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Acronyms

AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
Ab-negative	Antibody negative
ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetricians and Gynecologists
ACP	American College of Physicians
AFIX	Assessment, Feedback, Incentive, and eXchange
AI/AN	American Indian and Alaska Native
AIM	Association of Immunization Managers
APhA	American Pharmacists Association
ASTHO	Association of State and Territorial Health Officials
AVA	Anthrax vaccine adsorbed
BCG	Bacillus of calmette and guérin (tuberculosis) vaccine
BRFSS	Behavioral Risk Factor Surveillance System
CCID	Coordinating Center for Infectious Diseases
CDC	Centers for Disease Control and Prevention
CE	Continuing Education
CMS	Centers for Medicare and Medicaid Services
CNRA	Community Needs and Resource Assessment
CoCASA	Comprehensive Clinical Assessment Software Application
CQI	Continuous quality improvement
CRS	Congenital rubella syndrome
CSTE	Council of State and Territorial Epidemiologists
CY	Calendar year
DA	Direct Assistance
DHHS	Department of Health and Human Services
DT	Diphtheria and tetanus toxoids vaccine (for children)
DTaP	Diphtheria and tetanus toxoids and acellular pertussis vaccine
EIPB	Education, Information, and Partnership Branch
EPSDT	Early Periodic Screening Diagnosis and Treatment Program
ERISA	Employee Retirement Income Security Act
FA	Financial assistance
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
FMO	Financial Management Office
FSR	Financial status report
FTE	Full-time Equivalent
FY	Fiscal year

GIS	Geographic Information System
GSA	General Services Administration
HAV	Hepatitis A virus
HBsAg	Hepatitis B surface antigen
HBIG	Hepatitis B immune globulin
HBV	Hepatitis B virus
HEDIS	Health Plan Employers Data and Information Set
Hib	Haemophilus influenzae type B conjugate vaccine
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HL7	Health Level 7
HP 2010	Healthy People 2010
HPV	Human papillomavirus vaccine
HRSA	Health Resources and Services Administration
HSREB	Health Services Research and Evaluation Branch
IAC	Immunization Action Coalition
IgM anti-HAV	IgM anti-hepatitis A virus
IgM anti-HBc	IgM anti-hepatitis B core antigen
IHS	Indian Health Service
IIS	Immunization Information System
IISAR	Immunization Information System Annual Report
IM	Intramuscular
IOM	Institute of Medicine
IPOM	Immunization Program Operations Manual
IPV	Trivalent inactivated polio vaccine (killed Salk type)
ISD	Immunization Services Division
ISO	Immunization Safety Office
IV	Intravenous
JE	Japanese encephalitis
LAIV	Live attenuated influenza vaccine
LQA	Lot quality assurance
LTC	Long-term care
M/CHC	Migrant/community health center
MCO	Managed care organization
MCV4	Meningococcal conjugate vaccine (quadravalent)
MDS	Minimum data set
MMR	Measles, mumps, and rubella vaccine
MMR2	Measles, mumps, and rubella vaccine second dose
MMRV	Measles, mumps, rubella, and varicella vaccine
MMWR	Morbidity and Mortality Weekly Report
MOU	Memorandum of understanding

MPSV4	Meningococcal polysaccharide vaccine (quadravalent)
MVP	Monthly voucher pickup
NACCHO	National Association of County and City Health Officials
NCIRD	National Center for Immunization and Respiratory Diseases
NCVIA	National Childhood Vaccine Injury Act
NEDSS	National Electronic Disease Surveillance System
NETSS	National Electronic Telecommunications System for Surveillance
NIC	National Immunization Conference
NIIW	National Infant Immunization Week
NIP	National Immunization Program
NIPVAC	(not an acronym; name of software that tracks vaccine target balances)
NIS	National Immunization Survey
NIVW	National Influenza Vaccination Week
NNDSS	National Notifiable Disease Surveillance System
NoA	Notice of Award
NVAC	National Vaccine Advisory Committee
NVPO	National Vaccine Program Office
OMB	Office of Management and Budget
OPV	Trivalent oral polio vaccine (live Sabin type)
PCV7	Pneumococcal conjugate vaccine (7-valent)
PGO	Procurement and Grants Office
PHIN	Public Health Information Network
PHTN	Public Health Training Network
POB	Program Operations Branch
PON	Pockets of need
PPO	Preferred Provider Organization
PPV23	Pneumococcal polysaccharide vaccine (23-valent)
PQA	Provider Quality Assurance
PRAMS	Pregnancy Risk Assessment Monitoring System
PRV	Pentavalent rotavirus vaccine
QA	Quality assurance
QIO	Quality Improvement Organization
RHC	Rural Health Clinic
SCHIP	State Children's Health Insurance Program
SMART	Specific, measurable, achievable, realistic, and time-phased (objective)
SOP	Standard operating procedure
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SubQ	Subcutaneous
TANF	Temporary Assistance for Needy Families

Td	Tetanus and diphtheria toxoids adsorbed for adult use
Tdap	Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine
TDY	Temporary duty
TIV	Trivalent (inactivated) influenza vaccine
TT	Tetanus toxoid
USDA	United States Department of Agriculture
UTD	Up-to-date
VAERS	Vaccine Adverse Events Reporting System
VACMAN	(not an acronym; name of vaccine ordering software)
VAR	Varicella vaccine
VaX.NET	Vaccine eXchange NETwork
VFC	Vaccines for Children Program
VICP	National Vaccine Injury Compensation Program
VIS	Vaccine Information Statement
VMBIP	Vaccine Management Business Improvement Project
VOFA	Vaccine Ordering Forecast Application
VPD	Vaccine-preventable disease
VSAB	Vaccine Supply and Assurance Branch
VZV	Varicella zoster virus
WIC	Women, Infants and Children Program
YF	Yellow fever
ZOS	Varicella zoster virus vaccine

Financing Childhood Immunizations

Types of coverage for immunizations for any child under age 19:

- Vaccines for Children (VFC) program: provides free vaccinations to Medicaid-eligible children, Alaska Natives, American Indians, children who have no health insurance, and privately insured children with no coverage for vaccinations (called underinsured children) who are served at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC).
- Section 317 program: provides free vaccinations to populations determined by the grantee. Most grantees use 317 to provide vaccinations to the underinsured seeking services at health departments and/or their medical home.
- State or locally funded vaccine program: provides free vaccinations to populations determined by the grantee.
- Private health insurance.

Vaccine Supply Policies:

Universal:

All children, regardless of insurance status, receive all ACIP-recommended vaccines free of charge via the immunization program. The immunization program uses a combination of VFC, 317, and state/local funds to purchase vaccine for all children in the state. Children may be vaccinated by any VFC-enrolled provider (public and private).

Universal Select:

All children, regardless of insurance status, receive all ACIP-recommended vaccines for free via the immunization program, except for one or more of the newer, more expensive vaccines such as PCV7, Varicella, MCV4, and Tdap. With universal select states, only VFC-eligible children receive all the newer vaccines free-of-charge at any VFC-enrolled provider (public and private). Therefore, universal select grantees must implement two-tiered systems in order for providers to be able to identify and then vaccinate the VFC-eligible children with the new vaccines. The immunization program tries to cover the non VFC-eligible children with 317 and state/local funds to the greatest extent possible, but most states' 317 and state/local funding fall short of the funds needed to reach all non VFC-eligible children. They are therefore left with the difficult decision to ask providers to turn away non VFC-eligible children or ask these children to pay for these newer vaccines out-of-pocket.

