



## MEMO

**TO:** North Dakota Prevention Partnership Providers

**FROM:** Tatia Hardy  
Vaccines For Children/AFIX Coordinator 

**RE:** Prevention Partnership Re-Enrollment/  
2011 Prevention Partnership Manual  
Mandatory Reporting for All Providers

**DATE:** March 2, 2011

Annually, all providers currently enrolled in the Prevention Partnership Program are required to renew their enrollment in this program. Copies of the Provider Enrollment and Provider Profile forms, as well as the updated version of the *Vaccine Management Plan* are enclosed. Also enclosed are updated copies of forms that the North Dakota Immunization Program has developed. We hope these forms will help make the process easier. **Please discard old versions, as some of the forms (Request for Vaccine/Materials, Vaccine Coverage Table, etc.) are frequently updated.** The most up-to-date versions are available on our website: <http://www.ndhealth.gov/Immunize/Providers/Forms>.

Please complete and return the originals of the **Provider Enrollment, Provider Profile and Vaccine Storage Certification** forms to the NDDoH by **March 31, 2011**.

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.

Please take note of the purple information sheet regarding mandatory vaccine accountability reporting requirements for all providers. They are detailed in the *Vaccine Management Plan*.

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 reverse side of the Provider Enrollment form. Hospitals do not need to list all physicians on the reverse side. 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. Please note that additional requirements relating to

March 2, 2011

Page 2

accountability and Centers for Disease Control and Prevention (CDC) security have been added in anticipation of the implementation of VTrckS.

VTrckS is a new vaccine inventory and ordering system that will allow providers to place and track orders for vaccine online. More information will be released on VTrckS as it becomes available.

#### 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. Complete the "Provider Estimates" section as accurately as possible--do not overestimate your VFC client population. For information on how to obtain proper estimates using the NDIIS, please see the guidance document posted to our website at <http://www.ndhealth.gov/Immunize/Providers/Providers.htm>.

#### 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.

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 (1-2011)

**Centers for Disease Control and Prevention**

**Grant Number H23/CCH822552-01-1**

**Immunization and Vaccines for Children Grant**

**CFDA No. 93.268**

**Immunization Grants**

**Budget Period 2008**

**Provider I.D. Number**

To participate in the Prevention Partnership Program and receive state and federally procured vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department or other health delivery facility of which I am the medical director or equivalent:

1. I will screen patients at all immunization encounters for eligibility and administer Vaccines For Children (VFC) or state-supplied vaccine only to individuals who meet the following criteria:
  - a. Is 18 years of age or younger
  - AND**
  - b. Is VFC vaccine-eligible
    - i. Is an American Indian or Alaska Native.
    - ii. Is enrolled in Medicaid.
    - iii. Has no health insurance.
    - iv. Is underinsured (a child whose health insurance benefit plan does not cover a particular vaccine). Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) or providers with a Letter of Agreement with a FQHC are the only providers who may vaccinate underinsured children.
  - OR**
  - c. Is considered state-supplied vaccine-eligible based on the most current North Dakota Vaccine Coverage Table.
2. I will comply with the immunization schedule, dosage, and contraindications that are established by the ACIP and included in the VFC program unless:
  - a. In my 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 those pertaining to religious and other exemptions.
3. I will maintain all records (including patient screening forms, temperature logs, etc.) related to the VFC program for a minimum of three years and make these records available to public health officials including the North Dakota Department of Health (NDDoH) or U.S. Department of Health and Human Services (DHHS) upon request.
4. I will immunize eligible children with VFC or state-supplied vaccine at no charge to the patient for the vaccine.
5. I will not charge a vaccine administration fee to VFC children or state-supplied vaccine recipients that exceeds the administration fee cap of \$13.90 per vaccine dose. I will accept the reimbursement for immunization administration set by the state Medicaid agency for vaccine administered to children enrolled in Medicaid.
6. I will not deny administration of a VFC or state-supplied vaccine to a patient because the child's parent or guardian or the patient 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 NDDoH requirements for ordering, vaccine accountability, and vaccine management. (See Vaccine Management Plan, Vaccine Fraud and Abuse Policy and the Vaccine Loss Policy.)
  - a. I agree to operate within the VFC program in a manner intended to avoid fraud and abuse.
  - b. I will comply with the North Dakota Immunization Program's Vaccine Loss Policy, which includes maintaining proper storage and handling procedures for vaccine and reimbursing for any vaccine lost due to negligence by employees of my facility.
9. I will document demographic, VFC-eligibility, and immunization information on a Vaccine Administration Record (VAR) or Patient Eligibility Screening Form and in the North Dakota Immunization Information System (NDIIS).
10. I will allow NDDoH staff to conduct site visits for review of vaccine administration procedures, vaccine storage procedures and coverage level assessments.
11. The NDDoH may terminate this agreement at any time for failure to comply with these requirements, or I may terminate this agreement at any time for any reason. If I terminate, I agree to return all unused VFC and state-supplied vaccine.
12. Should my staff, representative, or I access VTrckS, I agree to be bound by CDC's terms of use for interacting with the online ordering system. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publicly funded vaccines.
13. In advance of any VTrckS access by my staff, representative or myself, I will identify each member of my staff or representative who is authorized to order vaccines on my behalf. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. If changes occur, I will inform CDC within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition or any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.

<b>Provider Signature (must be M.D. or D.O.):</b>	Date:
---	-------

This record is to be submitted and kept on file at the North Dakota Department of Health Immunization Program and must be updated in accordance with state policy.

