



MEMO

TO: North Dakota Prevention Partnership Providers

FROM: Abbi Pierce, MPH
Vaccines for Children (VFC) Manager

RE: 2013 Prevention Partnership Enrollment

DATE: February 26, 2013

Annually, all providers currently enrolled in the Prevention Partnership Program are required to renew their enrollment in this program. Please complete and return the originals of the **Provider Enrollment, Provider Profile** and **Vaccine Storage Certification** forms to the NDDoH by **March 22, 2013**.

Updated policies, including the Vaccines for Children Questions and Answers, Vaccine Coverage Table, Vaccine Loss Policy, Vaccine Management Plan, and Fraud and Abuse Policy are included in the packet. Updated program forms, such as the borrow/return form and emergency vaccine relocation plan, are also included.

Starting in 2013, VFC/AFIX coordinators will begin implementing unannounced storage and handling visits. This is a new requirement from the CDC based on a recent report from the Office of Inspector General which indicated healthcare providers were not following proper protocol regarding vaccine storage and handling. During these visits, VFC/AFIX coordinators will check the procedures and vaccine storage equipment to ensure that all state-supplied vaccine is being stored correctly. Corrective actions will be generated for any practices not meeting VFC requirements just as they are done at scheduled VFC site visits.

The following instructions pertain to each form:

PROVIDER ENROLLMENT FORM (Yellow)

The chief physician or medical director who signs standing orders for immunizations is required to sign the Provider Enrollment Form. All other persons with prescription-writing authority who administer state-supplied vaccine must be listed on the Provider Enrollment form. Hospitals do not need to list all physicians. If provider information changes (i.e., providers join or leave the practice), it must be reported to the NDDoH Immunization Program as soon as possible. **Providers should read the enrollment form in its entirety and ensure that all program requirements are being met by the facility. Compliance with program requirements will be assessed at provider site visits, at a minimum of every other year.**

PROVIDER PROFILE FORM (Salmon)

Please indicate any changes in the contact person's name, address, or any special delivery instructions using the Provider Profile Form.

"Provider Estimates" have been completed for you based on North Dakota Immunization Information System (NDIIS) data for calendar year 2012. If you disagree with the pre-populated estimates, please cross them out and change them. If NDIIS data is unavailable for your facility, you will have to complete this portion on your own using benchmarking or encounter data.

Underinsured children may only be vaccinated with VFC vaccine at a rural health center (RHC), federally qualified health center (FQHC), or local public health unit due to changes in federal policy regarding delegation of authority. Delegation of Authority Agreements from 2007 between Coal Country Community Health Center and private providers in North Dakota are no longer valid. **Federal 317 vaccine may be used to vaccinate underinsured children at private provider offices in North Dakota. Private providers should continue to vaccinate underinsured children with state-supplied vaccine and enter the doses into the NDIIS as underinsured.**

The Immunization Program is asking all Prevention Partnership providers for their current e-mail addresses on the Provider Profile. E-mail will be used to inform providers of new recommendations and other important information in the ever-changing world of immunizations. If your facility does not have e-mail capabilities, please indicate this on the Provider Profile.

VACCINE STORAGE CERTIFICATION (Green)

In order to receive state-supplied vaccine, the storage certification form must be completed including facility address, shipping and storage and handling information. **As a reminder, starting January 1, 2013, dorm-style refrigerators cannot be used for the storage of any state-supplied vaccine, this includes temporary storage.**

If you have any questions, please contact the NDDoH Immunization Program at 701.328.3386 or toll-free at 800.472.2180.

Thank you for your participation in this important program.

Enclosures



PREVENTION PARTNERSHIP PROVIDER ENROLLMENT

NORTH DAKOTA DEPARTMENT OF HEALTH

SFN 58496 (12-2012)

Facility Name: _____ **VFC Pin #** _____

Facility Address: _____

Telephone: _____ **Fax:** _____

Medical Director or Equivalent

Last Name, First, M.I. Medical License No. Medicaid/NPI No.

Last Name, First, M.I. License No. Medicaid/NPI No.

Providers Practicing at this Facility (all additional providers within the practice must be listed here)

1) _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

2) _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

3) _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

4) _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

5) _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

6) _____
Last Name, First, M.I. Medical License No. Title (MD, DO, NP, PA) Medicaid/NPI No.

