tool by established deadlines; see Table 26.

Table 26: IQIP Program Monitoring Metrics Reporting Schedule			
	Targets and Activities	Mid-Year Report	End-Year Report
Reporting period	N/A	First half of the budget year: July 1- December 31	Full Budget Year: July 1 through June 30
Last day for data entry into IQIP Database	N/A	January 10th	August 10th
Due date	Due annually in June	Due annually in February	Due annually in August

CDC-Required IQIP Program Performance Metrics Reporting Schedule

Refer to Table 26 for information on reporting periods, data entry cutoff dates and report due dates. Refer to the IQIP Performance Metrics Reporting Guidance resource in the VFC CAMP Knowledge Center for more detailed guidance on fulfilling the program monitoring metrics reporting requirement, including how to access the IQIP Awardee Performance Metrics Tool.

Recipient-Developed IQIP Program Performance Metrics

CDC encourages immunization program managers and IQIP coordinators consider development of metrics and goals for aspects of their IQIP program that need improvement. For more information about performance management in public health, see [Performance Management](#).

IQIP Consultant Training



Program Requirement: Recipients must provide training for all IQIP consultants upon hire and prior to the consultant conducting IQIP activities. All consultants must receive training each budget year to ensure effective program implementation.

IQIP coordinators should develop a training plan to ensure that all required IQIP training components are included in the recipient-developed curricula for newly hired IQIP consultants and annual training requirements. The training plan should be incorporated into the recipient's operations guide.

In cases where a recipient conducts combined IQIP and VFC site visits and the IQIP and VFC programs oversight involve separate coordinators, the VFC coordinator should be included in the annual IQIP training process.

CDC encourages newly hired IQIP consultants to:

- Shadow an experienced consultant on an IQIP visit as part of their training.
- Be accompanied by the IQIP coordinator (or designee) on at least one site visit before conducting visits independently.

CDC encourages all IQIP programs to offer shadowing opportunities for all IQIP staff, regardless of experience, to support professional development and foster collaboration and mentorship among new and experienced IQIP staff.

IQIP Consultant Training Topics

Recipient staff need training in CDC and recipient-specific IQIP requirements and recommendations. New employee and annual refresher training should cover:

- The purpose and overview of IQIP, highlighting the requirements for each step in the IQIP cycle
- Program documentation requirements and how to use the IQIP Database
- How to conduct both in-person and tele-IQIP site visits (if applicable)
- How to effectively communicate with provider staff

- How to ensure that decision-makers are present at the IQIP site visit
- How to observe, assess, and document provider immunization workflows
- How to generate assessment reports in the IIS for providers
- How to interpret assessment reports
- Core IQIP strategies (and custom strategies if applicable), and their evidence base
- How to assess current strategy implementation and the workflow assessment and the provider's assessment reports in combination to identify areas most in need of attention
- How to create provider-specific action items that will lead to increased immunization uptake
- How to monitor, discuss, and document provider QI implementation progress
- Available job aids and resources to support the IQIP process
- How to provide ongoing technical assistance to provider staff to support the implementation or improvement of selected QI strategies
- CDC required IQIP program performance metrics

Consultant Job Aids and Resources

CDC has created several IQIP program resources and consultant job aids to assist in IQIP program implementation. These resources are available in VFC CAMP Knowledge Center.

CDC recommends that IQIP coordinators curate a collection of job aids and immunization education resources for use by all consultants for their IQIP program implementation.

IQIP Program Oversight

Routine IQIP program oversight helps to ensure consistent quality across IQIP program activities throughout each budget year.

Monitoring Implementation Status and Performance

When preparing their IQIP program oversight approach, recipients should document IQIP program performance and quality standards in their recipient IQIP operations guide, communicate them during training, and use them to assess consultant performance. Recipients should also plan to monitor all facets of IQIP program implementation and quality at a regular cadence throughout each year to maintain awareness of implementation status, assure smooth operations, and assure consistent adherence to quality standards.

