Coalition Strategies Supporting Success

By

Amy Hardin, RN

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the manuscript of AMY HARDIN find it satisfactory and recommend that it be accepted.

[Signatures]

Chair

[Signatures]

[Signatures]
ACKNOWLEDGEMENTS:

I would like to thank Dawn Doutrich and Linda Eddy for their support, advice, and counsel throughout my program of study while at WSUV. I have stated many times how regrettable that just as I begin to appreciate the multiple opportunities of graduate education, not the least of them personal and professional growth, it is time to finish up.

I would also like to thank Robin Kratz at Clark County Health Department. I have found Robin to be one of the most passionate, dedicated, community-minded, and involved immunization champions I have ever known. It has been a pleasure to work with her.

I would also like to thank my husband Craig, for his constant support and encouragement, as well as for his more than occasional computer and technical assistance.
COALITION STRATEGIES SUPPORTING SUCCESS

Abstract

By Amy Hardin
Intercollegiate College of Nursing
Washington State University Vancouver
April 2006

Chair: Linda Eddy

The project described within this manuscript originated with the author’s participation in a local coalition of immunization providers in Clark County, Washington. This dedicated, multidisciplinary group of immunization providers met routinely, focusing on provider education and liaison with local and state immunization offices. However, lacking a clearly defined mission statement, additional leadership support, and funding, the coalition appeared non-sustainable.

Locally, immunization levels for two year olds locally have been assessed as persistently flat, and below Healthy People 2010 targets. Electronic immunization registries have been demonstrated as a proven strategy to increase immunization levels. Washington State’s electronic immunization registry, CHILD Profile, is available for use to all immunization providers at no additional cost. However, currently only 28% of local providers in Clark County have integrated CHILD Profile use into routine operations.

The purpose of this manuscript, and the project described, is threefold: (a) to review pertinent local and community assessment factors that warrant sustaining the Clark County (WA) Infant Immunization Coalition, (b) to explore and define coalition and related constructs, and (c)
to describe a meaningful project strategy that would improve immunization coverage levels within the community, while also promote coalition sustainability.
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DEDICATION:

This manuscript is dedicated to my mother, Marilyn;

She has always believed I could do anything I wanted to do.
Introduction

Beginning January 2005, this author accepted a volunteer, co-chair position for the Clark County Infant Immunization Coalition. Multidisciplinary coalition members represent several local immunization provider offices, public health clinics, and schools in and around Vancouver, Washington. The co-chair position responsibilities were accepted in support of the group’s existing goals: to increase the rate of childhood immunizations, and to increase the numbers of providers participating in Washington State’s immunization registry, CHILD Profile.

This author reviewed the history of this coalition with Robin Kratz, RN, Immunization Coordinator for Clark County Health Department (CCHD). One of the coordinator job responsibilities included re-invigoration of this previously active coalition of local immunization providers, largely to support and encourage provider enrollment into Washington State’s electronic immunization registry, CHILD Profile. (Robin Kratz, personal communications, November, 2004). The Infant Immunization Coalition began (and continues today) as an “arm” or “agent” of CCHD. As such, coalition members were assigned a priori goals and outcomes arrived at by CCHD; for example, “increase the numbers of local immunization providers enrolled in...CHILD Profile, to 50% by 12/31/2004.” While a worthwhile goal (and a goal successfully met, partially due to coalition member awareness and effort), it was not arrived at by an independent, coalition-based strategic planning or goal setting process.

Shortly after taking on this responsibility, coalition members worked together with this author and her co-chair to begin evaluating the coalition’s effectiveness. If the coalition were to continue, it appeared imperative that the group have an opportunity to participate in organized, democratic strategic planning efforts. The purpose of this paper is threefold: (a) to review pertinent local and community factors that warrant sustaining the Clark County (WA) Infant
Immunization Coalition, (b) to explore and define coalition effectiveness related to immunization issues, and (c) to describe a meaningful project strategy that would both improve local immunization coverage levels for two year olds, and also promote coalition sustainability.
Statement of the Problem

Healthy People 2010 includes immunization as one of ten leading health indicators, and lists relevant objectives and targets. Specifically, objective 14-24 requires “increasing the proportion of young children and adolescents who receive all vaccines that have been recommended for universal administration for at least 5 years,” with a target goal established at 80% for children aged 19-35 months of age. The target goal for adolescents aged 13-15 years is in development (Healthy People 2010, n.d., p. 14-39). For the remainder of this paper, the terms “complete” and “up to date” may be used interchangeably to indicate that a child has received at least 4 doses of diphtheria, tetanus toxoids, and any acellular pertussis vaccine, 3 doses of poliovirus vaccine, 1 dose of measles-containing vaccine, 3 doses of *Haemophilus influenzae* type b (Hib) vaccine, and 3 doses hepatitis B vaccine (the 4:3:1:3:3 series). Specifically, this target is established for children who have received at least 4 doses of diphtheria, tetanus toxoids, and any acellular pertussis vaccine, 3 doses of poliovirus vaccine, 1 dose of measles-containing vaccine, 3 doses of *Haemophilus influenzae* type b (Hib) vaccine, and 3 doses hepatitis B vaccine, hereafter referred to as the 4:3:1:3:3 series. Beginning next year, the measure for childhood immunizations will include focus on varicella vaccine (the 4:3:1:3:3:1 series), since varicella will have been included on the recommended childhood immunization schedule for the past five years (Darling, Santibanez, & Santoli, 2005).