VFC Vaccine Manager: _____

Phone Email

Back-Up VFC Vaccine Manager: _____

Phone Email

To receive publicly funded vaccines at no cost I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the healthcare facility of which I am the medical director or practice administrator or equivalent:

- 1) I will screen patients and document eligibility status at each immunization encounter for VFC eligibility and administer VFC-purchased vaccine only to children who are 18 years of age or younger who meet one or more of the following categories:
 - i. are an American Indian or Alaska Native;
 - ii. are enrolled in Medicaid;
 - iii. have no health insurance;
 - iv. are underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement.

Persons who meet one or more of the following categories are considered state vaccine-eligible and are **not** eligible for VFC-purchased vaccine:

- i. underinsured children at private clinics;
 - ii. insured newborns immunized with the birth dose of hepatitis B at enrolled birthing hospitals;
 - iii. insured children at participating health units;
 - iv. uninsured and underinsured adults for Td, Tdap, HPV, PPSV23, MCV4, and MMR.
- 2) I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC program unless:
 - a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate;
 - b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
 - 3) I will maintain all records related to the VFC program for a minimum of three years, or longer if required by state law, and make these records available to public health officials, including the state or Department of Health and Human Services, (DHHS) upon request.
 - 4) I will immunize eligible children with VFC-supplied vaccine at no charge to the patient for the vaccine.
 - 5) I will not charge a vaccine administration fee to non-Medicaid VFC-eligible children that exceeds the administration fee cap of \$20.99 per vaccine dose. For Medicaid VFC-eligible children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
 - 6) I will not deny administration of a federally purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.
 - 7) I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).

- 8) I will comply with the requirements for vaccine ordering, vaccine accountability, and vaccine management. Agree to operate within the VFC program in a manner intended to avoid fraud and abuse. VFC providers may not store federally purchased vaccine in dormitory style refrigerators at any time. Return all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration.
- 9) I will participate in VFC program compliance site visits, storage and handling unannounced visits, and other educational opportunities associated with VFC program requirements.
- 10) I will document demographic, VFC and state eligibility, and immunization information in the North Dakota Immunization Information System (NDIIS) within four weeks of administration, in accordance with N.D.C.C 23-01-05.3.
- 11) For providers with a signed Memorandum of Understanding between a FQHC or RHC and the state/local immunization program to serve underinsured VFC-eligible children, I agree to:
 - i. Include "underinsured" as a VFC eligibility category during the screening for VFC eligibility at every visit;
 - ii. Vaccinate "walk-in" VFC-eligible underinsured children and
 - iii. Report required usage data
- 12) I agree to reimburse the North Dakota Department of Health for any vaccines lost due to my facility's failure to properly store, handle or rotate vaccine inventory, as outlined in the North Dakota Immunization Program Vaccine Loss Policy.
- 13) For Specialty Providers (identified as pharmacies, urgent care, or school located vaccine clinics), I agree to vaccinate all "walk-in" VFC-eligible children and will not refuse to vaccinate VFC-eligible children based on a parent's inability to pay the administration fee.
- 14) I agree that all records, regardless of physical form, and the accounting practices and procedures of my facility relevant to this agreement are subject to examination by the North Dakota Department of Health, North Dakota State Auditor or the Auditor's designee in accordance with N.D.C.C. 54-10-19.
- 15) I understand this facility or the state/local immunization program may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If I choose to terminate this agreement, I will properly return any unused VFC vaccine.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Vaccines for Children enrollment requirements listed above and understand I am accountable for compliance with these requirements.

Medical Director or equivalent Signature: _____

Date: _____



PREVENTION PARTNERSHIP PROGRAM PROVIDER PROFILE

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 58495 (01-2013)

Provider I.D. Number:

All North Dakota public and private health care providers participating in the Vaccines for Children (VFC) program must complete this form. This document provides shipping information and helps the state determine the amount of vaccine to be supplied through the VFC program. This form may also be used to compare estimated vaccine needs with actual vaccine supply. The Provider Profile form must be updated annually or more frequently if 1) the number of children being served changes, or 2) the status of the facility changes. One provider may complete the form for the entire practice.

