



**Illinois Hospitals Prepare
for
COVID-19 Vaccine Distribution
November 30, 2020**

*This webinar is a collaboration between the Illinois Department of Public Health Office of Health Protection
and the Illinois Health and Hospital Association*

Agenda

- Overview/Purpose and Introduction of Speakers (Tim Nuding)
- Goal and Scope of IL Mass Vaccination Plan (Brandy Lane)
- Priority Populations (Brandy Lane)
- Overview of I-CARE (April Caulk)
- COVID-19 Vaccine Provider Enrollment (Heather Shryock)
- Summary (April Caulk)
- Questions (IDPH team)

State of Illinois Mass Vaccination

Overall Goal:

Administer, potentially, two doses of a COVID – 19 Vaccine to **80% of Illinois citizens** according to CDC guidelines.



Priority Populations

IDPH is adopting the NASEM Framework

- **Phase 1a: High-risk health workers and first responders. Hospitals play a critical role in this phase.**
- **Phase 1b: People with significant comorbid conditions (2 or more); and older adults in congregate or overcrowded settings.**
- **Phase 2:** K-12 teachers and school staff and child care workers; critical workers in high-risk setting; people with moderate comorbid conditions; people in homeless shelters or group homes and staff; incarcerated/detained people and staff; and all older adults.
- **Phase 3:** Young adults; children; workers in industries important to the functioning of society.
- **Phase 4:** All other individuals residing in the US who are interested in receiving the vaccine for personal protection.

- *Source: [nationalacademies.org/COVIDVaccineFramework](https://www.nationalacademies.org/COVIDVaccineFramework) Accessed 11/25/20*

Most hospitals are already enrolled in I-CARE

If not, enrollment in I-CARE must be completed **prior** to accessing the COVID-19 Provider Enrollment Forms(*can take up to 14 days*).

**most efficient to use staff that already have access to I-CARE to submit the COVID vaccine provider enrollment.*



- INSTRUCTIONS:**
1. Apply for a web portal account to access I-CARE at <https://wpur.dph.illinois.gov/WPUR/>
 2. Each user within your facility must complete this form
 3. Return page one of this form (1) by scanning document and e-mail as an attachment to: DPH.ICARE@illinois.gov.



Definitions

PRA: Portal Registration Authority users accessing the IDPH web portal must first have approval from their PRA. There can be up to two PRAs per site

I-CARE User: any one with approved portal and I-CARE access. *This should be a limited number of people per site. Every person who administers vaccine does NOT need access to I-CARE.

Redistribution: an affiliated site orders and receives the vaccine, but then redistributes that vaccine to an affiliated site(s). *Each site involved in this process would need an approved COVID-19 Vaccine Provider Agreement submitted via I-CARE.

Emergency Use Authorization: allows the FDA to allow unapproved medical products used to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases

Before you begin Provider Enrollment, please...

- Determine if your facility is already enrolled in I-CARE. If not, I-CARE enrollment comes first.
- Check to see who your I-CARE authorized employees are: It will be helpful to utilize current I-CARE users to complete the Provider Agreement.
- Gather information on current make/model/brand of refrigerator/ freezers for vaccine storage (this will save you time later) and capacity of each unit.
- Gather information needed for the Provider Agreement, including the estimated amount of influenza vaccine delivered and total number of individuals served by the individual organization.



Provider Agreement and Redistribution Forms

- Created and required by the Centers for Disease Control and Prevention (CDC) for all entities planning to administer the COVID-19 vaccine.
- Section A refers to the *Legal Agreement and Provider Requirements*. It requires signatures from the responsible officers.
- Section B, the *CDC COVID-19 Vaccination Program Provider Profile*, **must be completed for each vaccination location covered under the Organization listed in Section A.**
- **Several signatures are required in Section A and one in Section B of the provider agreement.**
- IDPH is required to submit this information at least twice weekly. It is extremely important that all information is correct. The CDC performs audits and will return forms that are incomplete.
- Copies of these forms can be accessed in I-CARE. However, all enrollment must be done online in I-CARE. *Once you complete the entries in I-CARE, the actual CDC form will be populated for you to print and obtain all required signatures for upload.*

Provider Agreement and Redistribution Forms

- **Redistribution:** an affiliated site orders and receives the vaccine, but then redistributes that vaccine to an affiliated site(s). *each site involved in this process would need an approved COVID vaccine provider agreement that they submitted via I-CARE.
- Who should complete a Redistribution form? Any parent site that will order and receive vaccine and redistribute it to other affiliated sites. Each of those receiving sites must also have a completed/signed vaccine provider agreement submitted in I-CARE.