FOR STATE USE ONLY	<b>Immunization Program Representative:</b>	<b>Date Certified:</b>
--------------------	---	------------------------



**PROVIDER ENROLLMENT - ADDITIONAL PROVIDERS WITHIN PRACTICE**  
NORTH DAKOTA DEPARTMENT OF HEALTH  
SFN 58494 (01-2011)

Last Name/First Name/ Middle Initial	Medical License Number	Medicaid Provider Number	<b>Title</b> <b>(MD, DO, ND, NP, PA)</b>  <u>Note:</u> Provider must have prescription writing privileges	Specialty (Pediatrics, Family Medicine, General Practitioner, Other-Please Specify)

<b>For State Use Only:</b>	
Immunization Program Representative:	Date Certified for Prevention Partnership:



# PREVENTION PARTNERSHIP PROGRAM PROVIDER PROFILE

NORTH DAKOTA DEPARTMENT OF HEALTH  
SFN 58495 (1-2011)

Provider I.D. Number:

All Prevention Partnership providers must complete this form. This document provides shipping information and helps the state determine the amount of vaccine supplied through the Vaccines For Children (VFC) Program. One person per practice should complete this form.

<b>Physician/Provider</b>				
Last Name:		First Name:		Middle Initial:
Facility/Clinic Name:				
Street Address:		City:	State:	Zip Code:
Contact Name(s):			Title:	
Telephone Number:		Fax Number:		
Email Address(es): If you need more space, please write on the back of this page.				
Are you currently using the North Dakota Immunization Information System (NDIIS)? <input type="checkbox"/> YES <input type="checkbox"/> NO				
<b>Type of Facility (Please check only one box):</b>				
<input type="checkbox"/> Private Hospital-Based Clinic		<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Indian Health Services	
<input type="checkbox"/> Private Practice		<input type="checkbox"/> Corrections Facility	<input type="checkbox"/> Substance Abuse	
<input type="checkbox"/> Private Hospital		<input type="checkbox"/> FQHC/ RHC	<input type="checkbox"/> Other Private Facility	
		<input type="checkbox"/> Public Health Department	<input type="checkbox"/> Other Public Facility	
		<input type="checkbox"/> HIV/STD Clinic		
<b>Vaccine Delivery Address (If different from above):</b>				
Street Address:		City:	State:	Zip Code:
<b>Provider Estimates</b>				
For the 12-month period beginning <b>January 1, 2011</b> , estimate the number of children, including out of state children, who will receive <b>VFC</b> vaccinations at your health facility by age group. Only count a child once in each 12-month period--no matter the number of visits.				
< 1 Year Old	1-6 Years	7-18 Years	Total	
<b>VFC Eligibility by Category</b>				
	< 1 Year Old	1-6 Years	7-18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
American Indian				
Underinsured				
Total: should equal provider estimates (above)				
<b>Type of data used to determine profile:</b>		<input type="checkbox"/> Benchmarking	<input type="checkbox"/> Registry	
		<input type="checkbox"/> Provider Encounter Data	<input type="checkbox"/> Dose Administered	
		<input type="checkbox"/> Medicaid Claims Data	<input type="checkbox"/> Other	
<b>For State Use Only:</b>				
Immunization Program Representative:			Date Certified for Prevention Partnership:	



**VACCINE STORAGE CERTIFICATION**  
 NORTH DAKOTA DEPARTMENT OF HEALTH  
 SFN 58498 (1-2011)

Provider Name/Facility:		Provider ID Number:	
Contact:	Telephone Number:		
Shipping Information (if different from address on provider profile):		NO POST OFFICE BOXES	
Street Address:	City:	State:	Zip Code:

THE FOLLOWING SECTION MUST BE COMPLETED TO RECEIVE VACCINE

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

Stand alone refrigerator
  Combined refrigerator/freezer with separate external refrigerator and freezer doors (i.e. household-style appliance)

Dorm-style refrigerator/freezer

Combined refrigerator/freezer with single door

---

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

Standard fluid-filled
  Minimum/maximum
  Digital

Continuous recording
  Dial
  Other (please specify):

---

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

Stand alone freezer
  Combined refrigerator/freezer with separate external refrigerator and freezer doors (i.e. household-style appliance)

Dorm-style refrigerator/freezer

Combined refrigerator/freezer with single door
  N/A – facility does not administer vaccines requiring freezer storage

---

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

Standard fluid-filled
  Minimum/maximum
  Digital

Continuous recording
  Dial
  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)?

YES                      NO

---

Signature of Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

<b>For State Use Only:</b>	
Immunization Program Representative:	Date Certified for Prevention Partnership:

## Mandatory Reporting Requirements for All Providers

1. Providers are required to monitor and log refrigerator and freezer temperatures twice daily for each unit that contains state-supplied vaccine. Only the current temperature should be recorded. **Copies of temperature logs must be sent monthly to the North Dakota Immunization Program even if a vaccine order is not placed.** This will help to ensure that vaccine is kept at appropriate temperatures.

**All vaccine except varicella (chickenpox), MMR, shingles and MMRV must be kept between 35° - 46°F or 2 – 8° C. Varicella, shingles and MMRV must be kept in the freezer at ≤ +5° F or ≤ -15° C. MMR may be either refrigerated or frozen.**

2. **Providers are required to send monthly doses administered and inventory reports to the North Dakota Immunization Program, even if a vaccine order is not placed.** These reports are necessary to monitor the accountability of our providers who receive vaccine from the VFC program. The report should contain **only state-supplied vaccine doses administered**. Orders are filled based on the number of doses administered each month, so it is very important that all doses given are entered into the registry or accounted for on hand-written reports.

**Vaccine orders will not be filled unless all mandatory reports are received.**

Please contact the Immunization Program at 701.328.3386 or 800.472.2180 with any questions regarding mandatory reporting. Thank you for your cooperation.