Data on current coverage levels reported from the 2004 National Immunization Survey are encouraging. Nationwide, coverage levels are reported at 80.9% for the 4:3:1:3:3 series, exceeding the Healthy People 2010 target for the first time. For the state of Washington during the year 2004, coverage levels are reported at 77.7% for the 4:3:1:3:3 series (Darling, Santibanez, & Santoli, 2005). Additionally, Washington State has demonstrated steady increases in coverage
levels for this same series during each of the previous three years (Anonymous, 2002; Barker, Darling, McCauley, & Santoli, 2003; Barker, Santoli, & McCauley, 2004).

Data at the local level are not as readily available, nor as encouraging. In a 1999 descriptive study conducted by the Clark County Health Department (then Southwest Washington Health District), Riehm & Payne (2000) randomly surveyed 203 parents of children within the 19-35 month age range at time of study. Parents were contacted by telephone, in person, or by mail, and interviewed to determine their child’s immunization history. A copy of that child’s immunization record was subsequently received from the child’s provider. Compiling and comparing all data, Riehm & Payne found that 42.4% of children were complete for the 4:3:1:3:3 series from parent records alone, 52.2% were complete when reviewing those same children’s provider records, and 65% were complete when reviewing combined parent and provider records.

The authors discussed several limitations of the study. First, parent data was self-reported. Attempts were made to verify parent self-report when reviewing and comparing each child’s provider records. Second, the study required significant resources (both internal and external) and time to complete data collection, analysis, and reporting. Marni Storey, Public Health Services Manager at CCHD, stated that although it would be helpful to conduct a similar, follow-up study, she believed it very unlikely that current or future resources would be available to support it (personal communications, Marni Storey, October, 2005). Third, the authors also recognized that (due to very different methodologies) it was difficult to compare national, state, and county or local immunization survey results. However, they concluded that local survey results were “very surprising given the efforts regarding childhood immunizations within the
community in recent years” and recommended “sustained, targeted efforts” (p. 34) to address low levels of immunization coverage within the county.

On an ongoing basis, the immunization coordinator at CCHD conducts audits of current coverage levels among local provider clinics using the clinic assessment software application (CASA). Of significance, CASA is electronically linked (interfaced) with CHILD Profile. This interface allows CASA audits to be performed entirely electronically, without visiting provider offices, and without pulling charts for audit. Procedurally, beginning in 2005, all CASA data were collected electronically, from CHILD Profile data. See Appendix A for CCHD 2005 CASA results for the nine local immunization provider clinics audited.

CCHD’s 2005 CASA results were widely inconsistent, and generally lower than the established 80% coverage level target. Of the nine clinics audited, only the smallest clinic (with 9 children in the sample) met the target, with 80% found up to date at 24 months of age (Kratz, 2005). The largest clinic (with 761 children in the sample) was audited with 47% up to date at 24 months of age. Resource and time savings realized using electronic audit methods must be weighed against resources and time required to evaluate and improve CHILD Profile data integrity. The current concern is that until more local providers are actively contributing data to CHILD Profile, and data are more complete, coverage levels audited electronically will be (and have been) lower than coverage levels determined by previously utilized chart audit methods (personal communications, Robin Kratz, October, 2005).

There is evidence supporting lack of complete data as at least one cause of inconsistent local CASA results, and decreased immunization coverage. As of November, 2005, 58% of Clark County providers were enrolled in CHILD Profile. However, the immunization registry manager for CHILD Profile cautions that although providers might have enrolled to participate
in the database, many are not actively contributing data to the registry (email communications, Sherry Riddick, CHILD Profile, November 22, 2005). Currently, only 28% of local immunization providers are enrolled and have established processes that result in data getting to the database, whether done real-time in the office by staff, or by sending electronic batch data from a clinic billing system to CHILD Profile offices in Seattle, Washington.

It is also possible that lack of complete data is not entirely to blame for poor coverage levels locally. However, integration of CHILD Profile use into routine operations would afford providers multiple additional benefits, addressing other common causes of poor immunization coverage levels (www.childprofile.org, 2006). Specifically, CHILD Profile allows providers to access records for children who don’t have records, and to add new records to the database. Providers may consolidate records for children who have moved or changed providers, decreasing record scatter. CHILD Profile also includes assessment and forecasting features, identifying children who need immunizations and children who are eligible to receive needed “catch up” immunizations. This helps to decrease provider missed opportunities. Most importantly, CHILD Profile allows providers to complete clinic level assessments, identifying areas for improvement.

