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CASE EXAMPLE

Creating a "Hub and Spoke" Model for a Statewide Immunization Program in Washington

THE CHALLENGE

Historically, the Washington Department of Health (DOH) administered the Childhood Vaccine Program with contract support from all 35 local health jurisdictions (LHJs) in the state. LHJs were responsible for conducting site visits to ensure participating providers' compliance with the program, providing technical assistance for quality improvement, and processing vaccine orders from participating providers. The CDC funding to support this work was, in part, based on the number of providers enrolled in the program in each county, with King County (where Seattle is located) receiving about one-third of the program budget. Smaller counties, with only one to two providers each, worked with much smaller budgets and spent much less time on the program activities.

In 2016, DOH became increasingly concerned about whether LHJs were sufficiently equipped to meet the contractor responsibilities. Immunization program leaders felt the integrity of the program was at serious risk because the number of required vaccines was expanding; the program requirements from CDC were becoming more stringent; the information technology used to track site visits changed; it was difficult for staff in smaller health departments to become proficient in their duties given competing priorities and small numbers of providers in their jurisdictions; and it was difficult to keep staff up-to-date on program requirements.

REDESIGNING IMMUNIZATION PROGRAM ADMINISTRATION

Consistent with their philosophy of engaging partners, DOH worked with the Washington State Association of Local Public Health Officials (WSALPHO) to jointly establish a workgroup to address the system problems. The workgroup comprised program staff from DOH and LHJs across the state. Based on other efforts at the state level, the workgroup considered three different models of service delivery for the immunization program components: centralized (services provided by DOH), "hub and spoke" model (services provided by select LHJs to designated regions), and decentralized (services provided by each LHJ in the state). The workgroup decided that a centralized model would be used to process all childhood vaccine orders throughout the state, and a hub and spoke model would be used to conduct site visits for compliance and provide technical assistance for quality improvement.

> *We had to ask ourselves 'Are all 35 contractors administering the immunization program the way they should?' If not, program integrity could be jeopardized."*

–MARY HYUNH

Deputy Director, Office of Immunization and Child Profile, Washington Department of Health

A next step was to define regions. The workgroup decided to align with the state's nine accountable communities of health (regional consortia for health services delivery, developed for another state mandate) with some minor adjustments. LHJs then applied to staff the regional office, and one LHJ from each region was chosen by DOH. Funding was allocated to regions based on the number of providers and the amount was based on data collected during the assessment process. The state used existing staff for the vaccine ordering function. Realized savings of $500,000 were found from efficiencies created by both regionalizing and centralizing functions. This money was reinvested into LHJs, using a population-based formula, for locally developed efforts aimed at improving immunization rates (mostly childhood related projects). The planning took about two years and entailed multiple iterations. Toward the end of this time, DOH received a competitive small grant from the Center for Sharing Public Health Services to develop a multi-layered program evaluation.

THE RESULTS

Comprehensive program evaluation plans are still being developed and, in the meantime, DOH staff are in regular communication with regional offices and all other LHJs in order to understand what is and is not working with the new system. DOH also is engaging LHJs in designing and implementing adjustments to the program's processes and contractor trainings.

Early indications are that providers appreciate higher levels of expertise for compliance and quality improvement activities. Furthermore, DOH staff report greater success in their ability to standardize program procedures by working with fewer LHJs. Local immunization rates are monitored annually and will be assessed over the longer term to identify any locally based strategies that result in increases.

In some regions, compliance activities and clinic office quality improvement activities are assigned to separate staff members; in other regions, one person conducts all of these activities. While it is more expensive to pay for two different trips at different times, one person does not always have both skills. DOH plans to examine this issue and identify potential strategies to ensure maximum efficiencies. In addition, some regional staff are adjusting to a schedule that now requires overnight stays when providers are a significant distance from the office.

An annual provider satisfaction survey indicated that it takes longer for participating providers to hear back from DOH and LHJ staff than before. This feedback highlights the need to consider provider expectations when developing a communications plan for a new system rollout.

Finally, DOH customer service for LHJs that no longer are program contractors continues to evolve. For example, DOH has learned LHJs need to know when a provider disenrolls from the program for the purposes of client referrals. LHJs also are interested in the results of compliance checks and quality improvement efforts.

KEYS TO SUCCESS

Plan for the significant outreach, engagement and time needed to enact systems change.

Develop a strong communications plan to support the work, beginning at the outset and continuing through implementation. Include all target audiences that will be impacted. In Washington, that meant workgroup members, all other LHJs, all other DOH immunization program staff, and providers.

Encourage relationship building among workgroup members. It is easier to navigate difficulties when all involved feel that everyone is working in good faith for successful resolution.

Use neutral facilitators. DOH staff did not facilitate the workgroup to avoid perceptions they would drive decisions. Instead, they hired highly experienced staff from LHJs Centers of Excellence to facilitate. The facilitators successfully kept discussions focused on operational issues and mutual goals.

The Center for Sharing Public Health Services supported the effort by providing a venue to learn from peers across the country engaged in other forms of cross-jurisdictional sharing. Monthly calls with the Center were a time to reflect and digest the effort underway and prompted DOH staff to document various aspects of their work.

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These resources were created under the original language around cross-jurisdictional sharing. As we've learned more about this work over time, we've broadened our language to service and resource sharing. However, the documents reflect the term 'CJS' for this reasons. They were created to provide guidance for two ore more health departments developing a shared arrangement. We will be updating these resources and adding new resources to describe the broader types of service and resource sharing models based on learnings.