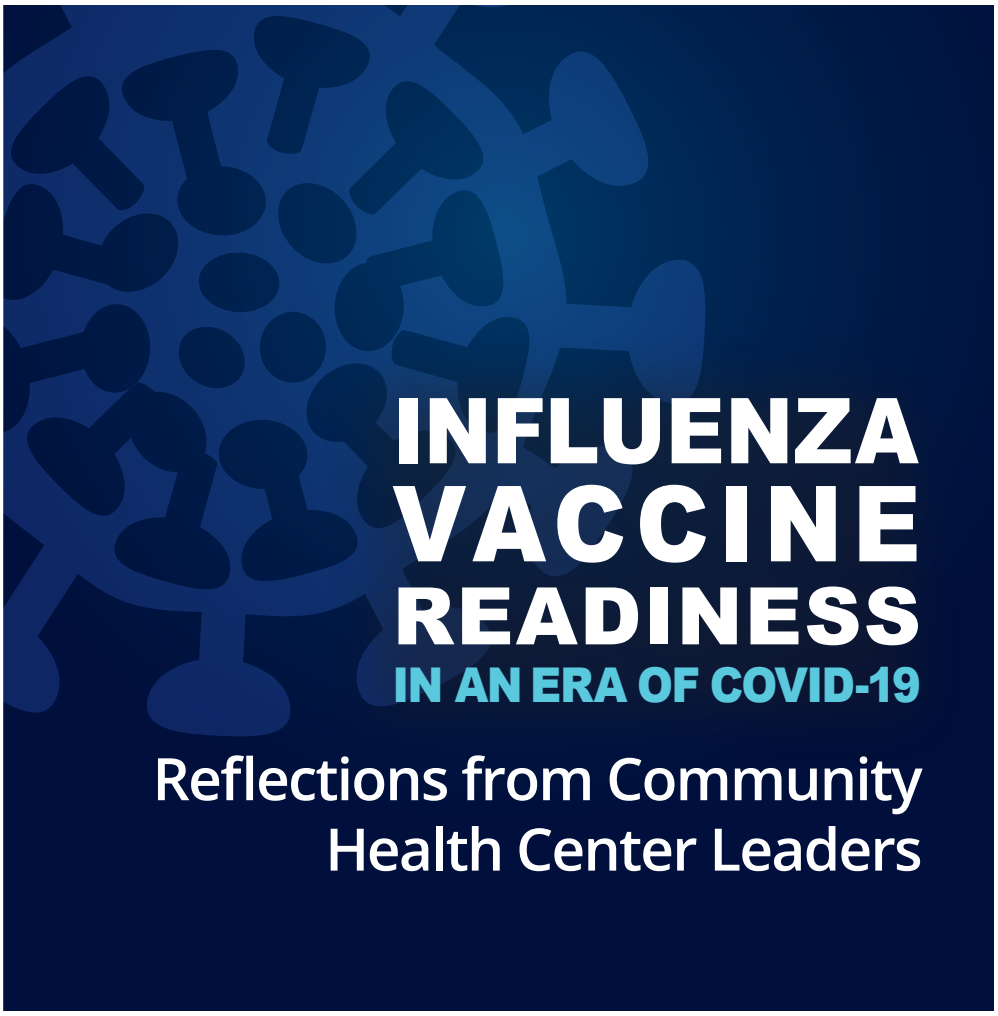

INFLUENZA VACCINE READINESS

IN AN ERA OF COVID-19

Reflections from Community Health Center Leaders

SEPTEMBER 2020

NATIONAL ASSOCIATION OF Community Health Centers®

BACKGROUND

The National Association of Community Health Centers (NACHC) interviewed a diverse group of health center leaders to ascertain issues being considered in light of the urgent need for expansive influenza vaccine coverage in the face of the novel coronavirus pandemic. A corollary feature of influenza vaccine readiness is the capacity of centers to nimbly provide a COVID-19 vaccine when it is available—a vaccine that will potentially have universal demand, limited initial stock, multiple dose requirements and several suppliers. Historical barriers to adult influenza vaccine coverage in health centers are now intertwined with new protocols for patient care and safety as well as changing public perceptions of contagion, risk and vaccine efficacy.