VFC & Underinsured:

All children who are underinsured are treated like VFC-eligible children, because the immunization program uses 317 and/or state/local funding for all ACIP-recommended vaccines, including the newer more expensive vaccines, to cover the underinsured. This enables the underinsured to receive all ACIP-recommended vaccines at any VFC enrolled provider (instead of having to refer the underinsured to an FQHC or RHC for vaccinations).

VFC & Underinsured Select:

All children who are underinsured are served by the immunization program, because the immunization program uses 317 and/or state/local funding to cover the underinsured. However,

the underinsured must be referred to an FQHC or RHC to receive one or more of the newer, more expensive vaccines. They may receive the older routine antigens at any VFC-enrolled provider.

VFC Only:
The immunization program provides all vaccines to private providers only for VFC-eligible children. The private providers do not receive 317 or state/local funded vaccine for non-VFC eligible children. However, non VFC-eligible children may be served via 317 and/or state/local funds in public clinics.

Funding Categories and Redirection Guidance

Vaccine Funding Categories

VFC vaccine target: For grantees to purchase vaccines covered under federal contract, to be administered to VFC eligible population.

317 vaccine target: For grantees to purchase vaccines covered under federal contract, to be administered to anyone not eligible for VFC, including adult population. Each grantee determines which populations can receive 317 vaccine.

317 financial assistance (FA) vaccine: For grantees to purchase vaccines that are not covered under federal contract as well as biologics, to be administered to children and adults, such as: DT, HBIG, IG for Hepatitis A, MPSV4, influenza purchases (if VFC and 317 vaccine target funding is insufficient), and any new vaccine for which a VFC resolution has been passed but a federal contract does not yet exist.

Operations Funding Categories

Financial Assistance

Financial Assistance (FA) - A category of funding that goes directly to the grantee, similar to a "check."

317 FA - Operations Funds. Funding directly to the grantee for program operations expenses. These funds are maintained by the grantee.

VFC Financial Assistance (FA) - Operations Funds. Funding directly to the grantee for VFC program operations expenses. These funds are maintained by the grantee.

VFC/AFIX - Operations Funds. Funding directly to the grantee for VFC/AFIX program operations expenses. These funds are maintained by the grantee.

Direct Assistance

Direct Assistance (DA) - A category of funding in lieu of financial assistance.

317 DA - Operations Funds. In lieu of financial assistance, an account maintained by CDC that allocates funds to procure products and services, and cover salaries and travel expenses for federal assignees (e.g., Public Health Advisors assigned to immunization programs).

317 DA Other - Operations Funds. In lieu of financial assistance, funds used for GSA contracts for immunization information system (IIS) development and maintenance. This funding is included in the grantee's total operations budget. It appears as a separate line item on

the operations budget spreadsheet. If a grantee wants to establish a GSA contract, a GSA schedule is available with a list of approved GSA contractors/vendors. Various task orders or IIS services must be chosen from this listing in order to enter into a contractual agreement. Otherwise, the grantee must use other (state or FA) funds for other contractors not approved on the GSA schedule. Statements of work for GSA contracts must be initiated annually by March 1. The process of obligating funds must be completed by August 31. Any redirections of 317 DA-Other to FA must occur by June 1.

Redirections

Grantees have latitude in making programmatic changes and budget revisions after funds have been awarded. Redirection of funds is the shifting of funds from one object class category to another. However, depending upon the object class category and the amount of funding being redirected, a formal request to PGO is required. In other situations, grantees are expected to send a courtesy notification by email to the grantee's project officer. Grantees are strongly encouraged to redirect funds within the same budget year. The criteria for formal redirections and courtesy emails are described below:

Criteria for sending a formal request to PGO:

- If request is >25% or $\geq$$250,000 of the total award (whichever is less)
- If moving funds to and from contracts
- If moving funds to and from key personnel
- If moving funds between FA & DA or FA operations & FA vaccine

The reason why CDC discourages the movement to and from FA to DA is because these are fundamentally different accounts that are tracked separately.

A formal request to PGO should include

- Justification that includes where monies are being moved to and from
- For personnel, include resume of individual to fill Key Position
- Signature of both Business Office Manager and Principal Investigator or Program Director
- All original documentation should be forwarded to PGO:

_____, Grants Management Officer
Attn: _____, Grants Management Specialist
Procurement and Grants Office, CDC
2920 Brandywine Road, NE, Suite 3000, MS-E15
Atlanta, GA 30341

Criteria for sending a courtesy e-mail to the grantee's project officer:

- If request is <10% of total operations award
- If request is not a new contract nor changes an existing contract's scope of work
- If request does not add personnel

Allowable Expenses with 317 and VFC FA Operations Funds

POB developed the following tables to assist grantees in preparing budgets that are in compliance with federal grants policies. The tables were developed using a combination of the OMB Circular A-87, PHS Grants Policy Statement 9505, and POB identified program priorities. Where there is more than one allowable funding source for a specific expense, a double check mark (✓✓) indicates the preferred single funding source for the full cost of that expense. All other expenses that allow more than one funding source are indicated with single check marks (✓); for these expenses the grantees must split the 317 and VFC expenses according to the population estimates.

Expense	Allowable with 317 operations funds	Allowable with VFC operations funds	Allowable with VFC ordering funds	Allowable with VFC distribution funds	Allowable with VFC/AFIX funds
Service delivery activities	✓				
Consumer information activities	✓				
Surveillance activities	✓				
Population assessment activities	✓				
Perinatal hepatitis B activities	✓				
Advertising (restricted to recruitment of staff or trainees, procurement of goods and services, disposal of scrap or surplus materials)	✓				
Locks/security devices for providers	✓				
Translations	✓				
Vaccine administration supplies	✓				
Building rearrangement/alteration costs (not construction)	✓				

Expense	Allowable with 317 operations funds	Allowable with VFC operations funds	Allowable with VFC ordering funds	Allowable with VFC distribution funds	Allowable with VFC/AFIX funds
Registry (restricted to one-time development support, inventory module design/development, adding fields and reports to collect VFC eligibility screening data, data entry personnel salary for VFC portion of entering vaccine histories, other enhancements with VFC-specific documentation)	✓	✓✓	✓		
Registry (all other registry-related activities)	✓				
Pagers/cell phones	✓	✓	✓	✓	✓
Rent on buildings and equipment (restricted to non-government owned building)	✓	✓	✓	✓	✓
Accounting services	✓	✓	✓	✓	✓
Vehicle lease (restricted to grantees with policies that prohibit local travel reimbursement)	✓				
Communication (electronic/computer transmittal, messenger, postage, local and long distance telephone)	✓	✓	✓	✓	✓
Compensation/fringe benefits	✓	✓	✓	✓	✓
Indirect costs	✓	✓	✓	✓	✓
Consumer/provider board participation	✓				
Contracts	✓	✓	✓	✓	✓
Data processing	✓	✓	✓	✓	✓
Maintenance operation/repairs	✓	✓	✓	✓	✓
Malpractice insurance for volunteers	✓	✓	✓	✓	✓
Local meetings/conferences (excluding meals)	✓	✓	✓	✓	✓
Memberships/subscriptions	✓				

Expense	Allowable with 317 operations funds	Allowable with VFC operations funds	Allowable with VFC ordering funds	Allowable with VFC distribution funds	Allowable with VFC/AFIX funds
Professional service costs (limited term staff)	✓	✓	✓	✓	✓
Public relations	✓				
Publication/printing costs (restricted to VFC program-specific needs; excludes VIS printing expenses)	✓	✓✓	✓	✓	✓
Publication/printing costs (all other immunization related publication and printing expenses)	✓				
Salary/wages	✓	✓	✓	✓	✓
Service charges	✓	✓	✓	✓	✓
Shipping (other than vaccine)	✓	✓			✓
Office supplies	✓	✓	✓	✓	✓
Training costs	✓	✓	✓	✓	✓
In-state travel costs	✓	✓	✓	✓	✓
Out-of-state travel costs (restricted to NIC, Program Manager's/PHA Meeting, ACIP meetings, and other CDC sponsored immunization program meetings specified in each year's grant guidance)	✓	✓	✓	✓	✓
VFC specific training	✓	✓✓			
VIS camera ready copies	✓	✓✓			
VFC promotional and recruitment materials	✓	✓✓			✓
VFC-only site visits	✓	✓✓			
VFC provider feedback surveys	✓	✓✓			
Toll-free phone lines for vaccine ordering	✓		✓✓		
Fax machines for vaccine ordering	✓		✓		
Printing of vaccine accountability forms	✓		✓✓		
Data entry for VACMAN	✓		✓✓		
Vaccine warehouse needs	✓			✓	

Expense	Allowable with 317 operations funds	Allowable with VFC operations funds	Allowable with VFC ordering funds	Allowable with VFC distribution funds	Allowable with VFC/AFIX funds
Vaccine cold chain supplies	✓			✓	
Vaccine shipping supplies/shipping costs	✓			✓	
Third party distribution contracts	✓			✓	
Equipment for public clinic sites for vaccine distribution	✓			✓	
Vaccine storage and distribution supplies for provider sites	✓			✓	
Temperature monitors	✓	✓			
Laptops	✓	✓			✓
Personal computers	✓	✓	✓	✓	✓
Printers	✓	✓	✓	✓	✓

NON-ALLOWABLE EXPENSES WITH 317 AND VFC FA OPERATIONS FUNDS

Expense	NOT allowable with 317 funds	NOT allowable with VFC funds
Honoraria	✓	✓
Advertising costs (conventions, displays, exhibits, meetings, memorabilia, gifts, souvenirs)	✓	✓
Alcoholic beverages	✓	✓
Building purchases, construction, capital improvements	✓	✓
Entertainment	✓	✓
Land purchases	✓	✓
Legislative/lobbying activities	✓	✓
Bad debts	✓	✓
Vehicle purchase	✓	✓

Expense	NOT allowable with 317 funds	NOT allowable with VFC funds
Bonding	✓	✓
Construction	✓	✓
Depreciation on use charges	✓	✓
Vaccine (exception: vaccines not on the federal contract may be purchased with 317 FA operations; this request must be reflected in VOFA)	✓	✓
Research	✓	✓
Dry cleaning	✓	✓
Fundraising	✓	✓
Interest on loans for the acquisition and/or modernization of an existing building	✓	✓

Allocation Process for Section 317 Immunization Grant Program Funds

Background

Federal funding for the Immunization Grant Program (also called the Section 317 grant program) was launched in 1963. In 2003, CDC awarded $408 million in federal grants to 50 states, six large urban areas, and eight U.S. territories and island nations' public health agencies for program operations and vaccine purchases. The majority of Section 317 program funding is dedicated to routine childhood programs, with a smaller portion remaining for adult immunization programs. The amount of funding available to be awarded to grantees varies depending upon the annual amount appropriated by Congress as well as any unobligated funds carried forward from one year to the next. Continuation awards are made within an approved project period (typically lasting five years) on the basis of satisfactory progress as evidenced by a review of required reports and the availability of funds.

The Section 317 grant program provides federal funds to supplement state and local resources to help ensure that children, adolescents, and adults receive appropriate immunizations. The program supports a partnership between public health and immunization providers in both the public and private sectors by helping them to implement effective immunization practices and proper use of vaccines to achieve high immunization coverage. It also supports infrastructure for essential activities such as immunization information systems, outreach, disease surveillance, outbreak control, education, and service delivery. A strong immunization infrastructure ensures optimal coverage with routinely recommended vaccines.

The Institute of Medicine (IOM), which reviewed funding for immunization infrastructure in the United States in its 2000 report *Calling the Shots: Immunization Finance Policies and Practices* recognized the importance of developing a rational, clear and standard approach for awarding section 317 grant funds. This report documented a combination of new challenges and reduced resources that have led to instability in the public health infrastructure that supports the U.S. immunization system. The IOM concluded that a renewal and strengthening of the federal and state immunization partnership was necessary and recommended the development of a consistent funding allocation strategy, additional funds, and a multi-year financing plan. The goals of this partnership are to expedite the delivery of new vaccines; strengthen the immunization assessment, assurance, and policy development functions in each state; and adapt childhood immunization programs to serve the needs of new age groups in different healthcare environments.

Purpose of Document

The purpose of this document is to establish criteria by which the Immunization Services Division awards 317 operations funding equitably across all immunization program grantees.

Assumptions

- The Section 317 immunization grant program is a non-competitive discretionary grant program (Source: OMB Circular A-133 CFDA 93.268), with only state health departments and certain other jurisdictions eligible to apply for the funds. Because this is a discretionary grant program, CDC, as the federal awarding agency, can exercise judgment (discretion) in determining the award recipient and the amount of funding awarded (Source: CDC Assistance Management Manual Part I.C.1-2).

- Available Section 317 funds are usually less than the total funds requested by grantees in their annual budget requests. When a significant discrepancy exists between grantees' budget requests and available funds, an allocation methodology is necessary to determine a fair and equitable funding amount for each grantee.

- Population and birth cohort should not be used as the sole factors in determining funding. States with smaller populations and a large proportion of the population living in rural areas may require additional resources needed to implement their programs that are not adequately addressed through a purely population-based methodology.

- A noncompetitive discretionary grant does not preclude the use of an allocation model to award funding fairly and equitably across grantees.

Methodology

1. After CDC's appropriation bill is signed into law[1], the Treasury Department transfers appropriated dollars from the general fund into a CDC-specific account by issuing a treasury warrant. These accounts are managed by the Office of Management and Budget (OMB). Within ten days after approval of the appropriations bill, CDC issues a request for an apportionment to OMB. An apportionment outlines the amount of money available for obligation and the time of its receipt. Upon receipt of an apportionment, CDC's Financial Management Office, (FMO) issues resource allocations to Coordinating Centers and Offices in the form of budget ceiling letters. Upon receipt of a budget ceiling letter, the Coordinating Center for Infectious Diseases (CCID) makes funding decisions and distributes a second budget ceiling letter to the National Center for Immunization and Respiratory Diseases (NCIRD). The Immunization Services Division (ISD) then determines the total amount of funds available to award to grantees for the fiscal year in which awards will be made.

2. The funding methodology addresses and quantifies three criteria for grantees as defined by the IOM: need, capacity, and performance. A grantee's need is determined by population, birth cohort, number of non-English speaking individuals, number of individuals living in poverty, number of individuals living in rural areas, and number of under-immunized children. Need accounts for 82% of the funding model [population and birth cohort accounts for 50% of the funding model; number of non-English speaking individuals (a surrogate for the number of non-legal residents) accounts for 8% of the model; number of individuals living in poverty accounts for 12%; number of under-immunized children accounts for 8%; and number of individuals living in rural areas accounts for 4%].

Capacity is further defined as the minimum personnel and other-than-personnel costs required to implement an immunization program. Capacity accounts for 13% of the model.