Additional challenges that further complicate local (and coalition) efforts to address persistently lower-than-target levels of local immunization coverage include a still-growing county population, with an average annual increase of 2.74% over the last five years, and growth forecasted to continue at a similar rate through 2025 (Clark County Department of Assessment & GIS, 2004). Also, new vaccines were recently licensed and recommended for adolescents, including meningococcal vaccine (Bilukha & Rosenstein, 2005) and tetanus, diphtheria, and pertussis “boosters” (Centers for Disease Control, National Immunization Program, 2005). The
everyday, ongoing work required to maintain adequate vaccine supplies, respond to vaccine shortages, and develop bioterrorism preparedness programs alone challenges available resources within the vaccine system on national, state, and local levels (Orenstein, Douglas, Rodewald, & Hinman, 2005).
Review of the Literature

Mizrahi & Rosenthal (2001, p. 63-64) define coalition as “an organization of organizations whose members commit to an agreed-upon purpose and shared decision making to influence an external institution or target, while these member organizations maintain their own autonomy.” Coalition has also been defined as “an alliance among different sectors, organizations or constituencies for a common purpose... (that tend to be) composed of individuals representing diverse organizations and community sectors; ...are relatively durable (and) issue oriented, structured, and focused on specific goals external to the coalition” (Parker et al, 1998, p. 25). The authors continue by stating that coalitions have been increasingly used as a strategy to address complex, community-based public health problems like tobacco control, pregnancy prevention, or substance abuse issues.

Conversely, it may be helpful to define what coalition is not. Coalition is not (nor is it intended as) an externally run or driven organization, is not a human service organization, is not an automatic link to real people at the grassroots level, and is not a cure-all (Kellogg Foundation, 1995). Himmelman proposes that community organizations working in coalitions employ four basic strategies (networking, coordinating, cooperating, and collaboration), and that coalitions “collaborate when they demonstrate their willingness to enhance each other’s capacity for mutual benefit and a common purpose” (Himmelman, 2001, p.278). The author goes on to compare and contrast collaborative betterment coalitions with collaborative empowerment coalitions. While not mutually exclusive, he states that collaborative empowerment coalitions are those relatively rarely-occurring coalitions that successfully transform power relationships, empowering grassroots members viewed as the ultimate beneficiaries of coalition actions.
Butterfoss, Webster, Morrow, & Rosenthal (1998) argue that underimmunization is one complex, multi-faceted, community-based public health problem for which coalition formation is an appropriate strategy. There are numerous accounts in the literature of coalition employed as a strategy to address local and statewide underimmunization problems, addressing a variety of underlying causes. The Consortium for the Immunization of Norfolk’s Children (CINCH) was established in 1993 as a Centers for Disease Control (CDC) four-year long coalition demonstration project to improve immunization rates among children younger than 2 years of age (Butterfoss, et al, 1998). As such, federal monies were used to support costs of project infrastructure, including staff, computers, and other administrative support; additionally, staff provided technical assistance, support, and follow-up. Staff recruited over 55 community members to the coalition, representing service organizations, academic and civic institutions, public, private and military healthcare providers, and ordinary citizens. Staff also completed community assessments pre- and post-interventions, and assisted coalition members to agree on mission and goals, form workgroups, and implement strategies. By the end of the project, indicators of project success included improved immunization rates among 2 year olds (from 49% to 66%), with 78% of planned strategies implemented (Butterfoss, et al, 1998). More importantly, CINCH sought and received local funding, expanded their mission to include perinatal health issues, and lobbied for a statewide immunization coalition.

Another statewide immunization coalition, The Arizona Partnership for Infant Immunization (TAPII) was also formed in 1993, in an effort to respond to and improve on a statewide immunization coverage level of 43% for two-year olds (www.whyimmunize.org, n.d.). In a more detailed description of TAPII’s strategies, Hirano (1998) describes coalition efforts specifically targeted to improve immunization service delivery, as well as improve provider and
community awareness of the problems of underimmunization. The author describes two important, successful coalition-driven policy strategies resulting in legislation requiring a statewide electronic immunization reporting system (registry), and additional, separate legislation mandating provider reporting of childhood immunizations to the registry. Hirano credits the coalition’s emphasis on the need for standardized measures of immunization rates and clinic-level assessments together with use of Arizona’s electronic immunization registry as the key element of their success.

What factors or dimensions make for an effective, well-functioning, or successful coalition? Butterfoss, Goodman, & Wandersman (1993) propose a framework that considers the stage of a coalition’s development as important in determining the specific factors that make coalitions successful. The authors state that different factors appear important at each unique coalition stage (formation, implementation, maintenance, or outcome). However, the authors cautioned readers regarding the lack of literature identifying and supporting specific factors that facilitate coalition effectiveness. Instead, they conclude that achievement of mission, goals, and objectives is the ultimate measure of coalition effectiveness.

Wolff (2001) identifies nine key dimensions important in supporting coalition effectiveness. He lists the most important among them as community readiness, intentionality (relevant, clearly developed, and commonly shared mission and vision statements), collaborative leadership, and diverse membership. Goodman et al. (1998) liken community readiness to a broader construct they define as community capacity. Leadership and participation, skills and resources, community power and values, and a sense of community paired with an understanding of community history are defined by the authors as important dimensions of community capacity.
Pharmaceutical company and vaccine manufacturer Sanofi Pasteur (then Aventis Pasteur) funded a descriptive study of existing state and local immunization coalitions across the United States, and how they are sustainable. Contact information and additional data regarding demographic characteristics, organizational structure, and project information were collected from 114 immunization coalitions. Survey findings revealed that immunization coalitions are successful at providing educational or outreach activities at many levels within their respective communities (Bakalian Consulting Group, 2005). More importantly, survey findings also indicated elements among coalitions that were credited as supporting their sustainability, including the following:

1. Solid public and private funding
2. Well-developed strategic planning processes
3. Clear organizational structures that include strong, collaborative leadership
4. A consistent membership base with a wide range of skills, resources, and commitment to coalition goals
5. Dedicated staff and volunteers with a shared vision

When these survey findings regarding coalition effectiveness were compared to the local Infant Immunization Coalition, lack of funding was quickly identified by members as most problematic (coalition communications, July 5, 2005). Lack of member participation and an unclear mission statement were also discussed. However, coalition members also quickly identified several strengths of the group, including member dedication and championship of immunization efforts, as well as community support for improvement.
Methods/Plan of Action

During 2005 spring and summer coalition meetings, coalition members were given opportunities to identify and discuss Infant Immunization Coalition strengths and weaknesses. In addition, they worked to review and revise the group’s mission statement, agreeing on “Protecting Clark County residents of all ages against vaccine preventable disease”. By the fall of 2005, coalition members were ready to agree on a new strategy to address Clark County’s persistently “flat” and lower-than-target immunization coverage levels for two year olds.

Coalition members recognized that due to CCHD’s procedural changes requiring audit of clinic immunization levels electronically, it was important to increase utilization of CHILD Profile, thereby improving data integrity. Coalition members also supported use of an electronic immunization registry as a proven strategy to improve immunization levels (Freeman & DeFriese, 2003). Coalition members acknowledged that until data are more complete, conducting valid future assessments (or planning meaningful strategies to address problems related to coverage levels) would be difficult at best.

In 2004, an interesting, related effort, the Children’s Preventive Healthcare Initiative (CPHI), was conducted collaboratively by the Oregon Medical Professional Review Organization (OMPRO) and Washington State’s Medical Assistance Administration (www.OMPRO.org, 2004). The primary goal for CPHI was “to improve preventive healthcare for children;” secondary goals included the promotion of CHILD Profile among immunization providers in Eastern Washington state. Healthy Steps Women’s and Children’s Center, an immunization provider located in Vancouver, Washington, served as a pilot site for the initiative. OMPRO personnel provided a short series of educational offerings about performance improvement methods, then worked with Healthy Steps staff to create an improvement process
targeted to improve use of CHILD Profile. As a result, Healthy Steps staff successfully integrated use of CHILD Profile into daily operations. Additional benefits were reported, including organization of clinic workflow and improved immunization documentation, as well as improved reminder, recall, and reporting features associated with CHILD Profile, especially for transitory patients.

A similar quality improvement effort regarding immunization practices among physician practice groups from two cities in Virginia State is described by Sinn, Morrow, & Finch (1999). The authors collaborated with a physician champion to lead a taskforce of physicians from several private pediatric practices within two communities to increase immunization rates. The project specifically included baseline and follow-up assessments of clinic-specific immunization rates, agreement on project objectives, and opportunities for peer collaboration to discuss “best practices” and other improvement strategies. Technical support personnel resources were included in the project, and were responsible to facilitate assessment and change.

Results of the 18 month-long project included an increase in the mean practice immunization rate for two-year olds from 50.9% to 69.7%. Additional benefits reported included improvements in practice record keeping, and addition of routine screening practices for immunizations at every visit. Qualitatively, participating physicians stated they valued the group participation process and the exchange of ideas (Sinn, Morrow, & Finch, 1999).

During discussions with coalition members, it seemed reasonable and appropriate to plan a project that partially replicated the above-mentioned efforts on a local level, in an effort to engage and organize coalition members, as well as improve local immunization rates. As a result, this author proposed submitting a grant request (on behalf of the Clark County Infant Immunization Coalition and Clark County Health Department) that would support the cost of a
nurse to coordinate a county-wide process improvement effort among local immunization providers. This process improvement project would target increasing provider use of CHILD Profile.

As proposed, this nurse consultant would meet with office managers from each immunization provider office to assess and evaluate existing electronic charting and billing systems, current clinic resource utilization regarding immunization delivery and data entry, and staff knowledge and understanding of CHILD Profile. A baseline CASA assessment would be completed and documented for each provider clinic. After this initial evaluation, specific assessment findings from each provider office would be reported back to the Infant Immunization Coalition by the nurse consultant for feedback, consensus, and planning.

During a second phase, the nurse consultant would then work with office managers (and/or administrative decision makers) to establish relevant, clinic-specific process improvement efforts that would support integration of CHILD Profile use into routine operations. At the same time, office managers (or administrative decision makers as designated) would be invited and encouraged to join Infant Immunization Coalition meetings, to follow project progress and to participate with the group. Follow-up CASA assessments would be completed and documented for each provider clinic at some agreed upon date following implementation of improvement efforts.

