

# IQIP Site Visit and Coverage Goals Form

## PROVIDER LOCATION INFORMATION

Provider Name:

VFC PIN:

IQIP Point of Contact:

Email:

Phone Number:

## SITE VISIT DETAILS

Date of site visit:

IQIP consultant who led the site visit:

Type of site visit:  IQIP only  
 IQIP and VFC Compliance

Method of site visit:  In-person  
 Tele-IQIP

Provider locations represented during the visit:  This provider location only  
 This provider location and others from the same multi-site practice or healthcare system

Number of provider locations represented during the visit (including this one):

Name of the health system or multi-site practice:

## SITE VISIT PREP NOTES

**Optional:** Notes relating to site visit preparation, including documentation of scheduling attempts

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## PROVIDER STAFF

### Immunization-Focused Staff

**Does the provider have an immunization champion?**

Yes

If no, encourage the provider to identify one and make it an action item.

No

**Name of immunization champion:**

**Does the provider have a QI coordinator?**

Yes

This refers to somebody other than an immunization champion. This refers to somebody who covers quality improvement across subject areas, not just immunization. Sometimes a QI coordinator works out of a specific practice, but oftentimes a QI coordinator works out of corporate headquarters with multiple sites in a health care system.

No

### Site Visit Participants

**How many staff from THIS provider location participated during this IQIP site visit?**

**Name and title or role of IQIP site-visit participants from THIS provider location:**

CDC recommends, and IQIP coordinators may require, this information to assist with record-keeping and follow-up.

**Did any representative(s) from the health system management/headquarters level participate?**

Yes

No

Examples may include health system-level QI coordinator, medical director, etc.

**Name and title or role of IQIP site-visit participants from the health system management/headquarter level:**

**Which option best describes participation during the visit of provider staff responsible for prescribing vaccines?**

This refers not only to physicians, but also to physician assistants and nurse practitioners.

Participated for the entire IQIP site visit

Participated for only discussion of coverage goals

Participated for discussion of IQIP core strategies

Did not participate

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## OVERVIEW OF VACCINATION WORKFLOW ASSESSMENT

### 1. Practice Management

### 2. Patient Check-In and Documentation Preparation

### 3. Prescriber Discussion and Exam

### 4. Vaccination

### 5. Patient Check-Out

## PATIENT LINE LISTS

Did this site visit include the review of any patient list(s)?  Yes  
 No

Patient list(s) reviewed:  Not UTD/missing doses  Active/inactive patients  
 Missed opportunities  Other

Specify "Other" patient list(s) used:

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## IQIP CORE STRATEGIES (SELECT AT LEAST TWO, Including one Communications)

### Facilitate Return for Immunization

Summarize this strategy's current implementation status.

Summarize challenges and opportunities for improvement in the implementation of this strategy.

Was this strategy selected for implementation or improvement?  Yes  
 No

Describe the technical assistance you provided for this strategy (e.g., resources, demos, role-playing, etc.).

How many action items for this strategy?

List created action items for this strategy

Recommended format for action items: \* Brief description of task [assigned staff: target date]

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## Leverage IIS, EHR, or Electronic System to Improve Immunization Practice

Summarize this strategy's current implementation status.

Summarize challenges and opportunities for improvement in the implementation of this strategy.

Was this strategy selected for implementation or improvement?  Yes  
 No

Describe the technical assistance you provided for this strategy (e.g., resources, demos, role-playing, etc.).

How many action items for this strategy?

List created action items for this strategy

Recommended format for action items: \* Brief description of task [assigned staff: target date]

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## Give a Strong Immunization Recommendation (Interpersonal Communications)

Summarize this strategy's current implementation status.

Summarize challenges and opportunities for improvement in the implementation of this strategy.

Was this strategy selected for implementation or improvement?  Yes  
 No

Describe the technical assistance you provided for this strategy (e.g., resources, demos, role-playing, etc.).

How many action items for this strategy?

List created action items for this strategy

Recommended format for action items: \* Brief description of task [assigned staff: target date]

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## Strengthen Immunization Communications to Address Vaccine Hesitancy (External Communications)

Summarize this strategy's current implementation status.

Summarize challenges and opportunities for improvement in the implementation of this strategy.

Was this strategy selected for implementation or improvement?  Yes  
 No

Describe the technical assistance you provided for this strategy (e.g., resources, demos, role-playing, etc.).

How many action items for this strategy?

List created action items for this strategy

Recommended format for action items: \* Brief description of task [assigned staff: target date]

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## Custom QI Strategy

Did you cover a custom QI strategy during the site visit?  Yes  
 No

Provide the approved name of the custom strategy:

Summarize this strategy's current implementation status.

Summarize challenges and opportunities for improvement in the implementation of this strategy.

Was this strategy selected for implementation or improvement?  Yes  
 No

Describe the technical assistance you provided for this strategy (e.g., resources, demos, role-playing, etc.).

How many action items for this strategy?

List created action items for this strategy

Recommended format for action items: \* Brief description of task [assigned staff: target date]

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## BIRTH COHORT COVERAGE GOALS – Optional

**FOR THIS COHORT: HepB should be selected for improvement**

Populate the 12-month coverage goal using the logic in the table below. You may edit these values if a different goal is preferred.