Organization must agree to: *(Accessed from COVID-19 Vaccination Program Provider Agreement)*

Administer COVID-19 vaccine in accordance with all requirements and recommendations of CDC and CDC's Advisory Committee on Immunization Practices.

Within 24 hours of administering a dose of COVID-19 vaccine, organization must record in the vaccine recipients' record and report required information to IDPH.

Submit Vaccine Administration Data through I-CARE per IDPH instructions.

Organization's COVID -19 vaccination services must be conducted in compliance with *CDC's Guidance for Immunization Services During the COVID-19 Pandemic for safe delivery of vaccines.*

Organization must comply with CDC requirements for COVID-19 vaccine management (*storage and handling, monitor vaccine storage unit temperatures, report temperature excursions, monitor expiration dates, maintain records for a minimum of 3 years*)

Organization must report the number of doses of COVID-19 vaccine and adjuvants that were unused, spoiled, expired, or wasted as required by the relevant jurisdiction (IDPH).



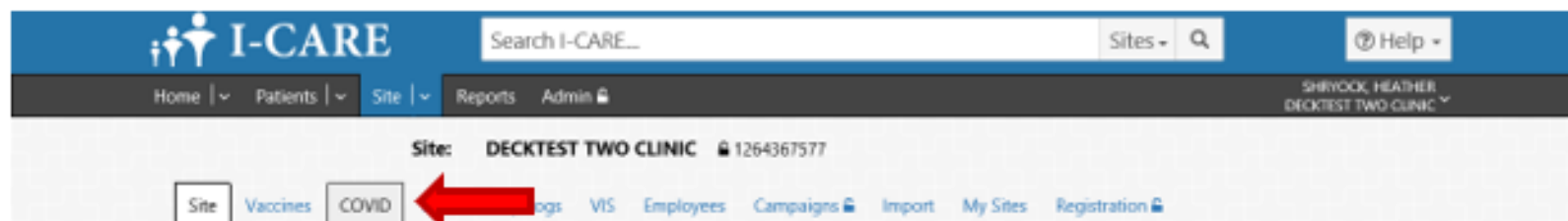
**Complete your Vaccine Provider Agreements as soon as possible.
Agreements received after 11/30/20 will still be processed.**

Read the Step-by-Step Instructions first!
Instructions with screenshots are located on the
I-CARE home page under Announcements.



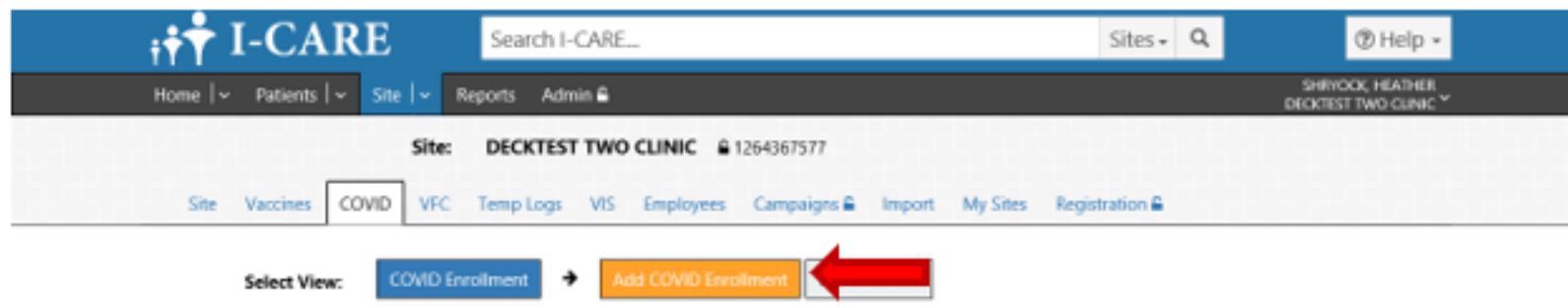
Directions for COVID-19 Enrollment in I-CARE

Locate your site in I-CARE and click on the **COVID** tab. *(If you do not see the COVID tab, you may not have the correct rights as an I-CARE user. Please contact DPH.ICARE@illinois.gov.)*



The screenshot shows the I-CARE web interface. At the top, there is a blue header with the I-CARE logo, a search bar, and navigation links for 'Home', 'Patients', 'Site', 'Reports', and 'Admin'. Below the header, the current site is identified as 'DECKTEST TWO CLINIC' with ID '1264367577'. A horizontal menu contains several tabs: 'Site', 'Vaccines', 'COVID', 'Logs', 'VIS', 'Employees', 'Campaigns', 'Import', 'My Sites', and 'Registration'. A red arrow points to the 'COVID' tab, which is currently selected.

