I want to thank Debra for inviting Spokane Regional Health District to share our experience with reducing barriers to immunizations.

One of the ways that we have reduced barriers is to facilitate mobile vaccination services in various forms tailored toward school aged children.

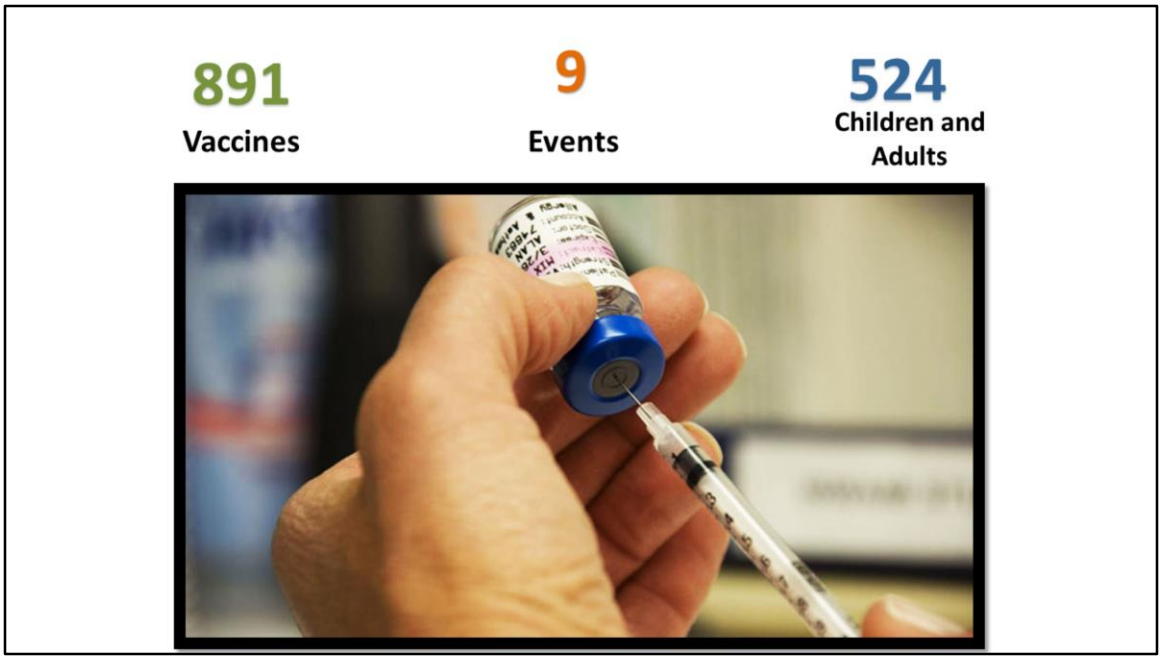
According to the US Department of Health and Human Services Community Preventive Services Task Force, these programs are best-practice strategies that have a demonstrated impact on increasing vaccination rates among school-age children and reducing rates of vaccine-preventable disease and associated morbidity and mortality.

The concept of mobile immunization clinics was developed on a much larger scale as part of public health preparedness in response to a pandemic. Hosting a large community clinic is well supported by a response system and tools to manage the planning, staffing and implementation of a clinic that could serve thousands of people in a short period. The partners of the Medical Reserve Corps, WSU Colleges of Nursing and Pharmacy and within the health district that were grown to support a pandemic response have all been leveraged to support smaller scale mobile clinics. Adapting those tools and the training are the foundation for school based immunization clinics.

The health district's Immunization and Emergency Preparedness staff embarked on a train-the-trainer model for the school nurses to learn and use the tools from large immunization clinics and adapt them to their school settings, leveraging the MRC volunteers and students from the Colleges of Nursing and Pharmacy as vaccinators instead of clinic coordinators. The goal from the health district's perspective was to work toward long-term sustainability of this model with schools and school nurses as the center, and other partners including local health department staff as supportive partners.

Today I want to

- Introduce you to our vaccination clinic models
- Discuss what is needed to get buy-in
- Share the partnerships that we have developed
- Considerations for planning the clinic and
- Provide a brief summary.



Before we get started though, I want to share a bit of data with you.

In 2018, we provided almost 900 (712 to kids) vaccines to 524 (400 kids) clients during our 9 vaccination events throughout Spokane County.

I am very excited about sharing the vaccination clinic models that have made it possible to reduce barriers to vaccination in our communities.