Performance is defined as childhood vaccination and adult influenza vaccination coverage in each grantee location. Performance accounts for 5% of the model; within that, childhood vaccination coverage accounts for 4%, and adult influenza vaccination coverage accounts for 1% of the model.

This model establishes a benchmark funding level for each grantee. Adjustment factors are applied to the model to account for variations in salaries and cost of living among the grantees. The U.S. Territories, and Island Nations do not currently receive funding according to this model because of their geographic locations, physical size (both land area and country/territory borders), small populations, limited resources, special needs, and unique challenges.

The individual factors and their weights may be adjusted as necessary to reflect changes in program or funding priorities.

3. The model is being applied gradually to available funding to determine the 317 operations award for each grantee.

This approach considers the necessity of awarding funds fairly and equitably across grantees, and at the same time includes the importance of considering a grantee's budget request and proposed use of funds to implement immunization activities.

Final decisions for awarding funds rest with ISD.

[1]When Congress has not approved a budget, we operate under a Continuing Resolution, which is defined as "legislation passed by both the House and the Senate permitting specific Executive Branch agencies to continue operating even though funds have yet to be appropriated for the following fiscal year."

Section 317:
Operational Funding Principles

Scope and Purpose of Federal Immunization Grant Funds

The Centers for Disease Control and Prevention (CDC) provides federal Section 317 immunization grant funds to ensure that children, adolescents, and adults receive appropriate immunizations by partnering with health providers in the public and private sectors. These funds support the 50 states, six large urban areas, and eight U.S. territories and island nations, hereafter referred to as grantees, in their efforts to plan, implement, and maintain a public health infrastructure that assures the existence of an effective national immunization system. The objective of the immunization grant program is to reduce and ultimately eliminate vaccine-preventable diseases by increasing and maintaining high immunization coverage. Emphasis is placed on populations at highest risk for under-immunization and disease. The funds help assure the implementation of effective immunization practices and proper use of vaccines by supporting infrastructure for essential activities such as outreach, disease surveillance, outbreak control, education, service delivery, and immunization information systems.

This approach of providing federal government funds in the form of financial assistance directly to the grantees is designed to supplement and not supplant state and local resources and assist grantees in implementing activities proven to be effective in raising vaccination coverage levels and reducing vaccine-preventable disease morbidity and mortality. This financial assistance is distributed to grantees as Section 317 operations funding. The grant funds are awarded for a 12-month budget period with a project period of five years. The amount of funding available to be awarded to the grantees varies depending upon the annual amount appropriated by Congress as well as carryover. Carryover funds are awarded in lieu of new funds in an effort to minimize carryover. Continuation awards are made within an approved project period on the basis of satisfactory progress as evidenced by a review of required reports and the availability of funds.

Assumptions

- The immunization grant program is a discretionary grant program, and only state health departments and certain jurisdictions are eligible to apply for the funds.
- When there is a significant discrepancy between grantees' budget requests and available funds, CDC uses an allocation methodology to determine how much funding each grantee should receive.

Funding Principles

1. Section 317 operations funds will be awarded in a manner that is equitable and is responsive to the Institute of Medicine's recommendations in *Calling the Shots*.
2. A core funding amount for each grantee, based on essential program operations, population-based program need, population-based performance, and jurisdictional capacity, will be considered when making decisions about award allocations.
3. Specific factors used to determine core funding will include: population size, birth cohort, proportion under-immunized, proportion living in rural areas, proportion living in

poverty, vaccination coverage levels, essential personnel requirements, cost of living increases, and salary and fringe rates.

4. All grantees will be funded at the core funding level adjusted to reflect the amount of funds appropriated by Congress and made available to the Immunization Services Division.
5. In the event that additional funds become available, they may be awarded, within the constraints of available funds, based on the degree to which grant applications meet the awarding criteria as defined in the grant guidance, the degree to which proposed activities have been demonstrated to be effective, and the degree to which progress in meeting established objectives and performance measures is demonstrated.
6. If the amount awarded differs from the amount requested by the grantee, the grantee shall submit a revised project implementation plan and budget based on the approved funding amount.
7. Subject to the availability of funds including appropriations and carryover, each year a grantee should receive at least 95% of its previous year's funding in order to avoid disruption of existing programs.
8. Final decisions concerning funding and allocation are the responsibility of the Immunization Services Division (ISD).

Guidelines for Writing Grant Objectives and Differentiating Between Objectives, Activities, and Evaluation Measures

The purpose of this document is to provide immunization program grantees with guidelines on how to write objectives, activities, and evaluation measures to meet grant requirements and program priorities.

All objectives must be SMART:
Specific (focused)
Measurable
Achievable (results-oriented)
Realistic
Time-phased

SMART objectives should be narrow and precise. You should be able to state an objective in one sentence that specifies what will be accomplished. A common problem is to write an objective that is too vast or complex and not achievable within a given time frame. If so, split it into two or more smaller objectives that will be SMART. If the objective is ongoing from the previous year, baseline data should be included, and the objective should state a specific percent increase or improvement that will be accomplished in the next budget period.

Objective:
SMART statement that tells what major project will be accomplished within a one-year budget period.

The following are two examples of SMART Provider Quality Assurance objectives as part of a perinatal hepatitis B prevention program:

If, for example, your program has never determined HBsAg screening rates, you might develop the following process objective:
Example: By December 31, 2006, HBsAg screening rates will be assessed by reviewing 100 charts in each of the three largest birthing hospitals.

If, however, your program has already conducted a screening assessment and has determined that Hospital X has a screening rate below 90%, you could develop an outcome objective for the next budget year as follows:
Example: By December 31, 2006, the HBsAg screening rate for Hospital X will increase from 83% to at least 90%.
It is acceptable to write objective statements without explicitly stating who will do the work because the activities statements (described next) clarify who will complete each task needed to achieve the objective.

Activities:
Small action steps that, when combined, lead to the achievement of the objective. Activities tell who will do how much of what by when and where and how. Action steps are listed chronologically.

The following are example activities statements that support the sample perinatal process objective above:

1. *Perinatal Hepatitis B Program Coordinator will determine appropriate sampling methodology for hospital delivery records by January 20, 2006.*
2. *Coordinator will determine which hospitals will be selected for a hospital record review based on sampling method identified in activity #1 by January 25, 2006.*
3. *Coordinator will either revise an existing data collection tool or develop a new one by February 1, 2006.*
4. *Coordinator and assistant coordinator will contact the Directors of Labor and Delivery in the selected X, Y, and Z hospitals by February 28, 2006 to plan visit dates to review charts.*
5. *Coordinator and assistant coordinator will visit hospitals to conduct record reviews between April 1 and June 30, 2006.*
6. *Coordinator and assistant coordinator will analyze data by July 31, 2006 to determine HBsAg screening rates for each of the hospitals.*
7. *Coordinator will provide feedback to hospitals X, Y, and Z with follow-up recommendations by November 30, 2006.*

Evaluation Measure:
The evaluation measure tells what will be used and how it will be used to determine whether or not the objective was met. Your statement must explain the process for using a specific instrument to assess the extent to which the objective was achieved. A common error in writing evaluation measures is to turn them into objective statements instead.

The following is an example evaluation measure that assesses achievement of the sample perinatal process objective:
Progress toward achievement of this objective will be determined by using a data collection tool that will indicate the number of charts pulled from each of the three hospitals, compared with the number of charts that indicated HBsAg screening.

Sample objectives from each of the other program components:

Program Management:
Example: By July 1, 2006, 100% of the new contracts with local health departments will be finalized to include measurable performance deliverables that cover priority activities identified by the immunization program.