Interviews were conducted with center leaders as well as Primary Care Association (PCA) leaders actively engaged with NACHC in quality improvement efforts directed toward influenza immunization coverage. Five of those interviews were selected for this summary as they reflected high performance in vaccine delivery, diversity in patient population and depth of understanding at the leadership level. Representative organizations are: **Georgia PCA, Alaska PCA, Holyoke Health Center (MA), Delaware Valley Community Health, Inc. (PA) and El Rio Community Health Center (AZ)**. Over 880,000 patients access care at sites related to these organizations, with more than half of these within the state of Georgia. Urban, rural, frontier, tribal, homeless, indigenous and migrant populations are included in the demographic profile of patients served by the participating health center networks.

Leaders were queried about the history of their organization's adult influenza vaccine efforts, preparations for the upcoming flu season, collaborations with non-center leaders, planning for COVID-19 vaccine efforts, changes to care related to the pandemic, and prioritization of influenza vaccine campaigns in their overall scope of work. Subtopics included vaccine procurement methods, outreach and education campaigns, vaccine hesitancy, cultural distinctions and adaptations, risk stratification, registry and data use, provider and staff practices, and emerging models of care. Universally, leaders stated that the upcoming influenza season, with its concomitant vaccine efforts, is an issue of highest importance in their scope of work. Interview findings are highlighted in the following pages, with implications for ongoing vaccine readiness efforts identified. ■

FINDINGS

Health center vaccine readiness is best exemplified by organizations that incorporate strong clinical quality improvement leadership at the board level.

Organizations that lacked senior leader knowledge of influenza vaccine plans also lacked concrete plans for adapting to the pandemic environment as they embarked on the upcoming flu season; likewise, they had not initiated a COVID-19 vaccine implementation planning process. In contrast, the five organizations highlighted here demonstrated the centrality of immunizations as a vital part of center operations and integral to all aspects of institutional practice. Both the Georgia and Alaska PCAs have clinical quality improvement staff report to, and interact collaboratively with, the board members. These staff have primary responsibility for advancing immunization initiatives. As the board members at the PCAs are CEOs and leaders of regional health centers, this direct relationship between quality improvement staff and board members provides a coherent comprehensive strategy that can then be adopted at the more local level. The quality improvement staff visit each local center, mediating the strategies of the region as they assist individual models of application. Additionally, in the case of health center controlled networks, vaccine purchasing is negotiated and streamlined at the PCA level, increasing the financial capacity of the individual centers.

This board level integration is also a component of the three health center entities represented (Holyoke, Delaware Valley and El Rio).

EL RIO COMMUNITY HEALTH CENTER reports that all board members and senior leaders get immunized with flu vaccine as soon as it is available to show solidarity in support of immunizations. They also join with other health center leaders to share immunization strategies and to learn from national organizations such as NACHC and the Centers for Disease Control and Prevention (CDC). Budgeting reflects commitment to comprehensive immunization practices.

HOLYOKE HEALTH CENTER has pharmacy leaders report to the board through their Quality Council. The Chief Medical Officer collaborates with pharmacy and board on immunization issues.

AT DELAWARE VALLEY, the Chief Performance Improvement Officer meets with the board and has collaborated with them on the development of a walk-in immunization clinic. Boards at these organizations understand immunizations are essential components of primary care practice to the underserved.

FINDINGS

(continued)

Multiple models of vaccine delivery and adaptations in workforce have produced demonstrable improvements in influenza vaccine rates.

All of the organizations represented utilize multiple models of vaccine delivery. This has assisted their continued progress in the face of the pandemic. All have some model of same day and walk-in appointments for immunizations. Though these have been reduced or eliminated due to COVID-19 concerns, call-back practices and rapid appointment options have helped stabilize immunization coverage. **EL RIO COMMUNITY HEALTH CENTER** has developed a drive-through model for flu vaccine coverage and **HOLYOKE** has a curbside model. Family members can be immunized if accompanying the primary appointment recipient.

Standing orders are commonplace. Schools, local employers and homeless shelters are also sites for vaccine delivery; most health centers plan to continue these with some modifications due to COVID-19.

Workforce adaptations are characteristic of performance improvement in influenza vaccine coverage.

HOLYOKE AND EL RIO both use advance practice pharmacists to lead immunization efforts**.** As providers, El Rio pharmacists prescribe vaccine but don't administer it. At Holyoke, pharmacy technicians do vaccinate, responding to standing orders for immunizations. They also have a certified community health worker in the pharmacy, facilitating patient education and scheduling for immigrant and culturally distinct patients. Dental and behavioral health staff are also involved in immunization outreach at El Rio, in concert with efforts to identify Social Determinants of Health in their community of interest.