Initial coverage	Suggested coverage goal for 12-month follow-up
0% to 79.99%	Increase by 10 percentage points
80% to 84.99%	Increase to 90%
85% to 89.99%	Increase by 5 percentage points
90% to 94.99%	Increase to 95%
95% to 99.99%	Increase by 1 percentage point
100%	Maintain initial percentage

Birth cohort age range evaluated:       At hospital discharge       Other age range: \_\_\_\_\_ months

Number of age-eligible birth cohort patients in the practice:

Number of age-eligible birth cohort patients assessed:

Dose/Series (*Optional)	Initial Coverage:	Notes:
<b>1 HepB</b>		
<b>1 RSV*</b>		

### 12-Month Coverage Goals:

**1 HepB goal:**

**1 RSV goal:** (Optional)

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## CHILDHOOD COVERAGE GOALS

**FOR THIS COHORT: Complete series and at least one additional specific vaccine should be selected for improvement.**

Populate the 12-month coverage goal using the logic in the table below. You may edit these values if a different goal is preferred.

Initial coverage	Suggested coverage goal for 12-month follow-up
0% to 79.99%	Increase by 10 percentage points
80% to 84.99%	Increase to 90%
85% to 89.99%	Increase by 5 percentage points
90% to 94.99%	Increase to 95%
95% to 99.99%	Increase by 1 percentage point
100%	Maintain initial percentage

Number of age-eligible adolescents in the practice:

Number of age-eligible adolescents assessed:

Dose/Series (*Optional)	Initial Coverage:	Notes:
<b>Combined 7-vaccine series</b>		
<b>4 DTap</b>		
<b>3 IPV</b>		
<b>1 MMR</b>		
<b>UTD HepB</b>		
<b>1 VAR</b>		
<b>UTD Hib*</b>		
<b>UTD PCV*</b>		
<b>UTD COVID-19*</b>		
<b>UTD Influenza*</b>		
<b>UTD RV*</b>		
<b>2 HepA*</b>		

**12-Month Coverage Goals:**

**Combined 7-vaccine goal:**

**Second specific vaccine goal:**

Include vaccine name and goal

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## ADOLESCENT COVERAGE GOALS

**FOR THIS COHORT: 1 HPV and at least one additional specific vaccine should be selected for improvement.**

Populate the 12-month coverage goal using the logic in the table below. You may edit these values if a different goal is preferred.

Initial coverage	Suggested coverage goal for 12-month follow-up
0% to 69.99%	Increase by 10 percentage points
70% to 74.99%	Increase to 90%
75% to 89.99%	Increase by 5 percentage points
90% to 94.99%	Increase to 95%
95% to 99.99%	Increase by 1 percentage point
100%	Maintain initial percentage

Number of age-eligible adolescents in the practice:

Number of age-eligible adolescents assessed:

Dose/Series (*Optional)	Initial Coverage:	Notes:
1 Tdap		
1 MenACWY		
1 HPV		
UTD HPV		
UTD COVID-19*		
1 Influenza*		
UTD HepB*		
2 MMR*		
2 VAR*		
2 HepA*		
UTD IPV*		

**12-Month Coverage Goals:**

**1 HPV goal:**

**Second specific vaccine goal:**

Include vaccine name and goal

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## OLDER TEEN COVERAGE GOALS

**FOR THIS COHORT: MenB and at least one additional specific vaccine should be selected for improvement.**

Populate the 12-month coverage goal using the logic in the table below. You may edit these values if a different goal is preferred.

Initial coverage	Suggested coverage goal for 12-month follow-up
0% to 69.99%	Increase by 10 percentage points
70% to 74.99%	Increase to 90%
75% to 89.99%	Increase by 5 percentage points
90% to 94.99%	Increase to 95%
95% to 99.99%	Increase by 1 percentage point
100%	Maintain initial percentage

Number of age-eligible older teens in the practice:

Number of age-eligible older teens assessed:

Dose/Series (*Optional)	Initial Coverage:	Notes:
UTD HPV		
1 Tdap		
2 MenACWY		
1 MenB		
1 Influenza*		
UTD COVID-19*		
<b>12-Month Coverage Goals:</b>		
<b>1 MenB goal:</b>		
<b>Second specific vaccine goal:</b> Include vaccine name and goal		

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## SITE VISIT WRAP-UP

ENCOURAGE PROVIDER STAFF TO COMPLETE THE FOLLOWING ACTION ITEMS AT THEIR NEXT STAFF MEETING:

- Introduce colleagues to IQIP and describe the year-long IQIP cycle.
- Review initial coverage reports, selected IQIP strategies, and roles/workflows to support implementation.
- Select – or introduce, if already selected – an immunization champion or QI coordinator and describe their role.

**Date planned for 2-month check-in with provider:**

**Date planned for 6-month check-in with provider:**

**Date planned for 12-month follow-up with provider:**

**How much time was devoted to IQIP during this site visit?**

Only account for time devoted to IQIP specifically. For example, if this is an IQIP-VFC combined visit, count only the IQIP portion.

## ADDITIONAL SITE VISIT NOTES