This is a process objective which is appropriate as an initial short-term objective, but over time, program managers would want to migrate toward more outcome-oriented objectives. For example, in the following year, this program manager, while maintaining the focus on counties with contracts having measurable performance deliverables, would want to develop an objective around the proportion of local health departments that can document the achievement of a specified percentage of their deliverables.

Vaccine Management:
Example: By October 31, 2006, vaccine wastage and unaccounted for doses will decrease from 5% to no more than 3%.

Immunization Registries:
Example: By December 31, 2006, private provider registry participation levels will increase from 50% to 55%.

Service Delivery:
Example: By September 30, 2006, WIC staff in XYZ counties will screen at least 95% of visiting WIC children for up-to-date immunization status and refer all children who are not up-to-date to appropriate provider sites for needed vaccinations.

Consumer Information:
Example: By August 31, 2006, the communications unit will develop and finalize a culturally sensitive pneumococcal immunization brochure targeted to Hispanic residents aged 65+ in zip code X.

Surveillance:
Example: By December 31, 2006, at least 90% of the HBsAg positive tests from all laboratories and clinics will be reported to the surveillance unit within 7 calendar days from the time that the test results are available.

Population Assessment:
Example: By May 31, 2006, the assessment coordinator will identify the top three pockets of need for the 4:3:1:3:3 series using GIS mapping.

Examples of immunization objectives from prior year applications

Below are examples of some objectives that were included in previous year grant applications. The statements below were modified for anonymity, and all dates were changed to 2006 for consistency, but the content remains unchanged. The examples are provided for your review to help you identify areas for improvement, and to help you distinguish between objectives, activities, and evaluation measures.

Critique the Objectives
1) Improve procedures for promoting immunizations for children and adults.

Critique: This is a vague statement of intent to do something regarding promotion of childhood and adult immunization. It does not have any of the 5 SMART elements.

2) Facilitate active and passive surveillance of childhood vaccine-preventable diseases.

Critique: Unspecific, non-measurable words like "promote, work toward, ensure, improve, facilitate" should be avoided. This statement does not have any of the 5 SMART elements. Possible outcome-oriented variations:

By ____, 2006, the weekly response rate of participants in the influenza sentinel site surveillance system will be increased from ___% to at least ___%.

By ____, 2006, field epidemiologists will complete investigations on __% of suspected cases of vaccine-preventable diseases reported to the surveillance system within ___hours/days of receipt by the immunization program.

3) *Pneumococcal coverage rates for residents in long-term care facilities will increase to at least 75%.*

Critique: The T in SMART is missing in this outcome objective and the statement could be more S as well:

By December 31, 2006, pneumococcal polysaccharide vaccine coverage rates for all residents of all (or an identified portion of) nursing homes in XYZ state will increase from ___% to ___%.

This format assumes that baseline data exist and that the program has a way to acquire new data for 2006. If no baseline data are available, then the end of the statement could be phrased "will equal or exceed ___%" instead of "increase from ___% to ___%."

4) *Surveys of the immunization status of children attending day care facilities will be conducted to identify children who are not up-to-date.*

Critique: The A exists but the SMRT do not. Examples of more outcome-oriented versions could include:

By ___, 2006, assessments of immunization coverage in (all/select target population) licensed day care facilities will be completed by (whom).

By ___, 2006, series complete immunization coverage will increase to 90% among licensed day care centers with coverage rates in 2005 of less than 80%.

By ___, 2006, series complete immunization coverage will increase from __% to __% among all children attending licensed day care centers in (specific geographic region).

5) *The immunization program will have a written, finalized strategic plan for implementation of the AFIX program.*

Critique: This process objective lacks T but otherwise is acceptable.

Is it an activity, objective, or evaluation measure?

1) *Distribute new VISs to VFC providers and inform professional medical organizations about the availability of new VISs within 30 days of notification from NIP.*

This statement is an activity. The grantee that submitted this erroneously considered it an objective.

2) *Download all reported hepatitis B cases in females 12–50 years of age from the state registry every month and compare download list with those perinatal hepatitis B cases that are already identified.*

This statement is an evaluation measure.

3) *Compare the number of privacy/confidentiality agreements with the total number of enrolled registry users.*

This statement is an evaluation measure.

4) *By December 31, 2006, at least 90% of all residents in long-term care facilities are immunized for influenza and pneumococcal disease.*

This statement is an objective. The grantee that submitted this erroneously considered it an evaluation measure.

5) *By January 1, 2006 and ongoing, immunization services are available for underserved populations of all age groups, in every county, through public health clinics and private providers as evidenced by low vaccine-preventable disease rates.*

This statement is an attempt at an objective, but it is not SMART. Also, even though the T is provided, all objectives must be too large in scope to be achieved on the first day of the year.

6) *Review the scope of the comprehensive influenza pandemic preparedness plan and the date each review was completed.*

This statement can be an evaluation measure if the term "scope" and the criteria for review are defined.

Role of the Project Officer/ Program Consultant in the Program Operations Branch

The Project Officer in the Program Operations Branch (POB), Immunization Services Division (ISD), National Center for Immunization and Respiratory Diseases (NCIRD) has direct responsibility for providing guidance, technical support and consultation regarding immunization program implementation and grant funding to assigned grantees throughout the United States, its territories and freely associated countries. The Project Officer (also known as the Program Consultant) serves as the primary liaison and first point of contact between the grantee and other branches, offices and staff within ISD. As POB representatives, Project Officers:

- Serve as a recognized authority or consultant for immunization grant programs and promote the overall improvement of health and safety of children and adults through immunization and efforts to reduce and/or eliminate morbidity and mortality from vaccine-preventable diseases
- Serve as an immunization grant project officer with full responsibility for carrying out all required project officer monitoring and management duties
- Foster the design and operation of innovative methods to promote information dissemination and exchange among state/local health agencies and organizations, research sites, and/or among CDC program offices
- Provide public health program support through discussions and analysis of barriers, identifying needs and recommending modifications or improvements to immunization programs
- Have a responsibility to be professional, timely and courteous in all of their interactions and in responding to grantee requests by providing the most accurate information available

More specifically, a Project Officer has the following responsibilities:

Technical Assistance

- Assists immunization grantees in the development of their annual grant applications. This includes, but is not limited to, providing advice and assistance in the development of overall program goals and objectives, task delineation, staffing patterns, scope of services, and program management systems to ensure that national program requirements are addressed as grantees plan and conduct activities within many different state and local programs
- Responds to requests for, collects and disseminates information in a timely manner
- Assists in the development, dissemination and collection of grantee surveys or questionnaires

Financial Consultation and Recommendations

- Reviews grant applications to ensure budgets are reasonable and planned activities are within the scope of program requirements and makes recommendations regarding financial assistance to grantees
- Works closely with the Procurement and Grants Office (PGO) regarding budgetary matters and makes recommendations involving funding restrictions, redirection requests, supplemental funding, and vaccine issues
- Reviews and approves population estimates and vaccine needs for assigned grantees
- Reviews and recommends operations grant awards
- Reviews and recommends VFC budgets
- Recommends funding for special projects
- Recommends funding for registry activities in collaboration with the Immunization Information Systems Support Branch
- Transmits vaccine balances to grantees from NIPVAC upon request

Monitoring

- Monitors grantee activities through site visits to substantiate that progress is being made toward achieving program goals and objectives, ensures that grant funds are appropriately used, and provides appropriate post-award technical assistance
    - Site visits (317, VFC, AFIX and perinatal hepatitis B prevention activities) should be conducted annually using the site visit tool developed by the Program Operations Branch
    - To the extent possible, site visits should be conducted between January and August so that project officers have current grantee information when reviewing grant applications
    - Project officers should take advantage of opportunities to meet with program managers for their assigned grantees at the National Immunization Conference and the Program Managers' Meeting
    - Follow-up visits within the same year may be appropriate for grantees for which specific corrective recommendations have been made or to provide additional technical assistance
    - Reports of all site visits should include responses to all questions in the site visit questionnaire and be completed and sent to the grantee within one month of completion of the visit
    - De-briefings are to be scheduled with the Branch Chief and Deputy no more than five business days following completion of the visit
- Evaluates programmatic performance, progress, and any requested changes in scope or objectives from the approved application using information in progress and financial reports, site visits, correspondence, and other sources. Identifies potential or existing problems, whether programmatic or business management, and informs appropriate National Center staff and PGO of these findings
- Analyzes data from grantees and follows up on any discrepancies
- Monitors grantee vaccine purchases and analyzes purchases with respect to the grantee's vaccine spending plan
- Assists in closing out completed projects to include review and programmatic evaluation of the final grantee progress and financial reports and other required documentation

Immunization Program Support

- Assists with the development of POB internal policies and procedures
- Participates in internal special projects/workgroups as needed
- Drafts appropriate responses to immunization-related inquiries received from Congress, state legislators, private physicians, hospitals, other federal, state and local agencies and other public and private organizations as necessary
- Assists with the selection of field-assigned Public Health Advisors
- Assists with performance evaluations for field-assigned Public Health Advisors
- Makes recommendations for field-assigned Public Health Advisor incentive awards

Working Relationships

- Develops and maintains close working relationships with appropriate staff in state and local public health agencies as well as other groups and individuals within jurisdictional assignments concerned with immunization programs and issues
- Serves as resource to other divisions within CDC, internal staff, field-assigned Public Health Advisors and other agencies
- Works collaboratively with consultants from the Immunization Information Systems Support Branch on issues related to funding requests and site visits

Performance Expectations

- Project Officers have the responsibility to exercise professional judgment and ensure prudent stewardship of CDC funds in accordance with the highest standards of professional and ethical conduct.
- Project Officers must consider the significance and impact of their actions not only on established program goals and objectives but also on CDC as a whole and its use and management of resources.
- Project Officers must be sufficiently knowledgeable of issues and needs that transcend the programmatic aspects of the individual project to coordinate with affected staff in ISD, other National Centers or PGO, when appropriate.
- Project Officers must carry out in a professional, fair, objective, timely, and consistent manner all functions for which they are responsible, whether in a primary capacity or in support of other CDC staff including other project officers for whom they serve as back-up support.
- Project Officers must respond promptly (usually within 24 hours) to voice mail and e-mail messages and to manage such messages in a manner that enables them to be knowledgeable of message content and to provide appropriate follow-up as needed

CDC Core Values: Accountability, Respect, Integrity

CDC/NCIRD Expectations and Responsibilities for Field Assignees and Host Agencies

Introduction

The role of a Public Health Advisor or Commissioned Corps Officer in a field assignment for the National Center for Immunization and Respiratory Diseases (NCIRD) is to represent NCIRD and serve the host agency based on the Core Values of the Centers for Disease Control and Prevention (CDC). The Core Values are as follows:

> **Accountability** - As diligent stewards of public trust and public funds, we act decisively and compassionately in service to the people's health. We ensure that our research and our services are based on sound science and meet real public needs to achieve our public health goals.
>
> **Respect** - We respect and understand our interdependence with all people both inside the agency and throughout the world treating them and their contributions with dignity and valuing individual and cultural diversity. We are committed to achieving a diverse workforce at all levels of the organization.
>
> **Integrity** - We are honest and ethical in all we do. We will do what we say. We prize scientific integrity and professional excellence.

Background

NCIRD provides assistance to state and local health department grantees by detailing NCIRD staff to state and local health department immunization programs. Field Staff are expected to assist grantees in achieving immunization program goals that are aligned with CDC's mission to control and prevent vaccine-preventable diseases. Because the state or local health department's satisfaction with field assignees is important, field staff is usually appointed to an immunization program that, in the opinion of the Program Operations Branch (POB) management, will ensure a strong partnership and a high likelihood of success. To facilitate a continued positive relationship between state/local immunization programs and CDC/NCIRD, the host immunization program will have input into the assignment of field staff.

Because all field staff are federal employees, they cannot lobby federal or state legislatures or advocate for bills or legislative actions. With that exception, the roles and positions in which field staff can serve during a detail to a state or local immunization program are not restricted and will generally be determined by the state or local program to which they are assigned.

Expectations of Field-Assigned Staff

The following are NCIRD's expectations of field assignees:

- Represent CDC and the host agency in a professional manner at all times.
- Maintain a professional appearance at all times.
- Assist host agencies in understanding CDC policies, requirements, and program components.
- Assist CDC in understanding the needs of state and local immunization programs.
- Assist others beyond the host agency to understand the role that CDC plays in public health.
- Promote and enhance capacity building through consultation and technical advice.
- Communicate clearly, thoughtfully, and considerately, both orally and in writing, at all times.
- Maintain regular contact with the project officer for the host program.
- Communicate problems to the POB deputy branch chief or the branch chief.
- Take pride in the organizations being served (CDC and the host agency) and in the role of a Public Health Advisor or Commissioned Corps Officer.
- Whenever possible, field assignees should
    - Act generously,
    - Offer compassion,
    - Seek to understand, and
    - Forgive when needed.

Field Assignee Responsibilities

Field assignees are, first and foremost, employees of CDC and not employees of the state/local immunization program. Field staff are expected to assist CDC and the state/local immunization program in carrying out disease prevention, health promotion and protection, and other public health activities; providing assistance to host agencies to develop, implement, and evaluate public health programs; and promoting and enhancing capacity-building through consultation, demonstration, and technical expertise. CDC recognizes that field assignees must be sensitive to the state/local immunization program's policies and needs, and NCIRD recognizes the sometimes difficult position and competing roles in which field assignees may be placed. From time to time, field assignees may make recommendations to host agencies that are counter to the host agency's standard operating procedures. NCIRD encourages field assignees to discuss such recommendations openly and honestly with both the host agency program management and the Program Operations Branch project officer.

Field Assignees are responsible for identifying themselves as CDC employees despite the role that the field assignee fills in the state/local program. Some examples of how a CDC field assignee may represent him/herself are as follows:

Jane Doe, CDC Senior Public Health Advisor, Deputy Program Manager, Immunization Program, Los Angeles County Department of Health;
John Jay, CDC Public Health Advisor, VFC Coordinator, Immunization Branch, North Carolina Department of Health and Human Services;
Susan B. Anthony, MPH, Nurse Officer, USPHS, Immunization Program, City of New York, Department of Health & Mental Hygiene.

Field Assignee Evaluations

NCIRD/ISD/POB will provide broad guidance, technical consultation, and official supervision to field assignees. Each assignee's performance will be formally assessed in accordance with established CDC performance management systems for civil service and Commissioned Corps employees. In completing an assignee's evaluations (both at mid-year and year-end) CDC will encourage, solicit, and use input from appropriate state/local immunization program staff regarding the assignee's performance.

Publications and Presentations

Field Assignees are encouraged to publish and give presentations at scientific meetings. However, any publication, presentation, or abstract that includes the name of a CDC assignee must be submitted for and receive CDC clearance prior to submission for publication or presentation. The publication must include the assignee's CDC affiliation as well as local affiliation. Standard guidelines for authorship should be followed when determining whether a CDC assignee's name should be included as an author on a publication (General Administration No. CDC-69).

Leave and Hours of Duty

Civil Service field assignees are required to work 80-hours during the two-week pay period. The state/local immunization program will determine hours of duty. Commissioned Corps field assignees are required to work a 40-hour week and must be available for duty 24 hours per day, 7 days a week. The state/local immunization program will determine regular hours of duty.

On Federal Holidays that are not observed by the host agency, field assignees that are not required to work by the host agency will be excused from duty without charge to accrued leave balances. If a field assignee is required to work on a Federal holiday, premium pay will be paid under Federal regulations for work on a holiday. Assignees will be excused without charge to accrued leave balances on state and local holidays that are not also Federal holidays. The assignee's federal supervisor must give prior written approval for the absence.

Assignees will be entitled to use annual and sick leave in accordance with Federal laws, regulations, and procedures. Earning and using overtime or credit time will be subject to the local rules and procedures of the host agency.

The on-site supervisor, whether another Federal assignee or host agency staff person, should review any leave request. The on-site supervisor may choose to initial the assignee's leave slips to indicate approval of the leave request. Final written approval for leave (signature on leave slips) is the responsibility of the assignee's Federal supervisor.

Training

Field assignees are expected to attend CDC programmatic and career development training, meetings, seminars and conferences, including national seminars and regional staff conferences. Assignees may attend optional training and professional development activities after first obtaining the consent of the host agency and the federal supervisor.

Reassignment Requirement

Changes in field staff assignments are frequently desirable and sometimes necessary, and field assignees must be available for relocation as a normal condition of employment. NCIRD expects that field assignees recognize that program needs, fiscal conditions, employee development needs, or circumstances beyond administrative control may occasionally necessitate reassignment to different positions and different locations. If a reassignment is necessary, the assignee can make personal preferences concerning desired location known, with the understanding that POB management reserves the right to make assignments and reassignment decisions based on the staffing needs of NCIRD.

Field assignees should expect to serve in a number of assignments in different locations throughout their employment with CDC. Each assignment provides opportunities for growth, new experiences, and expanded knowledge about immunization programs and about ways those programs can be served. As such, field assignees are encouraged to apply for openings as they become available. Openings for field staff positions that result from assignment changes or newly created positions will normally be announced competitively so that interested field staff have an opportunity for a promotion or lateral move. In exceptional instances, competition may not be possible, advisable or warranted, and management may make assignments without competition.

Host Agency Activities and Interaction with ISD and POB

Requests for assignment of a field assignee should be sent by letter from the host agency to the POB Chief. Requests will be considered based on availability of full-time equivalents (FTEs).

The POB Chief will discuss any federal assignee re-assignments with the host agency as soon as a re-assignment is being considered.

The POB project officer will provide the host agency with updates on the recruitment efforts to fill vacant field staff positions.

Host agency supervisors will work closely with assignees to resolve any routine questions or issues that arise regarding the assignment or the assignee's performance.

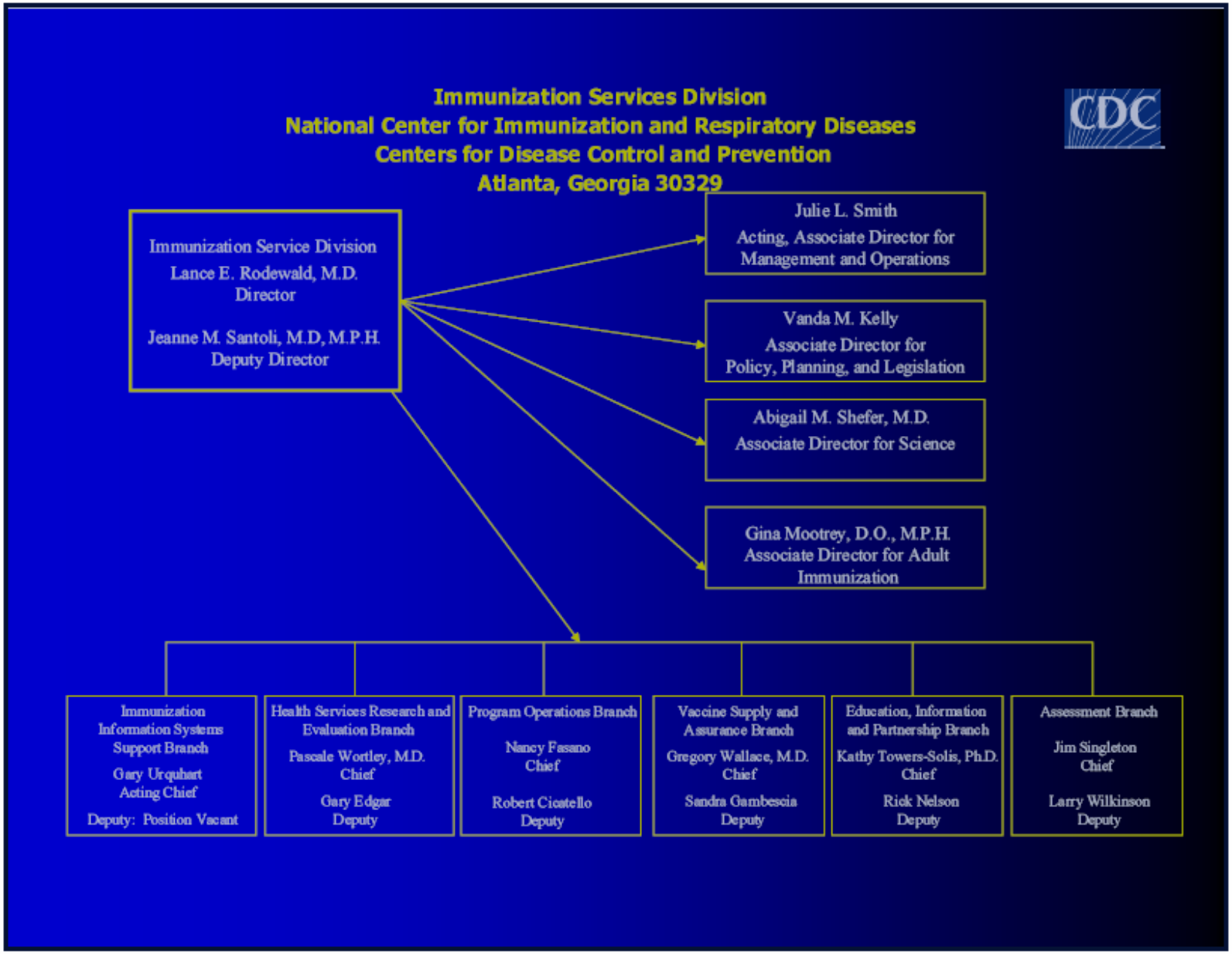
Host agencies will be asked to provide input regarding the field assignee's performance.

The host agency will promptly advise the POB Branch Chief or Deputy Branch Chief of any performance or behavioral concerns about an assignee. In these cases, host agency and POB staff will work together to attempt to resolve such concerns with the assignee, either informally or formally, depending upon the nature and degree of the concern. Other CDC resources may be called upon by the immediate POB supervisor to help resolve the issues.

If a host agency determines that a field assignee is no longer an asset to the program, the host agency should send a letter to the POB Chief requesting removal of the federal field assignee.