Click on **COVID** tab and select **Add COVID Enrollment**. *(If you do not see the COVID tab or if nothing happens when you click on it, you may not have the correct rights as an I-CARE user. Please contact DPH.ICARE@illinois.gov.)*



This screenshot shows the I-CARE interface after the 'COVID' tab is selected. The 'COVID' tab is now active, and a sub-menu is visible with options: 'VFC', 'Temp Logs', 'VIS', 'Employees', 'Campaigns', 'Import', 'My Sites', and 'Registration'. Below this menu, there is a 'Select View:' section with two buttons: 'COVID Enrollment' and 'Add COVID Enrollment'. A red arrow points to the 'Add COVID Enrollment' button, which is highlighted in orange.

If your site is a current provider in the Vaccine for Children (VFC) Program, the **State VFC PIN number** will be listed. If your site is not a current VFC provider, the PIN will be assigned when your enrollment is approved. Your initial enrollment will appear in **Draft Status**.

Site COVID Enrollment: **New Record**

COVID Enrollment Add

COVID-19 Vaccination Program Provider Agreement

Site Name: [DECKERT TWO CLINIC](#)
Site VFC PIN: --
Enroll Status Date: 11/22/2020 08:23 AM
Enroll Status: Draft

The **Date Application Received** and **Date Application Dispositioned** will be completed by internal staff during the enrollment approval process and need not be completed by the enrolling site.

Date Application Received:  
This is the date the awardee receives the organization's Provider Enrollment application.

Date Application Dispositioned:  
This is the date the awardee finished assigning a status to each individual location within the organization's Provider Enrollment application.

The **Org COVID ID Num** may populate for current VFC providers. For non VFC providers, this will be assigned when your enrollment is approved.

Please ensure the following fields are complete and accurate:

Organization's Legal Name

Number of Locations (*Enter the number of locations affiliated with this organization and will participate with vaccine administration.*)

Organization Telephone, including any extension

Email address must not exceed 40 characters total. *Email addresses exceeding 40 characters will not be accepted. ***This email address must be monitored and will serve as dedicated contact method for the COVID-19 Vaccination Program ****

Organization Address (Street, City, State, Zip Code)

County

Section A. COVID-19 Vaccination Program Provider Requirements and Legal Agreement

Organization Identification	
Org COVID ID Num:	<input type="text"/> *
<small>The jurisdiction's immunization program is required to create a unique COVID-19 ID for the organization named in Section A that includes the awardee jurisdiction abbreviation. This ID is needed for CDC to match Organizations (Section A) with one or more Locations (Section B). These unique identifiers are required even if there is only one location associated with an organization.</small>	
Organization's Legal Name:	<input type="text" value="DECKTEST TWO CLINIC"/> *
Number of Locations:	<input type="text" value="1"/> *
<small>Number of affiliated vaccination locations covered by this agreement</small>	
Organization Telephone:	<input type="text" value="217-555-0909"/> *
Email:	<input type="text" value="fist.jast@email.org"/> *
<small>Must be monitored and will serve as dedicated contact method for the COVID-19 Vaccination Program</small>	
Organization Address:	<input type="text" value="535 W JEFFERSON ST FL GROUND"/> *
	<input type="text" value=""/> *
	<input type="text" value="SPRINGFIELD"/> <input type="text" value="IL"/> <input type="text" value="62702-5076"/> *
	<small>City State Zip Code</small>
County:	<input type="text" value="SANGAMON"/> *

For the Chief Medical Officer (or Equivalent), please complete:

CMO Last Name

CMO First Name

CMO Middle Initial

CMO Title, Licensure Number and State

Telephone, including any extension

Email address * ([limit of 40 characters](#)) *****

Address (Street, City, State, Zip Code)

County

Responsible Officers

For the purposes of this agreement, in addition to Organization, Responsible Officers named below will also be accountable for compliance with the conditions specified in this agreement. The individuals listed below must provide their signatures after reviewing the agreement requirements.

Chief Medical Officer (or Equivalent) Information

CMO Name:	LAST	FIRST	I
	Last Name	First Name	Middle Initial
Title / License:	MD	03699999	IL
	Title	Licensure Number	State
Telephone:	217-555-9999		
Email:	first.last@email.com		
CMO Address:	535 W JEFFERSON ST FL GROUND		
	SPRINGFIELD	IL	62702-5076
	City	State	Zip Code
County:	SANGAMON		

For the Chief Executive Officer (or Chief Fiduciary), please complete:

CMO Last Name

CMO First Name

CMO Middle Initial

CMO Title, Licensure Number and State

Telephone, including any extension

Email address * ([limit of 40 characters](#) *****

Address (Street, City, State, Zip Code)

County

Chief Executive Officer (or Chief Fiduciary) Information

CEO Name:	LAST	FIRST	I
	Last Name	First Name	Middle Initial

Telephone: 217-555-8888

Email: fist.l.jast@email.com

CEO Address: 535 W JEFFERSON ST FL GROUND

SPRINGFIELD	IL	62702-5076
City	State	Zip Code

County: SANGAMON

Please enter **CMO** and **CEO Signature/Dates**. (**Signatures** are mandatory for approval. Signatures may be obtained digitally or manually when the completed enrollment form is downloaded or printed.)

Organization Medical Director (or equivalent) Signoff

CMO Name: --

CMO Signature Date: 11/22/2020

Chief Executive Officer (chief fiduciary role) Signoff

CEO Name: --

CEO Signature Date: 11/22/2020

Enter the **Organization Location Name**.

If another Organization location will be ordering COVID-19 vaccine for this site, please select **YES** and list that **Organization name**.

Organization Location Name: *

Will another Organization location order COVID-19 vaccine for this site?: If YES; provide Organization name:



Enter the following information for both the **primary** and **backup COVID-19 Vaccine Coordinators**:

Last name

First Name

Middle Initial

Telephone, including any extension

Email address * ([limit of 40 characters](#) *****

Contact information for location's primary COVID-19 vaccine coordinator

Primary Coordinator Name: *

Last Name First Name Middle Initial

Telephone: *

Email: *

Contact information for location's backup COVID-19 vaccine coordinator

Backup Coordinator Name: *

Last Name First Name Middle Initial

Telephone:

Email: x

Enter the following **Shipping Information** for COVID-19 Vaccine.

*** This is an extremely important field. Check for accuracy. ***

Address (Street, City, State, Zip Code)

County

Shipping Phone, including any extension

Shipping Fax

Organization location address for receipt of COVID-19 vaccine shipments			
Shipping Address:	535 W JEFFERSON ST FL GROUND *		
	SPRINGFIELD	IL	62702-5076 *
	City	State	Zip Code
County:	SANGAMON *		
Shipping Phone / Fax:	217-555-0909 _____	217-555-0999 _____ *	
	Telephone	Fax	

Enter the address where COVID-19 vaccine will be administered *** ONLY *** if different from the receiving location.

*** Address** (Street, City, State, Zip Code)

*** County**

*** Shipping Phone**, including any extension

*** Shipping Fax**

Organization address of location where COVID-19 vaccine will be administered (if different from receiving location)			
Administered Address:			
	City	State	Zip Code
County:			
Phone / Fax:			
	Telephone	Fax	

Enter days and times vaccine coordinators are available for receipt of COVID-19 vaccine shipments. These are **required** and must be listed in military time. Both AM and PM must have time ranges.

*** This area is very important. It will be used by the vaccine couriers. ***

Days and times vaccine coordinators are available for receipt of COVID-19 vaccine shipments

Use 24-hour time notation for time entries (i.e. 8:00 AM = 08:00, 1:15 PM = 13:15, 5:00 PM = 17:00).

	Monday	Tuesday	Wednesday	Thursday	Friday
AM:	08:00-12:00	08:00-12:00	08:00-12:00	08:00-12:00	08:00-12:00
PM:	12:00-16:00	12:00-16:00	12:00-16:00	12:00-16:00	12:00-16:00

One selection must be made for COVID-19 vaccination provider type for this location

COVID-19 vaccination provider type for this location (select one)

Select Location Type:

Public health provider - public health clinic

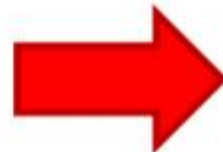


- Commercial vaccination service provider
- Corrections/detention health services
- Health center - community (non-Federally Qualified Health Center/ non-Rural Health Clinic)
- Health center - migrant or refugee
- Health center - occupational
- Health center - STD/HIV clinic
- Health center - student
- Home health care provider
- Hospital
- Indian Health Service
- Tribal health
- Medical practice - family medicine
- Medical practice - pediatrics
- Medical practice - internal medicine
- Medical practice - OB/GYN
- Medical practice - other specialty
- Pharmacy - chain
- Pharmacy - independent
- Public health provider - public health clinic
- Public health provider - Federally Qualified Health Center
- Public health provider - Rural Health Clinic
- Long-term care - nursing home, skilled nursing facility, federally certified
- Long-term care - nursing home, skilled nursing facility, non-federally certified
- Long-term care - assisted living
- Long-term care - intellectual or developmental disability
- Long-term care - combination (e.g., assisted living and nursing home in same facility)
- Urgent care
- Other (Specify):

All settings where COVID-19 vaccinations from this location will take place should be selected:

Setting(s) where this location will administer COVID-19 vaccine (select all that apply)

Select Location Settings:



- Child care or day care facility
- College, technical school, or university
- Community center
- Correctional/detention facility
- Health care provider office, health center, medical practice, or outpatient clinic
- Hospital (i.e., inpatient facility)
- In home
- Long-term care facility (e.g., nursing home, assisted living, independent living, skilled nursing)
- Pharmacy
- Public health clinic (e.g., local health department)
- School (K - grade 12)
- Shelter
- Temporary or off-site vaccination clinic - point of dispensing (POD)
- Temporary location - mobile clinic
- Urgent care facility
- Workplace
- Other (Specify):



Enter the number of patients/clients served by this location as well as the Influenza vaccination capacity for this location. Unknown is acceptable as is zero **only** if not previously vaccinating. These are **required**.

Approximate number of patients/clients routinely served by this location

Number of children 18 years of age and younger: Unknown *
(Enter "0" if the location does not serve this age group.)

Number of adults 19 - 64 years of age: Unknown *
(Enter "0" if the location does not serve this age group.)

Number of adults 65 years of age and older: Unknown *
(Enter "0" if the location does not serve this age group.)

Number of unique patients/clients seen per week on average: Unknown *
(Enter "0" if the location does not serve this age group.)
 Not applicable (e.g., for commercial vaccination service providers)

Influenza vaccination capacity for this location

Number of influenza vaccine doses administered during the peak week of the 2019-20 influenza season: Unknown *
(Enter "0" if no influenza vaccine doses were administered by this location in 2019-20.)

Select **all populations** to be served by this location. Also indicate if organization is currently reporting in I-CARE. If currently reporting, the IIS Identifier is I-CARE.

Population(s) served by this location (select all that apply)

Select Population:

<input checked="" type="checkbox"/> General pediatric population	<input type="checkbox"/> Pregnant women
<input checked="" type="checkbox"/> General adult population	<input type="checkbox"/> Racial and ethnic minority groups
<input type="checkbox"/> Adults 65 years of age and older	<input type="checkbox"/> Tribal communities
<input type="checkbox"/> Long-term care facility residents (nursing home, assisted living, or independent living facility)	<input type="checkbox"/> People who are incarcerated/detained
<input type="checkbox"/> Health care workers	<input type="checkbox"/> People living in rural communities
<input type="checkbox"/> Critical infrastructure/essential workers (e.g., education, law enforcement, food/agricultural workers, fire services)	<input type="checkbox"/> People who are underinsured or uninsured
<input type="checkbox"/> Military - active duty/reserves	<input type="checkbox"/> People with disabilities
<input type="checkbox"/> Military - veteran	<input type="checkbox"/> People with <u>underlying medical conditions</u> that are risk factors for severe COVID-19 illness
<input type="checkbox"/> People experiencing homelessness	<input type="checkbox"/> Other people at higher risk for COVID-19
	(Specify) <input type="text"/>

Does your organization currently report vaccine administration data to the state, local, or territorial immunization information system (IIS)?

IF YES: List IIS Identifier:

IF NOT: WE DO NOT CURRENTLY GIVE VACCINE AT THIS SITE, ONCE GIVEN A PIN WE WILL REPORT TO
Please explain planned method for reporting vaccine administration data to the jurisdiction's IIS or other designated system as required.

IF NOT APPLICABLE:
Please explain

List the number of 10-dose multidose vials the location can store during peak vaccination periods at the following temperatures (**required**). List brand/model/type of storage units to be used. Complete the date and signature of the of Medical/pharmacy or location's vaccine coordinator date.
(Medical/pharmacy director or location's vaccine coordinator **Signature** will be obtained digitally or manually after the competed enrollment form is downloaded or printed.)