Table 27: Oversight Method and Performance	
Oversight Method	Program Performance Aspect
Observe consultants annually during site visits, check-ins, or 12-month follow-ups	IQIP site visits, check-ins, and follow-ups are performed in a consistent manner and according to CDC and recipient specifications
Reviewing random selection of consultant notes in the IQIP	Consultants enter data and notes into the IQIP Database according to CDC and recipient timelines and specifications

Database	
Consult the IQIP Dashboard	Site visits are completed at a pace to meet mid-year and end-year metrics targets
	Coverage assessments are done using IIS data and according to IQIP program specifications for each cohort
	Check-ins and follow-ups are completed on time
Survey providers who have completed an IQIP cycle	Satisfaction with the IQIP program

For additional guidance for using the IQIP Dashboard see the “Using the IQIP Dashboard for Monitoring Program Implementation and Quality” section later in this module. Recipients may use other methods of program monitoring specific to their jurisdiction’s structure.

Resources for IQIP Program Management and Oversight

CDC provides multiple resources to assist IQIP programs fulfill their management and oversight activities. Key resources for program planning and implementation are listed below.

IQIP Dashboard

The IQIP dashboard visualizes data from the IQIP Database. These visualizations convey information such as status towards IQIP required performance metrics (i.e. timeliness of site visits, check-ins, and follow-ups). They also provide tools to view data using filters such as site visit type, date, and QI strategy and to support coordinator follow-up. Recipients can see only their own data. See [Using the IQIP Dashboard for Program Oversight](#) for specific tips.

IQIP Database File Repositories

The IQIP Database File Repositories are file sharing areas in REDCap that CDC uses to share IQIP program resources relevant to these systems with users. Each IQIP Database within REDCap has its own file repository.

Accessing and Using the IQIP Dashboard

Access

CDC provides IQIP dashboard access to the IQIP coordinator, program manager, and CDC field assignee (if applicable) for each immunization program. Access can be provided to additional staff with IQIP monitoring responsibilities upon request. For dashboard access instructions refer to “IQIP Monitoring Dashboards – How to Access.”

IQIP Dashboard Pages

The IQIP dashboard has five pages, each with data visualizations to help monitor IQIP program

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implementation and data quality.

- **Overview:** This page loads whenever you open the dashboard and displays visualizations to summarize key program implementation status data. At the top of this page, you will see how many providers have received a site visit, QI type, Site visit type, method, and distribution of strategies selected. Scroll down for information on check-in and follow-up status and visits by consultant.
- **Metrics:** This page provides tools for monitoring required IQIP program metrics and other metrics such as lost to follow-up.
- **Data Quality – General:** View the Data Quality-General page to see any records with data quality issues needing follow-up. A record is shown on this page ONLY if it has a data quality issue (except for the provider line list at the bottom) needs follow up. If there are no records listed on this page, then no follow-up is needed.
- **Data Quality – Coverage:** This page provides tools for monitoring the quality of coverage assessment data entered into the IQIP Database. Use the Parameters tables by cohort to make sure consultants generate coverage assessments using the intended parameters. Click on any parameters that do not meet the jurisdiction’s specifications to view those providers in the coverage assessment line list below and follow up with those consultants to provide any training needed to correct the discrepancy moving forward. Keep in mind that all 12-month follow-up coverage assessments should be conducted using the same parameters used for the initial assessment.
- **Coverage:** This page includes coverage data for all IQIP providers with the current budget year requirements met (i.e. with complete initiation and initial coverage and site visit stages, as defined on the “Overview” page). Review the information in the “About This Page” section for interpretation guidance.

Using the IQIP Dashboard for Program Oversight

The most powerful oversight tool available to IQIP coordinators is the IQIP Dashboard. The dashboard supports program oversight by presenting implementation data in concise, easily interpreted visualizations that viewers can filter and sort by several variables such as city, county, consultant, and site visit, check-in and follow-up status. Coordinators can use the dashboard to maintain overall awareness of implementation status, data quality, and timeliness of IQIP program activities and use the filtering and sorting functionality to identify why performance may be below desired levels. Below are several use cases for determining status for required IQIP program performance metrics.

Table 28: IQIP Dashboard Use Cases	
Use Case	Actions
Find number and percentage of minimum required site visits	• Overview page > Site visit complete. – The number of site visits completed is inside the arc of the gauge.

