

2008 VFC Provider Site Visit Questionnaire

All Grantees (includes all vaccine purchase policies)

(This form is to be completed by the public health official who is conducting the site visit review. Section I of this questionnaire is considered the CDC minimum standard for conducting routine VFC provider site visits. Immunization Projects should incorporate these standard questions into their existing VFC site visit protocols and VFC provider on-site questionnaires. Section II is based on the Standards of Pediatric Care. Completion of Section II is optional.)

Date: _____ Reviewer's Name: _____
Provider Site Name: _____
Provider address: _____
Contact person: _____ Telephone & FAX Numbers: _____
Email: _____ VFC Number: _____
County: _____ Region: _____

Note: ! An incorrect or inappropriate response to any question marked with this icon automatically requires that a corrective action be recommended.

Type of Practice:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Public hospital based clinic | <input type="checkbox"/> Private Practice | <input type="checkbox"/> Public Health Dept Clinic | <input type="checkbox"/> Military Health Care Facility |
| <input type="checkbox"/> Private hospital based clinic | <input type="checkbox"/> FQHC/RHC | <input type="checkbox"/> Private Preschool/daycare/etc | <input type="checkbox"/> Public Preschool/daycare/etc |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> WIC | <input type="checkbox"/> Indian Health Center | <input type="checkbox"/> Corrections Facility |
| <input type="checkbox"/> HIV/STD Clinic | | | |

How many physicians are practicing at this site? _____

The following question should be answered prior to the site visit, so the findings can be discussed during the site visit.

! Are vaccine orders consistent with most current provider profile? _____ If no, follow up actions must be documented in 32b.

SECTION I. VFC COMPLIANCE

Questions 1-7 should be answered by the provider.

- !** What is the vaccine administration fee charged to non-Medicaid VFC eligible patients (uninsured, American Indian/Alaska Native, under-insured if vaccinated at FQHC/RHC)? _____
- Under what circumstances is a child referred to another facility for immunization services?
 - Not applicable children are never referred
 - Child is underinsured
 - Vaccine is unavailable
 - Parent is unable to pay administration fee
 - Parent is unable to pay office visit fee
 - Other (specify) _____
- Which of the following vaccines are **NOT** routinely administered in this clinic/practice?

<input type="checkbox"/> DTaP	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pneumococcal Polysaccharide*
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Meningococcal Conjugate	<input type="checkbox"/> Polio
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> MMR	<input type="checkbox"/> Rotavirus
<input type="checkbox"/> HIB	<input type="checkbox"/> MMR-V	<input type="checkbox"/> Td
<input type="checkbox"/> Human Papillomavirus	<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Tdap
		<input type="checkbox"/> Varicella

Other: _____

* to high-risk patients

4. **!** When does this clinic/practice provide patients with copies of the Vaccine Information Statements (VIS) to keep?
- Every time the patient receives a vaccination
- When the child receives the first dose of vaccine within a particular series (e.g. 1st dose of DTaP)
- Do not provide
- Other (specify) _____
5. In order to complete the annual provider profile, how does this clinic/practice determine the number of VFC-eligible patients in this clinic/practice?
- Use doses administered data
- Use benchmarking data
- Use Medicaid & billing data
- Immunization Information System (Registry)
- Other (please describe): _____
6. **!** When does the clinic/practice screen patients for VFC eligibility?
- First immunization visit to the office
- Every immunization visit
- Do not screen for VFC eligibility
- Not applicable, clinic/practice serves 100% VFC eligible children and has appropriate Comprehensive Certification form with up to date signature on file
- Other (specify) _____
7. **!** Does this clinic/practice always notify the Immunization Program when publicly purchased vaccine has been involved in a cold chain failure, has expired or been wasted?
- Yes No
8. **!** When does this clinic/practice prepare vaccine for administration to patient?
- Immediately before administration Other: specify
process: _____

Questions (9-28) should be answered based on a physical review of provider's written plan, VISs, refrigerator(s) and freezer(s).

9. **!** Does the clinic/practice have a **written plan** for vaccine management including the following (review for accurate content):

	Yes	No
Designation of primary vaccine coordinator and at least one back-up staff	<input type="checkbox"/>	<input type="checkbox"/>
Proper vaccine storage and handling	<input type="checkbox"/>	<input type="checkbox"/>
Vaccine shipping (includes receiving, & transport)	<input type="checkbox"/>	<input type="checkbox"/>
Procedures for vaccine relocation in the event of a power failure, mechanical difficulty or emergency situation (emergency plan)	<input type="checkbox"/>	<input type="checkbox"/>
Has the emergency plan been reviewed or updated annually or since change in responsible staff?	<input type="checkbox"/>	<input type="checkbox"/>
Vaccine ordering	<input type="checkbox"/>	<input type="checkbox"/>
Inventory control (e.g. stock rotation)	<input type="checkbox"/>	<input type="checkbox"/>
Vaccine wastage	<input type="checkbox"/>	<input type="checkbox"/>

10. **!** Please identify the publication date for each of the VIS currently being used in this clinic/practice and then check the appropriate status for each VIS.

VACCINE*	VIS VERSION BEING USED IN THIS CLINIC/PRACTICE			
	Current	Outdated	None Used	Does Not Administer
DTaP (5/17/07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio (1/1/00)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MMR (1/15/03)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B (7/18/07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicella (01/10/07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A (3/21/06)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hib (12/16/98)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal Conjugate (9/30/02)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inactivated Influenza (07/16/07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Live Intranasal Influenza (07/16/07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Td (6/10/94)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult Pneumococcal Polysaccharide (PPV23) (7/29/97)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningococcal (08/16/07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tdap (07/12/06)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus (4/12/06)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Human Papillomavirus (2/02/07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VIS Website: <http://www.cdc.gov/vaccines/pubs/vis/default.htm> Current VIS publication dates as of 09/26/2007

11. **!** What type of storage units does this clinic/practice use to store varicella-containing vaccines and all other vaccines? (check all that apply)

Varicella Containing Vaccines	All Other Vaccines
<input type="checkbox"/> Stand alone freezer	<input type="checkbox"/> Stand alone freezer
<input type="checkbox"/> Stand alone refrigerator	<input type="checkbox"/> Stand alone refrigerator
<input type="checkbox"/> Dormitory style refrigerator/freezer	<input type="checkbox"/> Dormitory style refrigerator/freezer
<input type="checkbox"/> Combined refrigerator/freezer with separate external refrigerator and freezer doors (e.g. household style appliance).	<input type="checkbox"/> Combined refrigerator/freezer with separate external refrigerator and freezer doors (e.g. household style appliance).
<input type="checkbox"/> Combined refrigerator/freezer with single door	<input type="checkbox"/> Combined refrigerator/freezer with single door
<input type="checkbox"/> Does not administer vaccines requiring freezer storage	

12. **!** Are working thermometers placed in a central area of each refrigerator and freezer?

	Refrigerator					Freezer				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Yes										
Have thermometer but not placed properly										
No thermometer										

13. (A) What type of thermometer is used by the clinic/practice (check all that apply)?

	Refrigerator					Freezer				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Standard Fluid Filled										
Continuous Recording										
Min-Max										
Dial										
Digital										
Other (specify)										

13. (B) **!** For each type of thermometer used by the clinic/practice, indicate if the thermometer is certified (check all that apply).

	Refrigerator					Freezer				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Standard Fluid Filled	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__
	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__
Continuous Recording	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__
	No__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__
Min-Max	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__
	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__
Dial	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__
	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__
Digital	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__
	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__
Other (specify)	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__	YES__
	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__	NO__

14. ! For each refrigerator and freezer indicate how often temperatures are recorded (check all that apply).

	Refrigerator					Freezer				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Once a day										
Less than once a day										
Twice a day										
More than twice a day										

15. Record the highest and lowest temperatures logged in the last 3 months. If no log is available for the past three months, record the highest and lowest temperatures from available logs. Please indicate if recordings are Celsius (°C) or Fahrenheit (°F).

Recommended temperature ranges: Refrigerator: (2-8°C / 35-46°F) Freezer :(-15°C / 5°F or lower)

	Refrigerator (2-8°C / 35-46°F)					Freezer (-15°C / 5°F or lower)				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Lowest	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C
	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F
Highest	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C	____ °C
	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F	____ °F
Log available for last 3 months?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

If any of the lowest and/or highest temperatures are out of the recommended range then **GO TO** question 16. If the temperatures are within the recommended guidelines, **SKIP** to question 19.

16. ! During past 3 months, how many times were the temperatures outside the recommended range?

	Refrigerator (2-8°C / 35-46°F)					Freezer (-15°C / 5°F or lower)				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Below Guidelines										
Above Guidelines										

17. **!** When the temperatures were outside the recommended range, what action did the clinic/practice take?