FINDINGS

(continued)

Continuous data monitoring and digital innovation drives improvement.

These high performing organizations don't rely on static data points or on external registries as primary tools for understanding immunization rates in their populations.

Robust use of population data is assisted by the collective use of the Azara platform in the **ALASKA COHORT OF CENTERS**. This has enabled risk stratification of patients for vulnerability to both influenza and COVID-19 morbidity. Rather than a binary risk/no risk designation, Azara categorizes risk as high, medium or low. As vaccine becomes available, patients can be recalled based on risk. Azara also allows registry construction and dashboard design. Alaska leaders report that easy accessibility to data is a key to their influenza vaccine rate improving from 8% to 34% in less than a year.

EL RIO also has a well-developed database and registry. Approximately 46,000 of their 130,000 patients are deemed high risk for influenza and COVID-19 complications. Understanding the challenges associated with prioritizing efficient rapid flu immunization coverage to one-third of their patients prepares them for eventual COVID-19 vaccine deployment. In all centers, electronic chart records of individual patients are screened for immunization needs at each visit. There are some frustrations with data integrity in state registries, so most centers rely on their own data. As patients currently can access flu vaccine at multiple community sites, and there aren't dependable databases letting providers know that their patient has been vaccinated, leaders express concern over how a state or national database might be compiled to document COVID-19 testing, recovery and immunization status.

Centers are also exploiting digital technology for immunization outreach and recall. Health education messages are sent via text and patient portals. Recall for immunization updates are texted to adolescents. As COVID-19 testing is performed, some centers plan to offer influenza vaccine to those testing negative through use of follow-up data. Contact tracing efforts are also being reviewed for possible linkageto vaccine outreach.

FINDINGS

(continued)

High performing centers collaborate with many outside groups and often are leaders in immunizing a large proportion of area residents, regardless of the patient's primary medical home.

Senior leadership in immunization practice issues is linked to community and regional leadership. The PCAs work closely with their state departments of health. **GEORGIA PCA** also has a strong relationship with the American Academy of Pediatrics. The **ALASKA PCA** and **EL RIO** closely collaborate with area tribal organizations. Both describe the tribes as very aggressive in pursuing full immunization coverage for their members. Tribal health plans pay for vaccines and tribal outreach influences vaccine acceptability. Representative centers collaborate with local employers, schools and organizations, often leading immunization efforts for community members regardless of primary care provider affiliation.

Vaccine supply, demand and cost have not been significant challenges to these organizations.

Influenza vaccine efforts are well integrated into center practices. Procurement is familiar, and supply is often determined from past efforts. Seasonality of the vaccine administration creates a predictable flow of work for all involved. Barriers to vaccine uptake are not typically related to cost, but to patient-centered access needs and to vaccine hesitancy. Multiple vendors are used so supply is typically stable with demand. Centers are increasing their orders for vaccine and associated supplies as they anticipate high demand this year.

FINDINGS

(continued)

In times of rapid change, centers rely on accessible frequent deployments of training opportunities for staff and consistent educational materials for patients.

Organizations highlighted the need for up to date training and trustworthy communication in the face of the pandemic. National fragmentation in messaging has adversely affected clinical practices.

> The **ALASKA PCA** participates in weekly 30 minute COVID-19 response meetings with centers and state health leaders. There are also a number of ECHO (Extension for Community Healthcare Outcomes) projects in Alaska, assisting remote learning. The ECHO model is being utilized to widely disperse COVID-19 vaccine development information for both medical professionals and for patient education. The **GEORGIA PCA** is presenting a webinar to its members on adult immunization practices before the upcoming flu season. In the face of swirling vaccine conspiracy messages, staff training in motivational interviewing is being prioritized at **EL RIO**. Their aim is to achieve a "culture of immunization" at their center by unifying staff, supplying accurate timely information and equipping knowledgeable responses to issues of vaccine hesitancy in partnership with tribal leaders.

Formal preparations for potential deployment of COVID-19 vaccine are not in place.

None of the organizations had a formal planning process in place to address the operational issues that will be associated with a COVID-19 vaccine. Several did have a database identifying those at highest risk from disease. But when faced with the sudden need to immunize tens of thousands of patients in their organizations, none had preliminary action plans, responsible staff or prioritization issues identified.

Some organizations had tried to stockpile vaccine supplies, anticipating a future shortage. One entity is joining a larger state planning effort that is now in early development. Holyoke is using lessons learned from their administration of the shingles vaccine to anticipate problems related to supply and demand. All organizations commented that storage of vaccine and supplies will be problematic.