Table 28: IQIP Dashboard Use Cases	
Use Case	Actions
completed and entered the IQIP Database	– Hover cursor over the red or green portion of the gauge to see the percentage the number represents.
Find percent of initial coverage assessments done using IIS data	• Data Quality – Coverage page > Coverage Assessment Method – Look at orange bar and percentage over “IIS platform”
Find number of 2- and 6-month check-ins are due	• Overview page for current BY > Check-In & Follow-Up Status table > “Due” column – Click on the number on the row for 2-Month or 6-Month – To drill down: ▪ Look at consultants table to see which consultants did those site visits ▪ Look at Provider Line List to see the providers who received those site visits ▪ Scroll to the right and look at 2-Mo. Date (Planned) or 6-Mo. Date (Planned) column to see due dates ▪ Click on the VFC PIN to view the IQIP record in REDCap
Find number of 2- and 6-month check-ins are overdue but can still be completed on time	• Overview page for current BY > Check-In & Follow-Up Status table > “Overdue (Still Time)” column – Click on the number on the row for 2-Month or 6-Month – To drill down: ▪ Look at consultants table to see which consultants did those site visits ▪ Look at Provider Line List to see the providers who received those site visits ▪ Scroll to the right and look at 2-Mo. Date (Planned) or 6-Mo. Date (Planned) column to see due dates ▪ Click on the VFC PIN to view the IQIP record in REDCap – To follow-up: ▪ Click on a consultant from the “Consultants” tile ▪ View the Provider Line List below to see which providers are due but can still be completed on time ▪ Hover over the header to show available header icons

Table 28: IQIP Dashboard Use Cases

Use Case	Actions
	- Click on  to copy as an image - Click on the green “Copy” button in the popup window - Go to your email application, open a new email, paste the image into the email body and send to the consultant with a message.
Find number of 12-month follow-ups are overdue	- Overview page for previous Budget Year > Check-In & Follow-Up Status table > “Due” column. - Click on the number on the row for 12-Month - To drill down: - Look at consultants table to see which consultants did those site visits - Look at Provider Line List to see the providers who received those site visits - Scroll to the right and look at 12-Mo. Date (Planned) column to see due dates - Click on the VFC PIN link to view the IQIP record in REDCap
Find number of 12-month follow-ups are overdue but can still be completed on time	- Overview page for previous Budget Year > Check-In & Follow-Up Status table > “Overdue (Still Time)” column - Click on the number on the row for 12-Month - To drill down: - Look at consultants table to see which consultants did those site visits - Look at Provider Line List to see the providers who received those site visits - Scroll to the right and look at 2-Mo. Date (Planned) or 6-Mo. Date (Planned) column to see due dates - Click on the VFC PIN to view the IQIP record in REDCap - To follow-up: - Click on a consultant from the “Consultants” tile - View the Provider Line List below to see which providers are due but can still be completed on time

Table 28: IQIP Dashboard Use Cases	
Use Case	Actions
	▪ Hover over the header to show available header icons ▪ Click on  to copy as an image ▪ Click on the green “Copy” button in the popup window ▪ Go to your email application, open a new email, paste the image into the email body and send to the consultant with a message.

Recipients may have other possible use cases for the IQIP dashboard and CDC encourages IQIP program staff to explore the dashboard and use the available filters.

NOTE: The dashboard only displays IQIP Database data; the only way to alter or delete data is in the IQIP Database itself. By exploring the various pages and data in the dashboard, users will not accidentally change any program data. If you encounter a problem with the dashboard, email IQIPdatabase@cdc.gov for assistance.

Monitoring Qualitative Data

In addition to reviewing the data visualized by the dashboard, CDC encourages review of qualitative data that is not displayed on the dashboard. These qualitative data are the IQIP Database entries made by consultants related to provider workflow or any topic for which they may make a text entry. The quality and accuracy of these text entries are important because they need to be of sufficient detail to support future discussions with the provider, or support follow-up by a different consultant.

Because there are many forms for each provider in the IQIP Database, coordinators may wish to review a random sample of records. To easily create a non-biased sample, coordinators can download data from the IQIP Database and generate a random sample using Excel (see <https://www.wikihow.com/Create-a-Random-Sample-in-Excel>).

Helping Consultants Self-Monitor

Coordinators may also wish to encourage consultants to self-monitor their work. The Status Tracker report in the IQIP Database is available to consultants for this purpose. Consultants can use the report to monitor visit and call status throughout the IQIP cycle, including planned and actual dates and whether visits or calls are complete or incomplete.