(✓ *all that apply*)

- Adjusted thermostat in refrigerator/freezer
- Measured temperature with different thermometer to check accuracy of original reading
- Moved vaccine to a different refrigerator/freezer maintained at proper temperature
- Called the vaccine manufacturer to determine the potency of the vaccine
- Called the local/state immunization program for assistance
- Did not do anything

18. **!** Does the clinic/practice have written documentation of the action taken when the temperatures were outside the recommended range?

- Yes No

19. Record the current temperatures

	Refrigerator (2-8°C / 35-46°F)					Freezer (-15°C / 5°F or lower)				
	#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
Practice Thermometer	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F
Reviewer's Thermometer	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F	____°C ____°F

20. **!** Are current temperatures within the guidelines according to the reviewer's thermometer?
(Refrigerator: 2-8°C / 35-46°F, Freezer: -15°C / 5°F or lower)

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

21. **!** Is food stored with vaccines in the refrigerator or freezer?

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

22. **!** Are vaccines stored in the doors of the refrigerator or freezer?

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

23. **!** Is vaccine stored in the middle of the storage unit and stacked with air space between the stacks and side/back of the unit to allow cold air to circulate around the vaccine?

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

24. **!** Is there a "DO NOT DISCONNECT" sign on the refrigerator/freezer electrical outlet?

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

25. **!** Is there a "DO NOT DISCONNECT" sign on the circuit breaker?

Yes No Don't Know

26. **!** Are short-dated vaccines stored in front and used first, rotating stock effectively?

Refrigerator					Freezer				
#1.	#2.	#3.	#4.	#5.	#1.	#2.	#3.	#4.	#5.
YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

27. **!** Can the clinic/practice physically differentiate privately purchased vaccine from publicly purchased vaccine? To answer yes, clinic/practice must be able to demonstrate how this is done.
- Yes, clinic/practice can physically differentiate public vaccine from private vaccine
 - No, clinic/practice cannot physically differentiate public vaccine from private vaccine
 - Not applicable, clinic/practice is located in a universal state, has no private stock
 - Not applicable, clinic/practice serves 100% VFC eligible children, has no private stock
 - Other
28. **!** Upon checking the clinic/ practice's vaccine supply, did the reviewer find any unreported wasted or expired vaccine?
- Yes
 - No

Questions 29 - 31 should be answered based on a review of patient charts, electronic medical records, or patient log (electronic or manual) or registry which records VFC eligibility status.

29. What is the VFC eligibility screening coverage in this clinic/practice?
- VFC screening coverage of 100%
 - VFC screening coverage of at least 95%
 - VFC screening coverage of at least 90%
 - VFC screening coverage below 90%
30. What methodology was used to determine VFC eligibility screening coverage during this site visit?
- CDC-supplied Lot Quality Assurance (LQA) protocol
 - CoCASA
 - Grantee-developed methodology
 - Other: _____
31. Do all immunization records contain the following documentation required by statute 42 US Code 300aa-25? (*✓ one box per item*)

Required Documentation	Yes	No
Name of vaccine given	<input type="checkbox"/>	<input type="checkbox"/>
Date vaccine was given	<input type="checkbox"/>	<input type="checkbox"/>
Date VIS was given	<input type="checkbox"/>	<input type="checkbox"/>
Name of vaccine manufacturer	<input type="checkbox"/>	<input type="checkbox"/>
Lot number	<input type="checkbox"/>	<input type="checkbox"/>
Name and title of person who gave the vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Address of clinic where vaccine was given	<input type="checkbox"/>	<input type="checkbox"/>
Publication date of VIS	<input type="checkbox"/>	<input type="checkbox"/>

Questions 32-33 should be answered based on results of the VFC site visit.

32a. Are corrective actions recommended for this VFC enrolled site?

- Yes No (*STOP here*)

32b. Please indicate which corrective actions regarding vaccine practices were recommended for this VFC-enrolled site.

Please refer to high-risk question (**!**) key to determine what questions were answered inappropriately. All questions answered with inappropriate responses require corrective actions. The reviewer may also enter corrective actions for non high-risk questions. Enter all recommended corrective actions in the appropriate space provided below. (*✓ all that apply and specify problem*)

Administrative practices

Vaccine storage and handling

Other:

33. Please indicate your plan for following-up with the site to ensure recommendations were implemented.

- Provided technical assistance at time of site visit, no further follow-up is needed
 Telephone call
 Site visit
 F/U letter
 Suspended delivery of VFC vaccine until storage/handling problems resolved
 Other: _____

SECTION II. Standards for Pediatric & Adolescent Immunization Practices (Optional)

