Questions from January 4, 2018 Webinar #1
Regional Representative for VFC and AFIX Site Visit Activities

1. **Is it one person per 100 site visits or is it 1.0 FTE per 100 site visits?**
   We are limiting staffing to one person per 100 VFC site visits and one person per 50 AFIX visits.

2. **What is the estimated time of each type of visit?**
   Based on data collected by Diamond Project members in 2017, the average amount of time needed to complete each type of visit is as follows:
   - VFC Compliance Visit = 4 hours
   - Unannounced Storage and Handling Visit = 1 hour
   - AFIX Visit = 6 hours

   Estimated hours for the various visits include time for scheduling, pre-visit preparations, the actual visit, required follow-up, and data entry. Time estimates do not include travel time.

3. **What happens if there isn't an applicant for the region?**
   We will determine our options once all applications are received. Options include: offering the region to another regional representative county, expanding that region, or utilizing DOH staff to conduct site visit activities in the region.

4. **What is the timing and number of DOH trainings expected?**
   We anticipate the following trainings:
   - A two-day in-person training to be held in June/July 2018
   - Quarterly Technical Assistance Calls via GoToTraining (approximately one hour each)
   - One VFC Observation visit per year
   - One AFIX Observation visit per year

5. **Did I understand that the funding will go through the ACH's?**
   No, funding for the regional representative will be contracted to the local health departments selected through the consolidated contract process.

6. **Will the supervisors of the reviewers need to be trained as well?**
   Supervisors will not be required to take or attend any VFC or AFIX trainings. It is important for supervisors to understand the requirements needed for their staff to complete the contracted work (car, computer, time, etc.) and be responsive should there be any issues completing assigned work in a timely manner. Detailed knowledge of the VFC and AFIX work is not required for supervisors. The program coordinators at DOH will be available to all regional representative reviewers for any technical assistance the reviewers may need to assure the work is uniform across all regions.

7. **What is the DOH staffing model for the other tasks? A staffing model was proposed as part of the Diamond Project and we'd like to understand better how that stands now?**
   Staffing models are being drafted by DOH. Factors contributing to the staffing model include funding, agency and union approvals, number of Regional Representatives identified, etc.

8. **Who/which organization will respond to the technical and immunizations questions we get from the clinics? Will these continue to go to the LHJ? The DOH nurse line?**
   The technical assistance related to vaccine management in the consolidated contract (Task 5) will be performed by DOH staff. LHJs may independently choose to provide clinical consultation, but this is not funded by the consolidated contract. DOH currently provides clinical consultation via the DOH nurse line.

9. **In addition to new provider enrollment, will the regional staff also complete disenrollment visits?**
   Yes. The regional representative will be responsible for conducting the disenrollment visit.

10. **How many new providers enrolled in 2017? How many providers dis-enrolled?**
    In 2017, there were 33 new providers enrolled statewide. We were also notified that 59 providers qualified as a disenrollment --- either the provider office was no longer participating in the Childhood Vaccine Program or had merged with other organizations.

11. **Who will be responsible for training new vaccine coordinators for providers within our region?**
    DOH is developing resources to provide new vaccine coordinator trainings. Regional Representatives are not expected to train new vaccine coordinators.

12. **Is there a draft communication plan for how we will message the changes to providers? Is there a communication plan out to providers and the timeline for that?**
    DOH will begin messaging to providers tentatively this spring. We will share communication plans with LHJs prior, to help stay coordinated with LHJs on messaging. The process and messaging will be similar to ones implemented during previous transitions of this work (i.e., LHJs that no longer contract with DOH for this work).

13. **Could you please clarify, for example if region 7 has 48 providers and the expectation is to do 5%, does this mean we only would conduct less than 3 visits within that large geographic area?**
    The regional representative will be responsible for conducting VFC compliance site visits for all providers when due (within 24 months of their last compliance site visit). In addition, the regional representative must conduct unannounced storage and handling visits with 5% of providers in the region. For a region with 48 providers, the number of unannounced storage and handling visits is 3 and the estimated number of VFC compliance visits is 24, plus the required AFIX visits.

14. **New provider enrollment visits don't appear to be accounted for in the funding announcement. Is there an estimate of new orientation visits in the budget formula? Enrollment requires a visit. Disenrollment doesn't take much time.**
    The funding formula is based on the percentage of providers in the region. This number will be calculated one time prior to the beginning of the contract period, and the expectation is that the funding will cover costs related to VFC Compliance site visits, unannounced storage and handling visits, AFIX visits, and new provider enrollment. There is not a separate formula for each type of site visit.

15. **Was funding for travel for rural regions considered?**
    We did gather travel time and distance data as part of our work on developing a funding formula. After much consideration, a decision was made to utilize a funding formula that was based on the percentage of providers in the region.

16. **Will the AFIX visits need to be allocated proportionately across all counties in the region, or can we focus on higher-volume providers regardless of county?**
    AFIX visits will not need to be allocated proportionately across the counties in a region. Regional representatives will be expected to follow a site-selection protocol meeting CDC guidelines. The protocol will be shared with reviewers during training.

17. **Is there a percentage of AFIX visits that DOH prefers to be separate from VFC visits?**
    CDC recommends that VFC and AFIX visits be conducted separately. DOH does not have a target percentage of separated versus combined visits.

18. **Due to the distance needed to travel could a combined visit of VFC and AFIX be completed?**
    CDC recommends that VFC and AFIX visits be conducted separately to allow sufficient time for both subject matters. However, we know this is not always feasible given the distance and time needed for some travel. Regional representatives should consider travel distances and other factors when determining whether the VFC and AFIX visits should be combined or conducted separately.

19. **There were a number of questions during the webinar regarding back-up staff, primarily around training costs and participation. DOH has combined those questions into one response below.**
    Our goal is to reduce the number of staff performing the VFC and AFIX activities statewide to achieve efficiencies and standardize the work. The expectation is that there will be one staff designated per 100 VFC site visits and one staff designated per 50 AFIX visits for each region. The funding does not support additional (i.e., backup) staff at the regional level. Regional representatives for VFC and AFIX should factor in any potential scheduling conflicts (vacations, planned leave, etc.) when scheduling site visits. If an unanticipated absence occurs (such as staff turnover or extended leave), DOH will work with the regional representative county on a case-by-case basis to determine how to best complete the contracted work.