Facility/Clinic Name:		Date:	
Street Address:	City:	State:	Zip Code:
Primary Contact:		Email Address:	
Backup Contact:		Email Address:	
Telephone Number:		Fax Number:	

Are you currently using the North Dakota Immunization Information System (NDIIS)? YES NO

Type of Facility (please check only one box):

<input type="checkbox"/> Private hospital based clinic	<input type="checkbox"/> Rural Health Center (RHC)	<input type="checkbox"/> HIV/STD Clinic
<input type="checkbox"/> Public hospital based clinic	<input type="checkbox"/> Private Preschool/daycare/etc	<input type="checkbox"/> Public clinic non-health department
<input type="checkbox"/> Private Practice	<input type="checkbox"/> Public Preschool/daycare/etc	<input type="checkbox"/> Mass Vaccinator-Flu only
<input type="checkbox"/> Public Health Dept Clinic	<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Mass Vaccinator-Flu & other vaccine
<input type="checkbox"/> Military Health Care Facility	<input type="checkbox"/> WIC	<input type="checkbox"/> Pharmacy-Flu only
<input type="checkbox"/> Federally Qualified Health Center (FQHC)	<input type="checkbox"/> Indian Health Center	<input type="checkbox"/> Pharmacy-Flu & other vaccines
	<input type="checkbox"/> Corrections Facility	

Vaccine Delivery Address (If different from above):

Street Address:	City:	State:	Zip Code:
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Provider Estimates:

The numbers below are estimates of the total number of children (VFC and non-VFC eligible children) who will receive vaccinations at your facility for the 12-month period beginning January 1, 2013. These numbers were determined using 2012 data from the NDIIS.

	< 1 Year Old	1-6 Years	7-18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
American Indian				
Underinsured*				
Insured				
Total				

*Underinsured children may only receive VFC vaccine at a FQHC, RHC, or local public health unit. Private providers may use federal 317 vaccine for underinsured children. **This provider profile is for VFC vaccine only, which is why private providers don't have to estimate the underinsured population for the purposes of this form.**



VACCINE STORAGE CERTIFICATION
 NORTH DAKOTA DEPARTMENT OF HEALTH
 SFN 58498 (12-2012)

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Facility/Clinic Name:	
Contact:	Telephone Number:

THE FOLLOWING SECTION MUST BE COMPLETED TO RECEIVE VACCINE

What type of storage units are used to store refrigerated vaccines? (Check all that apply)

<input type="checkbox"/> Stand-alone refrigerator	<input type="checkbox"/> Combined refrigerator/freezer with separate external refrigerator and freezer doors (i.e. household-style appliance)
<input type="checkbox"/> Dorm-style refrigerator/freezer Circle one: (Temporary) or (Permanent)	
<input type="checkbox"/> Combined refrigerator/freezer with single door	

What type of thermometer is used in the refrigerator(s)? (Check all that apply)

<input type="checkbox"/> Standard fluid-filled	<input type="checkbox"/> Minimum/maximum	<input type="checkbox"/> Digital
<input type="checkbox"/> Continuous recording	<input type="checkbox"/> Dial	<input type="checkbox"/> Glycol Probe
<input type="checkbox"/> Other (please specify):		

What type of storage units are used to store frozen vaccines? (Check all that apply)

<input type="checkbox"/> Stand-alone freezer	<input type="checkbox"/> Combined refrigerator/freezer with separate external refrigerator and freezer doors (i.e. household-style appliance)
<input type="checkbox"/> Dorm-style refrigerator/freezer Circle one: (Temporary) or (Permanent)	<input type="checkbox"/> N/A – facility does not administer vaccines requiring freezer storage
<input type="checkbox"/> Combined refrigerator/freezer with single door	

What type of thermometer is used in the freezer(s)? (Check all that apply)

<input type="checkbox"/> Standard fluid-filled	<input type="checkbox"/> Minimum/maximum	<input type="checkbox"/> Digital
<input type="checkbox"/> Continuous recording	<input type="checkbox"/> Dial	<input type="checkbox"/> Glycol Probe
<input type="checkbox"/> Other (please specify):		

Are the thermometers used certified and calibrated in accordance with National Institute of Standards and Technology (NIST) or the American Society for Testing and Materials (ASTM)? **Note: Must have certificates of calibration for all thermometers in vaccine storage units containing state-supplied vaccine.**

YES NO

Please list expiration dates found on all NIST certificates of calibration:

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___ #6 ___/___/___

Signature of Person Completing Form:	Date:
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For State Use Only:	
Immunization Program Representative:	Date Certified for Prevention Partnership: