

**2009 Bull's Eye Award Nomination: Washington State Department of Health
Immunization Program CHILD Profile
Washington Hib Shortage Vaccine Management Initiative**

Background Description

In December, 2007 a national Hib shortage was declared. Hib vaccine supplies were restricted, with an interim recommendation to complete only 3 of the 4 doses in the Series. The shortage situation was complicated in August of 2008 with the introduction of a Hib containing combination vaccine. Addressing the shortage and implementing the new vaccine in the least confusing manner, and assuring children had access to a minimum of the 3 dose primary series was the goal of the Washington State Department of Health Immunization Program CHILD Profile (IPCP).

Setting: Washington State

Population: Children 0 through 19 years of age, 1250 providers, 35 health jurisdictions

Annual budget and funding sources: The project was completed using existing program resources. No special funding was used for the project.

Timing: The initiative ran from December 2007 through March of 2009.

Innovation

Allocations were created for geographic areas, and monitored at the geographic level by local health departments, and by state staff prior to order placement. Data analysis was used to determine the best strategy to integrate the Hib containing combination vaccine. Review of the data helped us determine the best course of action was to target high volume providers to receive the new combination vaccine. The goal was to limit confusion by targeting providers and health districts. Strategies included: maintaining consistency across provider organizations with multiple geographic locations, focused communication, consultation and education efforts. Communication strategies included: e-mail list serve, internet and provider professional organizations. Longer term strategies were developed when the shortage was extended for an additional 8 months. Provider orders during the shortage were monitored using an excel spreadsheet to track individual provider orders against the state allocation. Local health

departments and state staff were trained in the use of the tracking tool, and every provider order was monitored to ensure Washington remained within the allocation for all Hib containing vaccine products. We were able to use data from this monitoring process to support our work with CDC when there were discrepancies between CDC allocation and the balance we had recorded.

Effectiveness

Washington Hib orders did not exceed the allocation in any month of the shortage. Washington data on allocation balances matched McKesson/CDC data with one exception. Providers received information in a timely manner and successfully implemented the new vaccine. Revisiting state demographics indicated more Hib containing vaccine was needed than received for the 3 dose series. Additional combination vaccine was obtained to fill the gap for providers who were unable to meet the 3 dose series, and guidance was given regarding recall for children unable to receive the primary series. Washington's immunization rate for the 3 dose Hib primary series did not decrease during the shortage.

Potential for replication

The strategy used during the Hib vaccine shortage could be replicated in other immunization programs. The basic population based strategy, evaluation of provider readiness, communication strategies, and supporting materials are all potentially replicated by other programs. Washington was willing to step out and tell providers they had no choice but to accept the new vaccine product, we were very directive in our approach initially, while at the same time trying to match the capabilities of providers with the product made available to them. More sophisticated offices, with experience with combination vaccines, and a high volume of patients created an environment for successful use of the new product, while limiting the potential waste of the existing combination vaccine. Providers with no experience with combination vaccines, or with very low patient volume's were not required to incorporate the vaccine. Once the integration was well established, we allowed expansion to other providers, including small volume practices as vaccine allowed and interest indicated was needed. Not all provider communities would be receptive to this approach, and a number of projects were unable to overcome the restriction of full provider choice to implement the new vaccine across the board. Using a population based

approach may not be something that is practiced in other project areas, and it might also pose a barrier to implementing this strategy. Limitations might include provider willingness to accept alternative products, and projects willingness to suspend provider choice to ensure the use of the available vaccines.

For additional information contact Helen Fox Fields at aiminfo@comcast.net