The host agency may make available to assignee(s) any training opportunities sponsored by the State or locality.

Reference documents: *Agreement to Detail, 12/2004; Acknowledgment of Understanding of Reassignment Requirement*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Sandra Gambescia
Deputy
Education, Information and Partnership Branch
Kathy Towers-Solis, Ph.D.
Chief
Rick Nelson
Deputy
Assessment Branch
Jim Singleton
Chief
Larry Wilkinson
Deputy

Immunization Program "Seasons"

Winter

- Influenza season
- Pre-booking of influenza vaccine for next influenza season

Spring

- National Immunization Conference (NIC)
- Annual Report for previous calendar year – due by end of March
- Population Estimates Survey for next calendar year – due in March or April
- Financial Status Report (FSR) for previous calendar year – due March 31
- School assessment data for current school year – due April 30
- CDC contract influenza vaccine orders for next influenza season

Summer

- Initial Vaccine Ordering Forecast Application (VOFA) submission for next fiscal year (VOFA software will be used until implementation of centralized ordering system)
- Six-month progress report for current calendar year and continuing grant application and budget for next calendar year – due in August
- Back-to-school vaccination campaigns

Fall

- National Immunization Survey (NIS) coverage rates published in Morbidity and Mortality Week Report (MMWR) for previous calendar year
- Beginning of influenza vaccination season
- Program Managers' Meeting (sometimes occurs at other times of the year)

Year-round

- Grant awards for program operations (distributed in several rounds; Round 1 in January)
- Vaccine target postings to grantees' NIPVAC accounts (posted quarterly along federal fiscal year calendar)
- Vaccine order monitoring
- Spend plan updates
- Time-sensitive requests and general information via Immunization Grantee Mailbox
- Association of Immunization Managers (AIM) conference calls
- Returns of wasted vaccine for refund of federal excise tax
- CDC technical assistance site visits to grantee immunization programs

How to Interpret the Subject Heading of NCIRD Immunization Grantee Mailbox Email Messages

Email messages are sent to state and local grantees through the National Center for Immunization and Respiratory Diseases (NCIRD) Immunization Grantee Mailbox and distributed from the Program Operations Branch (POB). A coding system has been developed to ease identification of message content and response requirements. Each message is prioritized according to the relevance to program operations and need for response. The numbering system allows message recipients to refer to messages and provides a system for archiving. Three levels (1, 2 and 3) are used to code messages according to program content, response required by recipient, and urgency of required response. The coding system is as follows:

Level	Program Content	Response Required	Response Time
1	Programmatic, funding or policy issues containing controversial information	Yes, to POB	$\leq$ 5 working days
2	Programmatic, funding or policy issues containing controversial information	Yes or No, to POB	None specified
3	General information, grantee requests to share or collect information, trade vaccine, etc.	No (May specify response to point of contact outside POB)	None specified (May be listed by point of contact outside POB)

The subject heading includes the message title, response date (if needed), priority code (Level 1, 2, or 3). Example: Draft Grant Guidance-Response Date-Level 2

Key Immunization Websites

Note: Links to non-Federal organizations are provided solely as a service to our users. These links do not constitute an endorsement of these organizations or their programs by CDC or the Federal Government, and none should be inferred. The CDC is not responsible for the content of the individual organization web pages found at these links.

"One-stop-shopping" site for immunization program managers
http://www.cdc.gov/nip/home-partners.htm#progmgrs

Program Managers contact list
http://www2a.cdc.gov/nip/progmgr/fieldstaff.asp?rpt=pm

VFC Coordinators contact list
http://www.cdc.gov/nip/vfc/contacts_vfc_coord.htm

Perinatal Hepatitis B coordinators contact list
http://www.cdc.gov/nip/diseases/hepb/hepb_contacts.htm

CDC immunizations homepage
http://www.cdc.gov/nip

Vaccine schedules
http://www.cdc.gov/nip/recs/child-schedule.htm
http://www.cdc.gov/nip/recs/adult-schedule.htm

Vaccines for Children (VFC) homepage
http://www.cdc.gov/nip/vfc

VFC Program Operations Guide
http://www.cdc.gov/nip/home-partners.htm#progmgrs

VFC resolutions
http://www.cdc.gov/nip/vfc/acip_vfc_resolutions.htm

Advisory Committee on Immunization Practices (ACIP) recommendations
http://www.cdc.gov/nip/publications/acip-list.htm

CDC vaccine price list
http://www.cdc.gov/nip/vfc/cdc_vac_price_list.htm

VFC questions and answers document
http://www.cdc.gov/nip/vfc/st_immz_proj/faqs_main.htm

Vaccine Management Business Improvement Project (VMBIP)
http://www.cdc.gov/nip/vmbip/default.htm

Vaccine storage and handling toolkit
http://www2a.cdc.gov/nip/isd/shtoolkit/splash.html

Users' guide for vaccine contracts
http://www.cdc.gov/nip/policies/guide-vac-contracts-508.pdf

Vaccine excise tax credits
http://www.cdc.gov/nip/vfc/st_immz_proj/forms/excise_tax_credit.htm

Assessment, Feedback, Incentive, and eXchange (AFIX) homepage
http://www.cdc.gov/nip/afix/default.htm

CoCASA homepage
http://www.cdc.gov/nip/cocasa/

Procurement and Grants Office (PGO) guidance on preparing a budget request
http://www.cdc.gov/od/pgo/funding/budgetguide.htm

Website for downloading and submitting immunization grant application and budget request:
http://www.grants.gov

Manual for the Surveillance of Vaccine-Preventable Diseases
http://www.cdc.gov/nip/publications/surv-manual/default.htm

National Immunization Survey (NIS) Tables
http://www.cdc.gov/nip/coverage/default.htm#NIS

Influenza
http://www.cdc.gov/flu

Human papillomavirus vaccine
http://www.cdc.gov/std/hpv

Division of Viral Hepatitis
http://www.cdc.gov/ncidod/diseases/hepatitis/index.htm

Framework for Program Evaluation in Public Health
ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4811.pdf

Healthy People 2010 Mid-Year Review immunization objectives
http://www.healthypeople.gov/data/midcourse/html/focusareas/FA14TOC.htm

Community Guide: Vaccine-preventable disease summary page
http://www.thecommunityguide.org/vaccine/vpd.pdf

Core Competencies for Public Health Professionals
http://www.phf.org/competencies.htm#view

The Community Tool Box
http://ctb.ku.edu/

CDC immunization website for healthcare professionals
http://www.cdc.gov/nip/home-hcp.htm

National Network for Immunization Information
http://www.immunizationinfo.org

Association of State and Territorial Health Officials (ASTHO) website's immunization resources
http://www.astho.org/templates/display_pub.php?pub_id=2344&admin=1

Vaccine Information Statements
http://www.cdc.gov/nip/publications/VIS/default.htm

Red Book Online
http://aapredbook.aappublications.org

Health Insurance Portability and Accountability Act (HIPAA)
http://www.hipaa.org

Behavioral Risk Factor Surveillance System (BRFSS)
http://www.cdc.gov/brfss/index.htm

Immunization Action Coalition
http://www.immunize.org

How to subscribe to Immunization Action Coalition (IAC) Express
http://www.immunize.org/subscribe/

How to subscribe to Morbidity and Mortality Weekly Report (MMWR)
http://www.cdc.gov/mmwr/mmwrsubscribe.html

Centers for Medicare and Medicaid Services (CMS) homepage
http://www.cms.hhs.gov/default.asp