2017
WASHINGTON STATE DEPARTMENT OF HEALTH
OFFICE OF IMMUNIZATION AND CHILD PROFILE

PROVIDER AGREEMENT FOR RECEIPT OF PUBLICLY SUPPLIED VACCINE

Organization Name: KITTITAS VALLEY HEALTHCARE
Clinic/Facility Name: KITTITAS COUNTY PUBLIC HEALTH
PIN: 163000

Vaccine Delivery Address
Address Line #1: 507 N NANUM ST
Address Line #2: SUITE 102
City: ELLENSBURG
State: WA
Zip Code: 98926

Mailing Address (if different)
Address Line #1: 507 N NANUM ST
Address Line #2: SUITE 102
City: ELLENSBURG
State: WA
Zip Code: 98926

Email Address: TIM.ROTH@CO.KITTITAS.WA.US

Primary Vaccine Coordinator Name: TIM ROTH
Phone Number: (509)962-7634
Fax Number: (509)933-8246
Email Address: TIM.ROTH@CO.KITTITAS.WA.US
[X] Check if completed annual training requirements

Back-up Vaccine Coordinator Name: LIZ WHITAKER
Phone Number: (509)962-7068
Fax Number: (509)933-8246
Email Address: LIZ.WHITAKER@CO.KITTITAS.WA.US
[X] Check if completed annual training requirements

Shipping Days and Times (when the facility will be open to receive vaccine shipments):

X Mon	9 a.m. to 4 p.m. /		to	X Wed	9 a.m. to 4 p.m. /		to
X Tues	9 a.m. to 4 p.m. /		to	X Thurs	9 a.m. to 4 p.m. /		to
X Fri	9 a.m. to 4 p.m. /		to				

I agree to notify my local health department or the state Department of Health immediately if my vaccine delivery address changes, and understand that this practice may be required to reimburse the state for vaccines that are wasted due to delivery failure resulting from an inaccurate address.

Type of Facility: PUBLIC_PUBLIC_HEALTH_DEPARTMENT_CLINIC

Vaccines Offered: X All ACIP Recommended Vaccines O Select Vaccines as a Specialty Provider (list the selected vaccines):

As a condition for receiving publicly funded vaccines from the WASHINGTON CHILDHOOD VACCINE PROGRAM, this practice agrees to the **FEDERAL AND STATE REQUIREMENTS** attached in DOH publication #348-022. This agreement is between the Washington State Department of Health and the clinic site listed above.

By signing this agreement and receiving vaccines from the state, I understand and accept the conditions of this agreement and agree to comply with these requirements on behalf of myself and all the practitioners associated with this medical office. I agree to notify the state Department of Health immediately and update my provider agreement if my clinic/practice name changes, my clinic or vaccine delivery address changes, or the signatory below leaves the practice or is replaced. The state Department of Health or the local health jurisdiction may temporarily discontinue the provision of vaccine or may terminate this agreement at any time for failure to comply with these requirements. I may terminate this agreement at any time for personal reasons.

I have selected to be certified to receive frozen vaccines from the Washington State Childhood Vaccine Program. I certify that appropriate storage is in place for frozen vaccine.

MARK LARSON	MD	91-6001349
Full name of Provider with prescriptive authority*	Title	National Provider I.D.
Signature of Provider with prescriptive authority*		Date 7/7/17

***The provider agreement must be signed by a provider who is licensed in the state of Washington to prescribe vaccines and is responsible for making decision about the clinic and its operations.**
The provider must print and sign the agreement and keep the signed original on site at their clinic.

2017

WASHINGTON STATE DEPARTMENT OF HEALTH IMMUNIZATION PROGRAM

2017 PROVIDER AGREEMENT REGULATIONS	
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 health care facility of which I am the medical director or equivalent:	
1.	I will annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if: 1. The number of children served changes; 2. The status of the facility changes during the calendar year.
2.	I will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e., federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories: A. Federally Vaccine-eligible Children (VFC eligible) a. Are an American Indian or Alaska Native; b. Are enrolled in Medicaid; c. Have no health insurance; d. 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. B. State Vaccine-eligible Children a. In addition, to the extent that my state designates additional categories of children as "state vaccine-eligible", I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses (including 317 funded doses) to such children. Children aged 0 through 18 years that do not meet one or more of the eligibility federal vaccine categories (VFC eligible), are **not** eligible to receive VFC-purchased vaccine.
3.	For the vaccines identified and agreed upon in the provider profile, 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 for the child; B. The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the VFC program for a **minimum of six years** and upon request make these records available for review. VFC records include, but are not limited to, VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $23.44 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
7.	I will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.

8.	I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
9.	I will comply with the requirements for vaccine management including: A. Ordering vaccine and maintaining appropriate vaccine inventories; B. Not storing vaccine in dormitory-style units at any time; C. Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Washington State Childhood Vaccine Program storage and handling requirements; D. Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration.
10.	I agree to operate within the VFC program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and for the purposes of the VFC Program: **Fraud –** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. **Abuse –** provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
11.	I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.
12.	For pharmacies, urgent care, or school located vaccine clinics, I agree to: A. Vaccinate all "walk-in" VFC-eligible children; and B. Will not refuse to vaccinate VFC-eligible children based on a parent's inability to pay the administration fee. *Note: "Walk-in" refers to any VFC eligible child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve VFC patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to VFC patients as well.*
13.	I understand this facility or the Washington State Childhood Vaccine Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the Washington State Childhood Vaccine Program.

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 (and each listed provider is individually accountable) for compliance with these requirements.	
Medical Director or Equivalent Name (print):	
Signature:	Date:
Name (print) *Second individual as needed*:	
Signature:	Date:

2017 PROVIDER AGREEMENT REGULATIONS – Washington State Requirements	
I agree to the additional Washington State-specific requirements:	
Vaccine Personnel	A. Designate one staff member to be the primary vaccine coordinator and at least one back-up vaccine coordinator who is able to perform the same responsibilities as the primary vaccine coordinator in the event that the primary person is unavailable. B. Ensure that all staff that administer and handle vaccines is properly trained and receive ongoing education and training on best practices in vaccine storage and handling, and current immunization recommendations. Notify the local health jurisdiction when new staff are hired. It is essential that staff perform duties within their scope of practice. All health care providers need to be in good standing with the State of Washington Department of Health. C. Assure that no practitioner associated with this medical office is on the Office of the Inspector General's provider exclusion list.
Vaccine Ordering and Inventory Management	A. Order vaccine according to assigned ordering schedule in accordance with actual vaccine need; avoid stockpiling or build-up of excess vaccine inventory. B. Develop and maintain complete, accurate and separate stock records for both public and private vaccines. Providers must be able to physically distinguish between their public and private vaccine stock.
Storage and Handling Plans	A. Every organization receiving publicly supplied vaccine should have the following written vaccine management plans. Providers may develop their own written plans or use the state or LHJ-supplied templates and customize the templates to reflect their office practice. a. Designation of primary vaccine coordinator and at least one back-up staff b. Vaccine ordering c. Vaccine shipping receiving d. Vaccine storage and handling e. Vaccine inventory control (e.g. stock rotation) f. Vaccine wastage g. Vaccine transport in the event of a power failure, mechanical difficulty or emergency situation (emergency plan) h. Staff training on vaccine management including storage and handling
Vaccine Storage Equipment	A. Providers must have appropriate equipment that can store vaccine and maintain proper conditions. If a provider does not have the appropriate storage units, the provider must work with state and local health staff to assure proper equipment is in place to continue receiving publicly supplied vaccine. B. Vaccine storage unit requirements: a. Dormitory style units may never be used for storing vaccines. b. Stand-alone refrigerators and freezers or pharmaceutical grade units are required for providers enrolling in the Program for the first time. c. Household combination units are no longer allowed for vaccine storage for providers enrolling in the Program for the first time. d. Frozen vaccine should not be stored in the freezer component of a combination storage unit. e. Pharmaceutical or medical grade refrigerators and freezers are recommended. f. All providers should move to stand-alone or pharmacy grade units when replacing or repairing an existing household combination units. C. Refrigerators or freezers used for vaccine storage must comply with the following requirements: a. Maintain required vaccine storage temperatures year-round b. Hold the year's largest inventory without overcrowding

	c. Store only vaccines and medical equipment D. Do not store food and beverages in a vaccine storage unit.
Vaccine Storage Practices	A. Rotate vaccine stock by placing vaccines with shorter expiration dates in front of those with longer expiration dates; check for short-dated vaccine every week. B. Notify the Local Health Jurisdiction (LHJ) of any vaccine doses that will expire before they can be administered, preferably three months before the expiration date. Only with the approval and direct guidance of the LHJ and only if the cold chain can be ensured, redistribute short-dated vaccines to high-volume providers who are able to administer it before it expires. C. Ensure that the storage and handling of vaccine is in accordance with the manufacturer's specifications and the guidelines as outlined in the CDC Vaccine Storage and Handling Guidelines.
Temperature Monitoring	A. Have a working thermometer certified in accordance with International Laboratory Accreditation Cooperation (ILAC) standards or by ISO-17025 standards. B. Providers enrolling in the Program for the first time are required to use either a digital data logger or a continuous temperature monitoring system with a detachable probe in a bottle filled with a thermal buffer. C. By 2018, all providers must use either a digital data logger or continuous temperature monitoring system with a detachable probe in a bottle filled with a thermal buffer. Providers should replace thermometers not meeting these specifications when existing thermometers are due for recalibration or replacement. The thermometers should have the following features: a. Alarm for out-of-range temperatures b. Current temperature, as well as minimum and maximum temperatures c. Reset feature d. Low battery indicator e. Accuracy of +/- 1° F (0.5° C) f. Memory storage of at least 4000 readings g. Device will not rewrite over old data and stops recording when memory is full h. User programmable logging interval (or reading rate) D. Have a current certificate of calibration for each thermometer used to monitor vaccine storage temperatures. Depending on manufacturer requirements, thermometers must be re-certified either every year or every other year. E. Post a temperature log on the vaccine storage unit door or nearby in a readily accessible place. Please use the state program's paper temperature log. F. Visually review and manually record refrigerator and freezer temperatures twice each day (beginning and end) ensuring that refrigerator temperatures are between 35° and 46° F (2° and 8° C), and that freezer temperature are between 5°F and -58°F or lower (between -15°C and -50°C). G. Take immediate action to correct improper vaccine storage conditions, including inappropriate exposure to light and inappropriate exposure to storage temperatures outside the recommended ranges. Document actions taken on the temperature adjustment tracking log. Inform your Local Health Jurisdiction (LHJ). H. Maintain an ongoing file of temperature logs, and store completed logs for 6 years. Providers must send copies of completed temperature monitoring logs monthly to the local health jurisdiction via fax or email. I. Providers should also send copies of their data logger data to LHJs each month with their paper temperature logs. J. Failure to comply could result in the discontinuation of the provision of vaccine.
Vaccine Preparation	A. Ensure that clinic staff does not pre-draw vaccines into syringes. B. Draw vaccine only at the time of administration to ensure that the cold chain is maintained and the vaccine is not inappropriately exposed to light.