Childhood Vaccine Program

- **"Universal"** State
- Ages **Birth thru 18 years**
- **80 Providers** enrolled
- WA receives **$10 M in vaccines** each year

As you probably know, the Federal Vaccine For Children program, now known as the Childhood Vaccine Program, was designed to ensure access to vaccines for the underinsured and uninsured children of our nation.

Each state runs this program individually. Here in WA state, we are what is known as a universal vaccine state. Through a combination of state and local funding, any child in Washington state, regardless of income or insurance status, is eligible to receive those vaccines recommended by the Advisory Committee on Immunization Practices. We are one of 8 states, including Alaska, Idaho, Maine, Massachusetts, New Hampshire, New Mexico and Rhode Island, allowing all children to receive all vaccines at no cost except an administrative fee.

As a reminder, the program applies to all children under 19 years of age, more specifically, up to age 18 years and 364 days.

There are currently over 80 providers enrolled in the program in Spokane County.

WA state receives approximately $10 million in vaccine each year

Clinic Models

I am going to share the three models that we at SRHD have implemented in response to reducing some of the barriers to vaccinating.

As I mentioned earlier, the foundation of these models is in Public Health Emergency Preparedness protocols and can also be used to support efforts to mass vaccinate in an outbreak situation.

School-Located

- School Nurse determines immunization need
- Primary planning is done by school nurse
- Preceptor/Vaccinators from universities
- SRHD provides & manages vaccines

The school-located clinics are triggered by the school nurse who has determined that there is a need based on out-of-compliance rates.

He or she is the primary planner including, where to hold it within the school, selecting the date/time, providing volunteers to staff non-medical roles, determine vaccinators and promote the clinic.

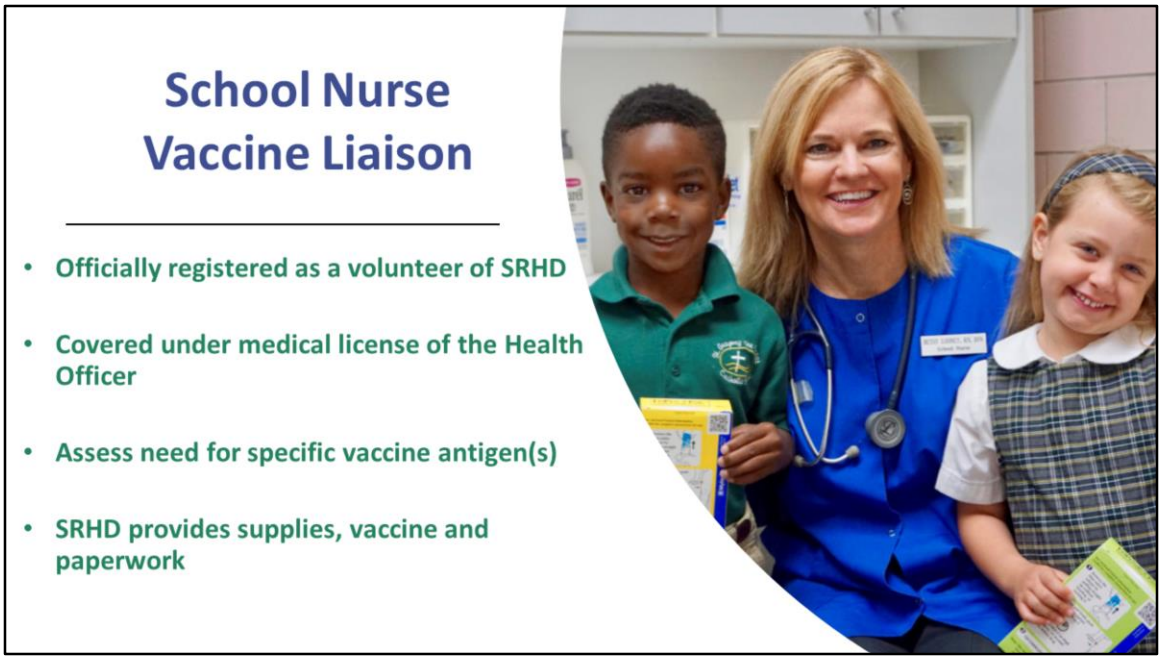
School nurses are typically the medical screeners, nursing or pharmacy students typically are the vaccinators and, other community partners or school staff can work the non-medical stations.

If we are being asked to provide the vaccine, then we attend the clinic and manage the vaccine as well.

Community –located clinics differ from school-located by who is making the request. These requests could be from a group such as Rotary Club or the Police Activity League.