After some review, local or area funding source possibilities included the following:

1. Northwest Health Foundation’s (located in Portland, Oregon) Community Grants program
2. Southwest Washington Medical Center’s (located in Vancouver, Washington) Healthier Communities fund
This author met several times with Marni Storey and Robin Kratz at CCHD to discuss this proposal, and possible funding sources (personal communications, Fall, 2005). Storey agreed to write a staff report in order to present the project proposal and written grant request to the CCHD Board of Health early in 2006. See Appendix B for the staff report.

The primary goals of this project will be to improve immunization rates, and to provide increased support to coalition members and immunization providers, in order to foster coalition member participation, ownership, and (in turn) coalition sustainability. A logic model describing this proposed project for the current Infant Immunization Coalition is included in Appendix C. Ferguson (1996) suggests using care in choosing the right project to jump-start a children’s health coalition. If the project is too large or does not engage the coalition membership, the projects (and the coalition’s efforts) are more likely to fail. Judging from the logic model as listed in Appendix C (with few current outputs listed), the coalition appears ready for and needy of leadership, organization, and funding supporting an appropriate, necessary, and unifying effort.

Specific project objectives are as listed below:

*Project Outcome Objectives:*

1. Increase the proportion of young children aged 19-35 months who receive all vaccines that have been recommended for universal administration for at least 5 years from 66% to 80% by December 31, 2008

2. Increase the number of local immunization providers actively contributing data to CHILD Profile to 75% by end of two year grant period

*Project Process Objective:*
1. Assess provider (and coalition member) satisfaction with coalition efforts to improve communication and support in achievement of project goal and objectives at midpoint of two year grant period.
Discussion

Proposed project and grant request details were shared with Infant Immunization coalition members by this author at the January and March 2006 meetings. The group’s response was generally positive; coalition members agreed that this project as proposed appeared a necessary and logical “next step” in a continuing effort to improve local immunization coverage levels for two-year olds. See Appendix D for the completed grant application materials, including project budget and timeline.

Coalition member input was also sought regarding possible funding sources. An initial “short list” of four relatively local funding source possibilities was identified. Each funding source possibility was evaluated for closeness of project “fit” with funding source mission and goals, budget and/or timeline limitations, funding cycle timelines, and application deadlines. As a result of these considerations, a plan was made to submit the project request first to Southwest Washington Medical Center’s (SWMC) Foundation and their Healthier Communities Committee. In the event that the project request is not approved, the project request would then be submitted to Vancouver’s Community Foundation Children’s Trust Fund. As of this writing, this author is awaiting CCHD Board of Health approval prior to submission of project request to SWMC Foundation Healthier Communities Committee.

Prior to specifying project details, consideration was made regarding whether this grant request might be duplicative of CCHD’s immunization coordinator responsibilities that are supported by other public monies or grant funds. CCHD’s current immunization coordinator contract was carefully examined. While increasing CHILD Profile use is listed as an outcome goal for the immunization coordinator position, there were no specific or prescriptive responsibilities or duties described that might be regarded as duplicative of efforts (or nurse
responsibilities) included in this grant request. Additionally, nothing specified or described a coalition-based, coalition-coordinated process improvement effort in the current immunization coordinator contract as outlined in this grant request.

There was also some discussion during planning phases with both CCHD and CHILD Profile staff regarding whether or not the grant request should support entry of historical immunization data for each participating provider office. If this provision was included, additional funding supporting clerical personnel would be required. In the end, because this provision increased the project's complexity and cost, and because it was not directly aligned with the project-specific goals (increasing providers contributing data to CHILD Profile, and engaging coalition members), this provision was not included.
Conclusion

Although meaningful discussion and steady progress has brought coalition members this far, it is likely that defining the project and writing the grant request gets at just the “tip of the iceberg.” In the event that funds are received, a position posting will need to be drafted, and a nurse will need to be hired and familiarized with project goals and objectives. The very part-time responsibilities supported by this project may make nurse recruitment difficult.

As soon as project efforts get underway, data will need to be collected using a variety of methods as specified in the project budget and timeline. These data will then need to be reported and disseminated in a systematic, meaningful way so that coalition members are made aware of project findings, progress, and possible set-backs. Formal evaluation statements or reports will need to be prepared.

The coalition as a whole will need to employ additional strategies to accomplish project objectives and goals. To date, coalition co-chairs have helped to establish liaisons with Washington State Department of Health and CHILD Profile personnel, and have networked locally to support CHILD Profile awareness. Previous coalition agendas have largely focused on information sharing and provider education. If funds are received and the project goes forward as planned, the nurse consultant should support coalition coordination throughout the project. However, coalition members themselves will need to demonstrate greater collaboration and cooperation as soon as the project begins. Multiple opportunities for coalition member feedback and participation will need to be scheduled as the project progresses. It may be appropriate to form a small workgroup to make clear assignments and facilitate completion of work.