Relationships remain critical to successful immunization efforts.

All respondents noted that their success in immunization practices is related to their personal connections in the community. The PCA leaders visit every center and are well known to clinical staff. The immunization leads are often part of an indigenous or at-risk population served by the centers for which they work. Pharmacists state that the patients trust them with vaccine care, as they are used to regular interchanges with them about their medicines and health care needs. Tribal and center leaders have spent years in close collaboration, typically sharing staff and patients. Overcoming vaccine hesitancy requires trust in individuals as well as systems.

IMPLICATIONS FOR THE FUTURE

Community health centers have a long and solid history of optimizing immunization coverage in at-risk populations. Influenza vaccine procurement and delivery is not considered a major difficulty by most. Yet, full flu vaccine coverage of adults remains a challenge, as the US national rate of adult flu vaccine coverage was estimated as 45.3% for 2018-19. The estimated rate across states was between 33.9%-56.3%. Findings highlighted by these organizations reveal that even with integration across the health care system, strong staff and leadership support, vaccine coverage is about 60% at best. Herd immunity, a term so often discussed related to COVID-19, has never been reached with flu vaccine.

Continuous data monitoring, open access, proven educational techniques, adaptations to a pandemic environment, workforce readiness and focused leadership are essential to continued improvement in influenza vaccine rates. Though flu vaccine coverage is a high priority for health centers, further changes are necessary for sustained success. Workflows will need to be restructured, whether to allow for protection from COVID-19 or to accommodate large increases in immunization demand. Constant attention must be given to anti-vaccine conspiracy theories, as new ones are now emerging in light of COVID-19 vaccine development. Budget and staffing decisions made in light of decreased demand for preventive health visits must allow for surges in need during flu season.

Consistency in messaging is essential, for staff as well as patients. Leadership is required to make routine what can be perceived as a temporary extra burden, whether that is flu vaccine or a future COVID-19 vaccine. Collaboration is foundational to goal achievement, whether at the community, regional or national level. Centers that participate in performance improvement cohorts and in health care networks are poised to use emerging data in rapid cycle improvement. Models such as ECHO and NACHC collaboratives are effective tools for promoting spread of evidence-based care as well as innovations in service delivery.

Centers may be ill-equipped to respond comprehensively, efficiently and safely to a COVID-19 vaccine. Current influenza vaccine experience doesn't often translate well to COVID-19 vaccine readiness. Current confusion over mechanisms of contagion, relative risk and sustainability of antibody protection will complicate vaccine uptake. Storage of vaccine and concomitant supplies may be obstacles. Workflow disruptions and staffing adaptations need to be anticipated. Protocols for prioritizing patients, giving subsequent doses as needed, assuring absence of disease before vaccinating and possibly issuing standing orders will be necessary. Centers must consider the rate at which they hope to vaccinate their populations—if tens of thousands are high risk, in what period of time does the center hope to complete their immunization needs? Who will they partner with and how will this affect their current models of care? What registries will be used?

If the 2020 flu season can be met with vigorous vaccination responses, it will not only reduce potential comorbidities with COV ID-19, but it will assist future immunization campaigns. With hygiene practices currently employed, there is even the possibility of a very mild flu season, allowing health care workers to continue to fight the pandemic with as many resources as possible.

WITH GRATITUDE

The following leaders shared their immunization practices in interviews for this paper:

Nancy Johnson
CEO
El Rio Community Health Center, Tucson, AZ

Ocie Wilson
Pharmacist
El Rio Community Health Center, Tucson, AZ

Marisa Rowe
Advanced Practice Pharmacist
El Rio Community Health Center, Tucson, AZ

Tara Ferguson-Gould
Quality Improvement Program Manager
Alaska Primary Care Association

Patty Linduska
Senior Director of Training and Technical Assistance
Alaska Primary Care Association

Jan Wilkerson
Quality, Risk and Compliance Manager
Georgia Primary Care Association, Decatur, GA

Duane Kavka
Executive Director
Georgia Primary Care Association, Decatur, GA

Daniel Serrano
Vaccine Coordinator
Delaware Valley Community Health, Inc., Philadelphia, PA

Alyssa Puia, PharmD
Clinical Pharmacist
Holyoke Health Center, Inc., Holyoke, MA

Lori Lewicki, PharmD
Chief Pharmacy Officer
Holyoke Health Center, Inc., Holyoke, MA