While the clinic could be held in a school it could also be held at a community center, library, park or other public location.
We pack the clinic supplies and vaccine and take it to the site.

These are facilitated by our Immunization Assessment & Promotion Team and we manage all logistics of the clinic.



We also have the model where a school nurse becomes a volunteer of our agency, therefore has liability coverage under our Health Officer. This process is important because our school nurses don't vaccinate as part of their scope of practice within their role in the school system.

Once the nurse has assessed that there is a specific need for vaccines; it may be for just a couple of students or for a group of students, we are contacted and coordinate with the nurse for logistics.

Program staff pack the vaccine for transport. The nurse comes to SRHD to pick up the vaccine and supplies and takes it back to the school for administration.

Ultimately, the purpose of each of these models is to reduce the barriers of access and cost for families.

By bringing the vaccines to the clients, it provides an opportunity that is usually well-received and greatly appreciated.

Background:

Up until the Fall of 2013, SRHD had a clinic and provided vaccines on site. Since closing the clinic, we continue to receive funding for vaccines but, we don't have the appropriately licensed staff to administer them.

There is also a cost for supplies and staff time so we work with community partners and private providers to assist with staffing. Sometimes supply purchases are allowable expenses under various grants or we purchase supplies under state/federal purchasing contracts, keeping costs to the program very low.

You can see here that the key roles in implementation of a vaccination clinic includes the local health jurisdiction, the school district, private providers and the community.

Public schools need to partner with an organization that is enrolled in the CVP program. That can be a local health jurisdiction if they are a CVP provider or a healthcare provider enrolled in the program.

The role of:
SRHD is to serve as clinic organizer or co-organizer; facilitate a MOA with school districts; develop Standing Orders under their Health Officer; Supply vaccines and vaccine administration supplies; supply day-of materials; leadership support to schools looking to implement model; provide just in time training regarding medical screening and vaccinating to group day of; provider overall direction on theday of clinic; structure development oversight for private provider clinics (billing, vaccine management, especially of frozen vaccines); created tool templates with which to plan and execute a clinic

Public School District - Gain admin buy-in; identify location/venue; assess student gaps in coverage; provide targeted marketing to families; serve as medical . They are able to adapt the tools in the clinic toolkit as needed.

Community Partners - Professional Nursing and Pharmacy Vaccinator Groups/Health Plans/MRC all serve in various capacities including: Safety coordinators; vaccinators; medical screening; clinic flow monitors; insurance/resource information and enrollment

Private Providers - A key difference when partnering with providers is that they supply everything needed to do the clinic rather than SRHD providing everything. One example that we have here in Spokane is working with the CHAS clinic. They bring vaccine, vaccinators, paperwork and vaccine supplies. This public/private partnership between the schools and a private provider/clinic is a model that can work in any community with very little energy necessary for sustaining the model once established. Public health moves into a role of facilitator or liaison between schools and the healthcare community. This is the primary model used by our smaller, more rural communities.

How can you get buy-in at all levels?

LHJ – Initially, within our health district, "Increasing access to immunizations by bringing mobile services to where need exists." was identified by NACCHO (National Association of City and County Health Officials) as a "best practice strategy".

We then demonstrated the need through a "school records review project" which identified a high percentage of school aged students whose records were out of compliance.

Finally, a partnership with a health foundation (Group Health Foundation) was identified early. It was through this grant that we obtained the financial resources to develop the model for our community as well as other resources to expand the model to various types of communities throughout the state. This included the pilot testing of the model and its revisions.

School Administration Engagement & Leadership – In most school districts, nurses are not empowered to be the decision makers for what happens in their district, even those things that are solely health related. Everything has to go through the administrators – e.g., the superintendent, director of special services, etc. One way to get involved with schools is to approach the local ESD and try to attend a superintendent's meeting. That is where information can be shared with the leaders of several school districts all at once. Schools can actually be held liable for disease outbreaks. That is information that many superintendents may not know and may be helpful in securing a partnership.

School staff – From the school perspective, getting buy-in from their staff is a major part of the partnership. School staff members help by volunteering in the clinic, being able to answer questions about the event, making copies, disseminating information, preparing mailings, making phone calls to families and setting up reminder calls. Helping admin staff understand how having kids up-to-date on their immunizations will make their jobs easier, you can win them over as great advocates and promoters of the event!