For now, coalition members remain hopeful that this initial request is successful. During the March 2006 meeting, coalition members discussed that although they recognize and support
the imperative to integrate CHILD Profile use into routine clinic operations, decreasing available resources and increasing competing priorities make getting this accomplished very difficult. Coalition members (many of them local providers) have also stated that they fully support efforts to improve local (and especially clinic-specific) immunization rates. They stated they would welcome and look forward to additional support and coordination, and would encourage greater coalition participation to achieve project goals and objectives (coalition communications, March 7, 2006).
References


Kellogg Foundation. (1995, September 1). Sustaining community-based initiatives. In *Building the coalition (chap. 3)*. Retrieved October 15, 2005, from [http://www.wkkf.org/Pubs/CustomPubs/SusComBasedInits/SusComBasedInits.asp#Module%201](http://www.wkkf.org/Pubs/CustomPubs/SusComBasedInits/SusComBasedInits.asp#Module%201)


Appendix A

CCHD 2005 CASA results

% up to date at 24 mos age

Clinic size, type

<table>
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<th>N</th>
<th>Clinic size, type</th>
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<td>N = 143</td>
</tr>
<tr>
<td>761</td>
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Values:
- N = 9: 33.33%
- N = 46: 23.91%
- N = 69: 34.78%
- N = 91: 59.34%
- N = 15: 80%
- N = 66: 59.09%
- N = 75: 74.67%
- N = 143: 63.64%
- N = 761: 47.44%
Appendix B

DEPARTMENT: Health
DATE: 3/21/2006
SPECIFIC REQUEST: Approval to apply for funding for Nurse Consultation to work with Health Care Providers to improve childhood immunization series completion rates from Southwest Washington Medical Center foundation.

BACKGROUND
A study of childhood immunization rates in Clark County conducted in 1999 indicated only 67% of resident children between the ages of 19 and 35 months were fully vaccinated for the 4:3:1 (DTP, polio, MMR) and only 65% were fully immunized for the expanded 4:3:1:3:3 vaccination series (4 Dtap, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B). Furthermore, in the last decade Clark County experienced several cases of vaccine preventable diseases adding further evidence of inadequate immunization coverage in the county. National data suggests that health care provider participation in an immunization registry is the most effective community approach to improve immunization completion rates. CHILD Profile, Washington State’s immunization registry, is currently utilized by 28% of Clark County health care providers.

This two year project would allow the Department to hire a nurse consultant, in a project position, to complete an assessment of local provider barriers to contribute immunization data in Child Profile, analyze the information gained from the assessment and work collaboratively with the coalition, DOH, CHILD Profile, and the local providers to improve participation in the registry.

COMMUNITY INVOLVEMENT:
In Clark County the Infant Immunization Initiative (I-3) is a group of health care providers, hospital representatives and community clinic representatives, including consumers who advise the immunization staff at the Department regarding initiatives to improve childhood immunization rates. This group is promoting a project to increase utilization of the Washington State Immunization registry, “Child Profile”.

ACTION REQUESTED:
Approve the Department to submit a grant application to Southwest Washington Medical Center foundation.

BUDGET IMPLICATIONS:
A budget request of $15,137 will be requested to fund the nurse consultant and administrative costs associated with this project. No County match is required or requested.

DISTRIBUTION:
John Wiesman, Department Director
Marni Storey, Program Manager

Approved:
CLARK COUNTY BOARD OF COMMISSIONERS
## Appendix C

### Logic Model for Clark County Infant Immunization Coalition project

<table>
<thead>
<tr>
<th>Current Resources:</th>
<th>Current Activities:</th>
<th>Current Outputs:</th>
<th>Proposed project outcomes:</th>
<th>Proposed project goal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated, voluntary group of healthcare providers (physicians, nurses, medical assistants, clinic managers, pharmacists, pharmaceutical reps)</td>
<td>Immunization provider education</td>
<td>Recognition program for immunization providers (and coalition partners) who achieve success</td>
<td>Increase the number of local immunization providers actively contributing data to CHILD Profile to 75% by end of two year grant period</td>
<td>To foster coalition member participation, ownership, action, and (in turn) coalition sustainability</td>
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<tr>
<td>CCHD administrative support (leadership, meeting space, mailings)</td>
<td>Liaison with the state Department of Health to track administrative and policy changes affecting vaccine supply, distribution, and service delivery</td>
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<td></td>
<td>Increase the proportion of young children and adolescents who receive all vaccines that have been recommended for universal administration for at least 5 years to 80%</td>
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</tbody>
</table>
Appendix D

| SWMC FOUNDATION |
| HEALTHIER COMMUNITIES GRANT APPLICATION |

Please fill out the following application in full, attaching appropriate documents as necessary. Applications not meeting funding guidelines or incompletely filled out may be returned or rejected. The Healthier Communities Committee meets quarterly (Mar, Jun, Sept, Dec).