Estimated number of 10-dose multidose vials (MDVs) your location is able to store during peak vaccination periods (e.g., during back-to-school or influenza season) at the following temperatures:

Refrigerated (2°C to 8°C):	<input type="checkbox"/> No capacity OR	Approximately	<input type="text" value="900"/>	additional 10-dose MDVs *
Frozen (-15°C to -25°C):	<input type="checkbox"/> No capacity OR	Approximately	<input type="text" value="400"/>	additional 10-dose MDVs *
Ultra-frozen (-60°C to -80°C):	<input checked="" type="checkbox"/> No capacity OR	Approximately	<input type="text"/>	additional 10-dose MDVs *

Storage unit details for this location

List brand/model/type of storage units to be used for storing COVID-19 vaccine at this location:

1:	<input type="text" value="ABS PHARMA REFRIGERATOR ABT-HCPP-23G"/>
2:	<input type="text" value="FREEZER-ABT-HC-UCBI-042055-LH"/>
3:	<input type="text"/>
4:	<input type="text"/>
5:	<input type="text"/>

Medical/pharmacy director or location's vaccine coordinator signature date:

List the primary prescribing provider(s) at this location and their license number(s). At least one prescribing provider is **required**.

Providers practicing at this facility

Instructions: List below all licensed healthcare providers at this location who have prescribing authority (i.e., MD, DO, NP, PA, RPh).

Provider Name	Title	License No.
FIRST I. LAST, M.D.	MEDICAL DIRECTOR	036-09999

Save the form. Print or electronically send for signatures. Once all signatures are obtained, upload a copy as shown below.

Site: DECKTEST TWO CLINIC 1264367577

Site Vaccines COVID VFC Temp Logs VIS Employees Campaigns Import My Sites Registration

Select View: COVID Enrollment Add COVID Enrollment Upload PDF...

Save and Select Change Status. Choose **Requested** from the drop down. Scroll to the bottom and select **SAVE**.

Select an Action: Save Change Status... Delete


Enroll Status: Draft

New Status: Requested

This completes your COVID-19 enrollment submission. Thank you.

How do I know if my Provider Enrollment has been approved by IDPH?

To check the status of your enrollment, locate your site in I-CARE and click on the **COVID** tab. If the enrollment has been approved, the State VFC PIN and the Enroll Status Date will be listed, and the Enroll Status will read **COMPLETE**.

Site VFC PIN:	V09002
Enroll Status Date:	11/22/2020 10:39 AM
Enroll Status:	Complete 

If you have questions regarding COVID-19 enrollment, please send an email to:

DPH.immunizations@illinois.gov



SIREN is a secure web-based persistent messaging and alerting system that leverages email, phone, text, pagers and other messaging formats to provide 24/7/365 notification, alerting, and flow of critical information. This system provides rapid communication, alerting and confirmation between state and local agencies, public and private partners, target disciplines and authorized individuals in support of state and local emergency preparedness and response.

ALL HOSPITALS SHOULD REGISTER: siren.illinois.gov to [Register](#)

SIREN is the communication system \ for information on COVID-19 Mass Vaccination.

Email: dph.siren@illinois.gov for registration assistance.



Summary

Read the Provider Enrollment instructions first! Screenshots and further explanation are provided here. Do not put in Requested status without making sure the completed and signed agreement is uploaded into I-CARE, all fields are completed in I-CARE, and the vaccine shipment receiving times are entered in a range for both am and pm, using military time.

If you can access the COVID tab in I-CARE but are unable to access the provider agreement or upload attachments, you may have restricted access within I-CARE. Please email dph.immunizations@illinois.gov as soon as possible.

Use only: dph.immunizations@illinois.gov for COVID vaccine provider enrollment issues or questions. Please do not email any other IDPH staff or other IDPH mailbox. It will slow the process and create duplication.

It is not necessary for every single provider practice in a hospital system to enroll as a COVID-19 vaccine provider (site). Some hospital system providers may choose to partner with another practice/clinic to provide COVID-19 vaccine to their staff and patients.

Complete the Provider Enrollment before you obtain all required signatures: Complete all fields, Hit SAVE, either print for wet signatures or upload the document and obtain digital signatures.

Register to receive SIREN Alerts.



DPH.immunizations@illinois.gov