Families – Getting families to buy in to the event is pretty easy. We typically offer the events immediately after school until early evening. Many parents are already coming to the school to pick up their child either after school or from after-school care and so, taking a bit of time to participate in the clinic is very convenient for them.

Once you have the buy in from the key players, you will want to find crucial partnerships within your community.

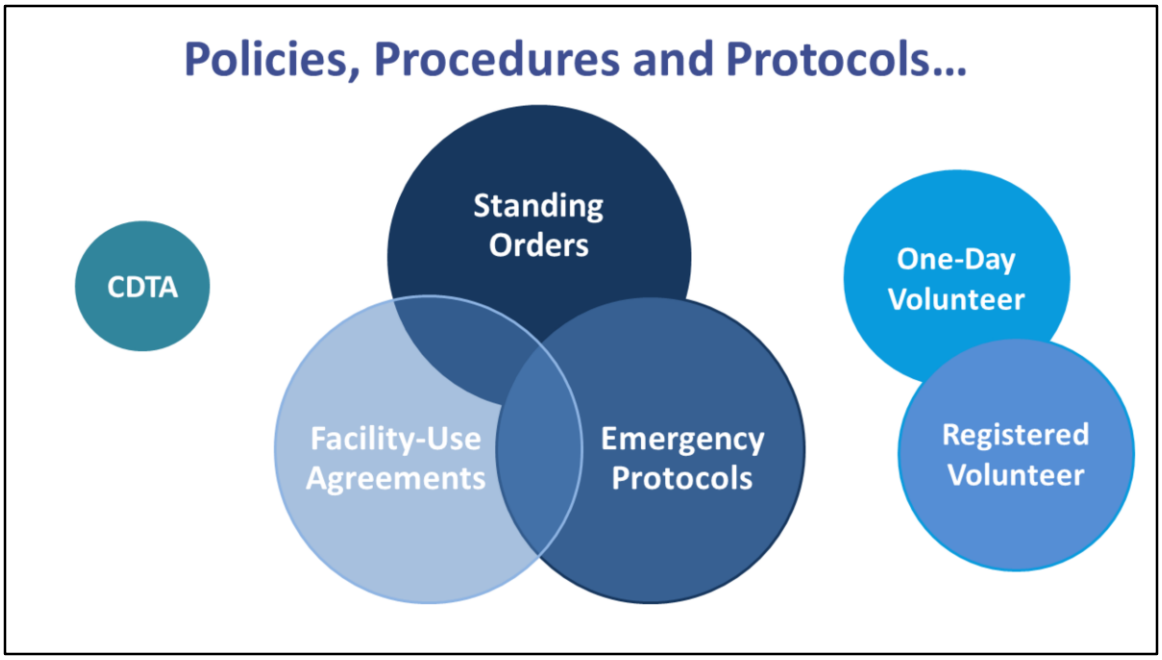
LHJ Programs: Immunization, Emergency Preparedness and Communicable Disease staff can lead or co-lead larger clinics or support school nurses new to hosting mobile clinics by working side-by-side. Because SRHD is a Childhood Vaccine Program provider we are able to provide vaccines and their management during the mobile clinics.

Medical Reserve Corps – is a volunteer organization for medical and non-medical personnel, whether they are actively practicing or retired. In Spokane, the program is housed and coordinated here at SRHD. Another group that we have recently partnered with is one of our local Rotary Clubs. One of their community projects is focused on vaccinations and so they are able to support our efforts with volunteers, snacks and games during the clinic and some marketing of the clinics.

Professional Training Programs such as: Nursing, Pharmacy, Medical Assisting, and Medical Academic Programs – we maintain agreements with the professional education programs at Gonzaga, WSU, UW and SCC for nurses, pharmacists and medical assistants to serve as vaccinators and medical screeners.

School Nurse Leader Corps/ School Nurse Leads/ School Administration – In our Educational Services District, there are monthly meetings that are comprised of the lead nurses in each school district. Several years ago SRHD was invited to join us in those meetings. That was the beginning of a beautiful partnership that continues today. Our communicable disease epidemiology staff and immunization outreach staff have an existing close relationship with the school nurses so, mobile clinics are an extension of those existing interactions.

Private Providers – Ideally, linking private provider practices with schools serves families on multiple levels, especially for families who may not yet have a primary care home for their children. Although this isn't the primary approach SRHD uses for school located mobile clinics, on occasion, SRHD may not have the staffing or time to host a vaccination clinic. In these situations, we look to other Child Vaccine Program providers in the community. One of our partners is Community Health Association of Spokane, better known as CHAS – a federally qualified healthcare clinic. We can provide assistance to them and other private providers to figure out how to partner with schools, order enough vaccine and establish protocols for vaccine management in a mobile environment.