**Date:** January 31, 2006

**Contact Persons:**
Robin Kratz & Amy Hardin, co-chairs, Infant Immunization Coalition

**Robin Kratz, Immunization Coordinator at Clark County Health Department**
Telephone: 360-897-8403 Email: robin.kratz@clark.wa.gov

Amy Hardin, Graduate Student, Department of Nursing, WSU-Vancouver
Telephone: 360-576-3875 Email: ahardin@vancouver.wsu.edu

Total Amount Requested: $ 15,137.00

I. Purpose: (Briefly describe the reason for your request and why this situation exists. Be as specific as possible. Attach a separate sheet if necessary.)

**Problem/issue/need to be addressed:**
Low infant immunization rates in Clark county and low health care provider participation in Child Profile, Washington State’s immunization registry

A study of childhood immunization rates in Clark County conducted in 1999 indicated only 67% of resident children between the ages of 19 and 35 months were fully vaccinated for the 4:3:1 (DTP, polio, MMR) and only 65% were fully immunized for the expanded 4:3:1:3:3 vaccination series (4 Dtap, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B). Furthermore, in the last decade Clark County experienced several cases of vaccine preventable diseases adding further evidence of inadequate immunization coverage in the county. National data suggests that health care provider participation in an immunization registry is the most effective community approach to improve immunization completion rates. The Washington State immunization registry, Child Profile is currently utilized by only 28% of Clark County health care providers.

**Purpose and description of proposed project, including objectives:**

The Immunization Coordinator at Clark County Health Department in Vancouver, Washington, has been directing efforts to improve infant immunizations rates as well as increase participation in Child Profile since the 1999 study. One effort includes formation of the Clark County Infant Immunization Coalition, a voluntary, multidisciplinary coalition of local immunization providers and champions from local provider clinics, public provider sites, and schools. The mission for this group is “to protect Clark County residents of all ages against vaccine preventable disease”. The Infant Immunization Coalition is now well-established and meets bi-monthly. 2005 accomplishments for this group include continuing provider education and support, as well as ongoing linkages with Washington State Department of Health (DOH) to discuss and plan for administrative and policy changes affecting vaccine supply and inventory. The coalition also recognizes local partners annually for achieving success; for 2005, this recognition included one local immunization provider office that successfully met the Healthy People 2010 target goal for two year olds.

At this time, the Clark County Infant Immunization Coalition proposes a process improvement project to improve infant immunization rates through a systematic review and evaluation of local immunization
providers' capabilities to contribute data to CHILD Profile. A Nurse consultant would be hired to complete this process collaboratively with the coalition, the DOH, CHILD Profile, and local providers. Findings from this initial evaluation would be reported back to the Infant Immunization Coalition for information sharing, discussion, problem solving, and planning. Coalition members and established partners, together with this nurse consultant, would arrive at strategies supporting achievement of project objectives (see below).

In a second phase, the nurse would then work collaboratively with each provider clinic’s administrative decision makers to establish internal, clinic-specific process improvements that would integrate CHILD Profile use into routine clinic operations. Those strategies might include staff education, evaluation and/or redesign of current clinic resources, changes in workflow, or a cost benefit evaluation for electronic interface. The nurse would also be responsible to evaluate provider satisfaction with process improvement efforts after implementation and share these findings with the coalition as appropriate to contribute to future partnerships with local providers.

The long term goal of this project is two-fold; we hope this project provides increased support to coalition members and local immunization providers, in order to foster coalition member participation, ownership, and (in turn) coalition sustainability and effectiveness. At the same time, we hope to increase the numbers of providers using CHILD Profile, in order to improve data integrity and increase local immunization coverage levels for two-year olds in our community.

II. What do you hope to accomplish with these funds? (What are the measurable outcomes?)

The outcome objective for this proposed project:
An increase in infant immunization completion rates from 67% to 80% by December 31 2008.

The process objective for this proposed project:
Increase the number of local immunization providers actively contributing data to CHILD Profile to 75% by end of two year grant period
Assess provider (and coalition member) satisfaction with coalition efforts to improve communication and support in achievement of project goal and objectives at mid-point of two year grant period

III. Community Benefit: (Give a brief description of how these funds will make a positive impact on the health and well being of our community.)

This project will directly serve local immunization providers, the Clark County Infant Immunization Coalition, and all members of the community. By improving our electronic data integrity, the coalition will be better able to make valid assessments of immunization coverage rates and recommend appropriate strategies for improving immunization status in Clark county. Additionally, if we could achieve and establish consistent immunization coverage levels for two year olds, resources would be more available to begin targeting other immunization issues such as adolescent and adult immunization promotion.

IV. Are there other funds currently available for this project? Yes ___ No __ If so, please explain.

V. Is this a one-time request? Yes ___ No ____ If so, please explain how the project will be funded on an ongoing basis.

VI. Have you submitted requests to other organizations? Yes ___ No ___ If yes, please list the top five and the status of those requests.
VII. Have you submitted requests to the SWMC Foundation before? Yes X No _ If yes, when and for what?

VIII. What is the timeline for the project and who is responsible for the outcome?

This is a two-year project; the timeline is included with budget (enclosed). Current co-chairs for the Infant Immunization Coalition at Clark County Health Department will be responsible for project outcomes.