Gathering Provider Feedback

Providers can be excellent sources for assessing specific aspects of the IQIP program. One way to

collect provider feedback is through a provider satisfaction survey on IQIP. Before conducting any survey, recipients need to determine the following:

- Any jurisdictional clearance needed for the survey
- Purpose of the survey
- Which providers to include
- What questions to ask
- How the survey will be conducted (e.g., e-mail)
- How results will be analyzed and shared

Recipients may use other methods of program monitoring specific to their jurisdiction's structure. The CDC is available to assist with survey design and data analysis if needed.

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IQIP Resources Mentioned in This Guide and Where to Find Them

Resource Name	Type	Location		
		VFC CAMP Knowledge Center	REDCap	PowerBI
Action Items Overview	Resource	X		
Alternate QI Program Credit Submission Form	Form	X		
Custom Strategy Submission Form	Form	X		
Effective Communications Strategies for Consultants	Resource	X		
IQIP At-A-Glance for Consultants	Job Aid	X		
IQIP At-A-Glance for Providers	Resource	X		
IQIP Awardee Performance Metrics (APM) Tool	System		X	
IQIP Consultant Training Packet	Resource	X		
IQIP Cycle Diagram	Job Aid	X		
IQIP Dashboard – How to Access	Resource	X		
IQIP Database	System		X	
IQIP Database User Guide	Resource	X	X	
IQIP Performance Metrics Reporting Guidance	Resource	X		
IQIP PowerBI Dashboard	System			X
IQIP Preparation Checklists	Job Aid	X		
IQIP Resources Index	Resource	X		
IQIP Resources Toolkit	Resource	X		
IQIP Site Visit Confirmation Letter Template	Job Aid	X		
IQIP Site Visit Diagram	Job Aid	X		
IQIP Supervisory Observation Tool	Job Aid	X		
IQIP Timeline Examples	Job Aid	X		
IQIP Tips	Job Aid	X		
The Role of the Immunization Champion	Resource	X		
Template for Provider Guidance on Patient Status Management	Resource	X		

Summary of IQIP NOFO Requirements and Program Requirements

Provider-Level Immunization Quality Improvement: Background and Overview

Program Requirement: Recipients should designate an individual to serve as IQIP coordinator.

Module 1– Provider Location Selection

NOFO Requirement: Awardees are required to partner with a minimum of 25% of VFC-enrolled providers to implement the 12-month IQIP process to increase vaccine uptake.

NOFO Requirement: Complete the IQIP process with a minimum of 85% of VFC-enrolled providers who receive an IQIP site visit within 12 months.

Module 2 – Generating Assessment Reports

Program Requirement: CDC requires assessment of coverage for any provider receiving an IQIP site visit and 12-month follow-up if the provider has IIS data that are appropriate and available for assessment.

Program Requirement: Provider coverage will be assessed at the site visit, 6-month check-in, and 12-month follow-up if the provider has data available for assessment.

Program Requirement: Awardees must select two cohorts in which the provider has active patients and for which IIS or EHR data are available.

NOFO Requirement: Recipients must collaborate with IIS staff to ensure provider-level vaccination coverage assessment capability for quality improvement projects.

Module 6 – Site Visit

NOFO Requirement: Recipients must report all IQIP program data to CDC within 10 days of every provider-level encounter.

Program Requirement: Recipients must assess the provider’s vaccination workflow prior to discussing coverage assessment data.

NOFO Requirement: Collaborate with providers to implement at least two quality improvement (QI) strategies, selecting at least one of the following: Strengthen Immunization Communications to Address Vaccine Hesitancy or Give a Strong Immunization Recommendation.

Module 8 – 12-Month Follow-Up

Program Requirement: The 12-month follow-up coverage assessments should be run using the same parameters used for the initial coverage assessment.

Module 9 – Conducting IQIP with Multisite Providers

Program Requirement: Representatives from each provider location should participate in multisite site visits and check-ins and follow-up.

Module 12 – IQIP Program Management and Oversight

Program Requirement: Recipients must provide training for all IQIP consultants upon hire and prior to the consultant conducting IQIP activities. All consultants should receive training each project year to ensure effective program implementation.

Program Requirement: Recipients must complete and send a custom strategy submission form to CDC for approval prior to offering it as an IQIP strategy. A custom strategy should not be entered into the IQIP Database prior to receiving CDC approval.

Program Requirement: Recipients must develop and maintain an IQIP operations guide tailored specifically for their IQIP program. The guide should align with CDC requirements, recommendations, and operational guidelines.

NOFO Requirement: Recipients must submit an IQIP performance metrics report to CDC every 6 months.