How do we "legally" make these clinics happen? There are some basic elements that need to be in place prior to implementation of the clinic models.

Standing Orders
Most of our vaccinators are not independent practitioners and so must work under a physician's standing orders. This document outlines all aspects of administering vaccines at an offsite location and is reviewed annually. In our case, the standing orders are signed by our Health Officer.

During the clinic itself, most of our vaccinators are students in professional training programs and so need a preceptor to oversee their work. If they are school or community nurses or Medical Assistants they can be registered volunteers of our agency, especially if they work with us regularly or they can be one-day volunteers. Both types of these volunteers work under the medical license of our Health Officer. Be sure to check with your state rules and regulations around standing orders, medical volunteers and academic preceptors.

Emergency Protocols
Anytime you are administering vaccines, there is a chance for a medical emergency. You will need a written set of emergency protocols that vaccination clinic staff and preceptor have reviewed so that they understand their role in the case of an emergency.

Facility Agreements
Finally, work with your community partners to establish facility agreements so that you are able to be onsite. We typically have agreements at the school district level. As I mentioned earlier, these agreements are written so that they can be used in case of a disaster or community outbreak or other wide-spread emergency, and include the caveat of smaller, onsite mobile clinics. The purpose of the facility use agreements is shared liability coverage in case a community member or volunteer staff gets injured on the premise during the mobile clinic.

We also have what is called a **CDTA** or collaborative drug therapy agreement with the college of pharmacy. This allows qualified pharmacists to assume the professional responsibility of performing patient assessments, counseling and administering the vaccines. In WA state, a pharmacists with a CDTA on file with the state can oversee both pharmacy and nursing students in the field.

Finally, we have two kinds of volunteers; those who may only work one clinic and those who volunteer on an ongoing basis. We have a modified version of our volunteer form for the one-time volunteers that does not require a background check.

We also have a vaccinator skills training program for all regular volunteers as well as just-in-time training for those who are working one clinic. Both of these trainings are designed to provide an orientation to the clinic processes, flow and their specific role as part of the clinic, as well as assure vaccinator competence for volunteers routinely representing our agency.

There are several aspects to consider when planning your vaccination clinic.

I am going to list them here but, due to time constraints, I won't go into detail.

Location and logistics; one thing I would like to mention is that, for the clinic, we set up 6 stations in a way that creates one-directional flow for parents/children.

The amounts of vaccine depends upon the assessment that the school nurse has conducted.

Supplies will include everything from the medical (sharps containers, syringes, etc.) to non-medical (consent forms, privacy screens, laptops, etc.).

Staffing includes vaccinators and volunteers and is based upon the estimated number of clients you will have come through the clinic. If you are expecting only about 20 clients, you probably don't need more than 2 vaccinators.

Finally, if you don't successfully market the clinic to the intended audience, all of your planning will be for nothing. We utilize a variety of "free" marketing approaches; social media, our website, the school's publicity and the local news channels are usually excited about promoting these community events.

To provide assistance to others who are interested in facilitating these clinics, SRHD developed a ***Mobile Immunization Clinic toolkit*** and two short videos, all housed on the WithinReach Immunity Community website.

You can access all of these using the link on this page.

I encourage you to watch the videos and then utilize the toolkit as you plan and implement your clinic.

In summary, I want to share some of the more obvious benefits of these clinic models.

These models have been designed to enhance access to vaccination services for underserved populations and families experiencing challenges accessing timely healthcare services in addition to reducing their out-of-pocket costs.

Through the school located model, school nurses are able to target specific families who are out of compliance and encourage them to attend the clinic. The hundreds of children that we vaccinate through these clinics may not otherwise receive the vaccines or receive them in a timely manner and so would risk being excluded from school.

Not only do these models positively impact a schools' student immunization out-of-compliance rates, they improve the assessment and tracking of vaccination status via the utility of our statewide immunization registry database. After each vaccination clinic, regardless of the model, our SRHD team enters the data into the IIS.

For our Healthcare Provider partners, this fulfills their community benefits obligation outlined in the Accountable Communities of Health portion of the ACA.

If you have any additional questions or would like examples of any of the documents I mentioned, please contact me.

Also, if any of your schools routinely vaccinate children, I would love to be able to talk with you about that.
Thank you so much for your time and attention today.