Signature(s) ___________________________ Date __________________________

(The Foundation reserves the right to limit the grant in any way it deems necessary. All awardees will be required to sign a letter of agreement before any payment is made.)

Please be sure to attach the following:

- Detailed operational budget for the project
- Most current agency financial statement
- Backup reports, including statistics or information supporting your request
- List of all persons, titles and expertise involved with this project
- List names of agency’s current board or governing body
- List of any collaborating agencies
- Copy of tax exemption letter

Please submit requests to SWMC Foundation at P.O. Box 1600, Vancouver, 98668
Phone – 360-514-3106; Fax 360-514-6466

For Office Use Only:
This request has been approved ____ denied ____ by the Healthier Communities Committee for the following reasons:

________________________________________ Date __________________________

(Foundation Executive Director)

Originated _____
Revised _____
<table>
<thead>
<tr>
<th>Item:</th>
<th>Timeline:</th>
<th>Cost:</th>
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<tbody>
<tr>
<td><strong>Salary:</strong></td>
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<tr>
<td>16 hours training/planning with CHILD Profile</td>
<td>0 months</td>
<td>480.00</td>
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<tr>
<td>4 hour initial consultation with each of 48 local immunization</td>
<td>0-12 months</td>
<td>5,760.00</td>
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<td>provider clinics to:</td>
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<tr>
<td>• Conduct baseline CASA</td>
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<tr>
<td>• Review, document existing electronic medical record systems, and/or</td>
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<tr>
<td>practice management systems</td>
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<td>• Review, document existing resource utilization regarding all</td>
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<tr>
<td>phases of immunization delivery</td>
<td></td>
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<td>Attendance at each bi-monthly Infant Immunization Coalition meeting</td>
<td>0-24 months</td>
<td>360.00</td>
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<td>to:</td>
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<td>• Plan/coordinate CHILD Profile training for clinic staff as needed,</td>
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<td>as appropriate</td>
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<td>• Plan/establish clinic-specific process improvement efforts that</td>
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<td>integrate CHILD Profile into routine clinic operations</td>
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<td>• Report project progress, successes</td>
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<td>• Discuss, problem-solve project difficulties or “failures”</td>
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<td>• Report follow-up CASA results</td>
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<td>• Information share/network</td>
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<td>• Disseminate findings from focus groups re: satisfaction</td>
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<tr>
<td>2 hour follow up consultation with each of 48 local immunization</td>
<td>6-24 months</td>
<td>2,880.00</td>
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<tr>
<td>provider clinics</td>
<td></td>
<td></td>
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<tr>
<td>• Follow up CASA</td>
<td></td>
<td></td>
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<td>• Plan/revise process improvements as needed</td>
<td></td>
<td></td>
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<tr>
<td>Review, design tool(s) to measure provider satisfaction</td>
<td>6-12 months</td>
<td>1,200.00</td>
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<td>• conduct provider focus groups (3 groups of 3-4)</td>
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<tr>
<td><strong>Travel:</strong></td>
<td></td>
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<tr>
<td>• to Seattle for CHILD Profile training</td>
<td>0-18 months</td>
<td>964.00</td>
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<td>• to local provider clinics (initial and follow-up visits)</td>
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<td><strong>Administrative overhead:</strong></td>
<td></td>
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<tr>
<td>• computer/telephone use</td>
<td>0-24 months</td>
<td>3,493.00</td>
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<td>• copies</td>
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<td></td>
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<tr>
<td>• mailings</td>
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<tr>
<td><strong>Project total:</strong></td>
<td></td>
<td><strong>15,137.00</strong></td>
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To: SWMC Foundation and Healthier Communities Committee

Please find enclosed a grant application submitted on behalf of Clark County Health Department and the Clark County Infant Immunization Coalition, including proposed project budget and timeline. Additional enclosures include the most recent financial statement for Clark County Health Department, and evidence of Clark County’s tax exempt status. Clark County’s Board of Health (the governing body for Clark County Health Department) also serves as the Board of County Commissioners, including:

Commissioner Marc Boldt, Chair
Commissioner Betty Sue Morris
Commissioner Steve Stuart

Persons most involved with this project include the current co-chairs for the Clark County Infant Immunization Coalition, Robin Kratz, RN, and Amy Hardin, RN. Ms. Kratz has been employed by Clark County Health Department for 19 years, and has worked in an immunization coordinator role for the past five years. Ms. Kratz has served in a leadership capacity on the Infant Immunization Coalition since its inception in 1996.

Ms. Hardin is a community member, a pediatric nurse with 20 years experience, and a graduate nursing student at Washington State University. Ms. Hardin has worked in various nurse educator roles for the past seven years, and has served as co-chair for the Infant Immunization Coalition since January 2005.

Additionally, personnel from CHILD Profile Offices and from Washington State Department of Health will be collaborating on this project. Contact information for both coalition co-chairs is listed on the grant application.

Thank you for your consideration.

Sincerely,

Robin Kratz and Amy Hardin, Co-Chairs Clark County Infant Immunization Coalition
Enclosures