Vaccine Administrative Policy

1. How does the clinic/practice offer immunization services to patients? (Check all that apply)

<input type="checkbox"/> During well-child visits	<input type="checkbox"/> Immunization-only appointments
<input type="checkbox"/> Walk-in immunizations	<input type="checkbox"/> Dedicated days/times for immunizations
<input type="checkbox"/> Off-site immunizations	<input type="checkbox"/> Other (specify) _____

2. Is an office visit fee charged in addition to any vaccine administration fees?

Yes No

 If yes, what is the amount of the office visit fee? _____

3. Is a physical exam required before immunizations are given?

Yes No

Assessment of Vaccination Delivery

4. Does the clinic/practice routinely immunize when the child has:

	Yes	No	Situational
A cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low grade fever (e.g. 100.4°F [38°C] or lower)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recently been exposed to infectious illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mild diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convalescing from an acute illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Effective Communication about Vaccine Benefits and Risks

5. Does the clinic/practice staff know how to obtain foreign-language Vaccine Information Statements (VIS) for patients/families whose first language is not English?

Yes No

Proper Storage and Administration of Vaccines and Documentation of Vaccinations

6. Does the clinic/practice have a current copy of the following documents?

	Yes	No
<i>Recommended Childhood Immunization Schedule</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Revised Standards for Child and Adolescent Immunization Practices</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Contraindications for Childhood Immunization</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Vaccine Management: Recommendations for Handling & Storage of Selected Biologicals</i>	<input type="checkbox"/>	<input type="checkbox"/>

7. Are up-to-date, written vaccination protocols accessible at all locations where vaccines are administered? (If Yes, ask to see a copy)

Yes No

8. Who gives immunization injections? (Check all that apply)

MD NP PA RN LVN LPN MA

9. How do persons who administer vaccines and staff who manage or support vaccine administration receive ongoing education regarding immunization? (Check all that apply.)
- No ongoing training
 - In-house training by health dept./professional organization at least once a year
 - In-house training by staff at least once a year
 - Off-site conferences or workshops at least once a year
 - Distribution of written materials
 - Web-based training
 - Other (specify) _____
10. Does the practice document ongoing education regarding immunization for persons who administer vaccines and staff who manage or support vaccine administration?
- Yes No
11. Does the clinic/practice simultaneously administer all vaccines for which the child is eligible?
- Yes No
12. What size needles are generally used for intramuscular injections?
- 5/8 " (inch)
 - 1 " (inch)
 - 7/8" (inch)
 - Depends on age
 - Other (Specify): _____
13. Does the clinic/practice pre-fill syringes?
- Yes No
14. Does the clinic/practice have VAERS forms and know how to report to VAERS?
- Yes No
15. Does the clinic/practice require staff who have contact with patients to be immunized or show proof of immunity against the following vaccine-preventable diseases? (Check all that apply)
- None required
 - Measles/Mumps/Rubella
 - Hepatitis B
 - Hepatitis A
 - Varicella
 - Influenza
 - Td
 - Other (specify) _____

Implementation of Strategies to Improve Vaccination Coverage

16. How does the clinic/practice remind patients of their next appointment? (Check all that apply)
- Mail
 - Written appointment slip given at last visit
 - Telephone
 - Does not remind patients of next appointment
 - Verbally at last visit
 - Other (specify) _____
17. How does the clinic/practice contact patients who miss their appointments? (Check all that apply)
- Mail
 - Telephone
 - Does not contact patients who miss their appointments
 - Other (specify) _____

18. How does the clinic/practice identify patients if no appointment is made and immunizations are due/overdue? (Check all that apply)

- Cannot identify patients due/overdue for immunizations
- Immunization registry
- Computer (office-based, not connected to a registry)
- Paper-based "tickler" system
- Other (specify) _____

19. How frequently does the clinic/practice generate reminder/recall notices (or phone calls) to patients who are due/overdue for a vaccination? (Check all that apply)

- Quarterly
- Monthly
- No regular schedule
- Weekly
- Clinic/practice does not distribute recall notices to patients

20. Is an office- or clinic-based patient record review and vaccination coverage assessment performed at least once a year (check all that apply)?

- No
- Yes
- Yes, by practice staff
- Yes, by immunization/VFC program
- Yes, by other external reviewer

When was the most recent office- or clinic-based patient record review and vaccination coverage assessment?

Date: _____

21. Does the practice/clinic participate in an immunization registry?

- Yes
- No

22. What community-based approaches does the clinic/practice use to increase immunization coverage? (Check all that apply)

- No community-based approaches used
- Participates in health fairs
- Provides off-site immunization services
- Conducts community-based outreach/education
- Partners schools/school nurses
- Other (specify) _____