Vaccine Shipments	A. Ensure that all vaccine shipments are promptly received and stored immediately and report any problems with vaccine shipments immediately to the LHJ. B. Make sure all staff who receive mail at the provider location know how to handle shipments of vaccine.
Vaccine Wastage	A. Implement written procedures for reporting and responding to losses resulting from vaccine expiration, wastage, and compromised cold chain. B. Notify the local health jurisdiction promptly (within 24 hours) of vaccine incidents where vaccine has been exposed to temperatures above or below the recommended range for vaccine storage. Follow state and LHJ guidance on how to document and report the incident. C. Bag affected vaccine, mark it do not use, and store it at appropriate temperatures until viability is confirmed by the manufacturer. D. Create a written report including the reasons for the vaccine loss. Note the measures taken to correct the cause of the loss and to prevent reoccurrence. This report must be submitted to the LHJ. E. If the vaccine is deemed non-viable, remove wasted/expired vaccine from storage containers with viable vaccine to prevent inadvertent administration. Return all unopened spoiled or expired publicly purchased vaccines following the state returns process. F. Vaccine losses determined to be the result of negligent vaccine storage and handling practices, or failure to comply with the storage and handling requirements in this agreement may result in corrective action. Corrective action may include restitution for the value of all federal- and state- supplied vaccine loss resulting from the incident.
Vaccine Accountability	A. Make immunization records available to the local health jurisdiction and the state Department of Health Immunization Program (if requested). B. Participate in a site visit by the local health jurisdiction or state Department of Health, which may include an immunization assessment (AFIX). C. Provide data on the number, age and VFC status of children seen in the practice by completing the annual data request for the provider profile. D. Complete a provider satisfaction survey (if requested). E. Complete the Private Provider's Report of Vaccine Usage form provided by the local health jurisdiction, which includes: the doses of vaccine administered by vaccine type and age group of each patient; doses of vaccine wasted, lost or expired; inventory of vaccine by vaccine type and number of doses.
Vaccine Security and Equipment Maintenance	A. Post "Do Not Disconnect" signs at both the electrical outlet where your storage unit is plugged in and the circuit breaker to prevent storage units losing power.

By initialing this form, I agree to the Washington State-specific requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.		
Medical Director or Equivalent Name (print):	Initials:	Date:

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Organization Name: KITTITAS VALLEY HEALTHCARE
Clinic/Facility Name: KITTITAS COUNTY PUBLIC HEALTH
PIN: 163000

Cold Storage Units

Freezer:

Freezer 1			
Freezer Name:	FREEZER 1	**Thermometer Serial Number:**	
Freezer Type:	Stand Alone Freezer	**Thermometer Type:**	Digital Data Logger
Manufacturer:	Kenmore	**Other Device:**	
Model Number:	253	**Temperature Scale:**	Fahrenheit
Effective From:	01/01/2013	**Date of Last Calibration:**	03/14/2016
Purchase or Issue Date:	04/01/2009	**Calibration Expiration:**	03/14/2018
Freezer 2			
Freezer Name:		**Thermometer Serial Number:**	
Freezer Type:		**Thermometer Type:**	
Manufacturer:		**Other Device:**	
Model Number:		**Temperature Scale:**	
Effective From:		**Date of Last Calibration:**	
Purchase or Issue Date:		**Calibration Expiration:**	

Refrigerator:

Refrigerator 1			
Refrigerator Name:	REFRIGERATOR 1	**Thermometer Serial Number:**	
Refrigerator Type:	Pharmaceutical (medical grade)	**Thermometer Type:**	Digital Data Logger
Manufacturer:	McCALL	**Other Device:**	
Model Number:	MCCR1-S	**Temperature Scale:**	Fahrenheit
Effective From:	01/01/2013	**Date of Last Calibration:**	03/08/2016
Purchase or Issue Date:	04/01/2009	**Calibration Expiration:**	03/08/2018
Refrigerator 2			
Refrigerator Name:		**Thermometer Serial Number:**	
Refrigerator Type:		**Thermometer Type:**	
Manufacturer:		**Other Device:**	
Model Number:		**Temperature Scale:**	
Effective From:		**Date of Last Calibration:**	
Purchase or Issue Date:		**Calibration Expiration:**	

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PROVIDERS WITHIN THE PRACTICE

Please print or type the names, titles, specialties, and Washington State medical license numbers of licensed health providers in your practice who are authorized to write prescriptions and may provide immunizations. Attach additional copies of this sheet as needed.

Last name, First, MI	Title (MD,DO, ND, NP, PA) (Provider must have prescription writing privileges)	Specialty (Peds, Fam Med, GP, Other (specify)	Washington State Medical License Number
LARSON, MARK W	MD	FAMILY_MEDICINE	MD00035733

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Organization Name: KITTITAS VALLEY HEALTHCARE
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PIN: 163000

Provider/Practice Profile

Provider Population based on patients seen during the previous 12 months. *Report the number of children who received vaccinations at your facility, by age group. Only count a child once based on the status at the last immunization visit, regardless of the number of visits made. The following table documents how many children received VFC vaccine, by category, and how many received non-VFC vaccine.*

VFC Vaccine Eligibility Categories	**# of children who received VFC Vaccine by Age Category**			
	<1 Year	**1-6 Years**	**7-18 Years**	**Total**
VFC eligible— Medicaid/Medicaid Managed Care	2	25	54	81
VFC eligible— Uninsured	0	19	30	49
VFC eligible— American Indian/Alaskan Native	0	0	0	0
VFC eligible— underinsured at FQHC/RHC/deputized provider	0	0	1	1
Total VFC:	2	44	85	131
Non-VFC Vaccine Eligibility Categories	**# of children who received non-VFC Vaccine by Age Category**			
	<1 Year	**1-6 Years**	**7-18 Years**	**Total**
Not VFC Eligible	0	1	9	10
CHIP	0	0	0	0
Private Insurance (WAA01)	0	48	58	106
Other Underinsured	0	0	0	0
Total Non-VFC:	0	49	67	116
Total Patients (must equal sum of Total VFC + Total Non-VFC)	2	93	152	247

What type of data was used to determine the provider population? (Check all the apply)

- ☐ Benchmarking
- ☐ Medicaid Claims
- ☐ Doses Administered
- ☐ Provider Encounter Data
- ☐ Billing System
- ☒ Washington State Immunization Information System
- ☐ Other-Please Specify: _____

Kittitas County
Review Form
Grants & Contract Agreement

#391690

Today's Date 05/25/2017		Agenda Date 6/20/17
Fund/Department 116-Public Health		

Contract/Grant Information

Contract /Grant Agency: Washington State Department of Health Immunization Program		
Period Begin Date: May 1, 2017		Period End Date: April 30, 2018
Total Grant/Contract Amount: None		
Grant/Contract Number:		
Contract/Grant Summary: This agreement is between Washington State Department of Health Immunization Program and Kittitas County Public Health Department. The agreement outlines the guidelines providers must follow in order to participate in the Vaccine for Children Program (VFC).		

Recommendation for Board of Health and Board of Health Review on ____

Department Head Signature: _____, Administrator Date: 6/27/17

Kittitas County Prosecutor, Auditor, and Board of Health Review and Comment:

APPROVED AS TO FORM:

_____ 6·1·17
Signature of Prosecutor's Office Date

_____ 6/5/17
Signature of Auditor's Office Date

_____
Signature of Board of Health member Date

Financial Information

Total Amount $	State Funds $	Federal Funds $
Percentage County Funds	Matching Funds $	CFDA#
	In-Kind $ Explain	
Is Equipment being purchased?	Who owns equipment?	

New Personnel being hired?	Contact HR hiring – reporting requirements
Future impacts or liability to Kittitas County:	

Budget Information

Budget Amendment Needed?	Yes ☐ attach budget form	No ☐ Why not
New Division Created?		
Revenue Code		

Pass Through Information

Agency to Pass Through	
Amount to Pass Through	$
Sub-Contract Approved	Date:

Prosecutor Review

Has the Prosecutor reviewed this agreement?	Yes ☐ No ☐

County Departments Impacted

	Auditor		Facilities Maintenance
	Information Services		Human Resource
	Prosecutor		Treasurer

Submitted

Signature:	Date:
Department:	

Assignment of Tracking Information

Auditor's Office	
Human Resource	
Prosecutor's Office	
Who Signed the grant application	

Reviewer	Date