

Request for Proposals:
Healthcare Workers Immunization Initiative
2-for-1 Vaccine Matching Program
(Tdap, Varicella, and Zoster)

Vaccine preventable diseases (VPD) cause tens of thousands of deaths and more than 200,000 hospitalizations annually. Healthcare workers play a critical role in preventing the spread of VPDs among vulnerable populations that are treated in the healthcare setting. Unvaccinated workers can cause outbreaks which can devastate a facility's operations, resulting in unprecedented sick leave and suspension of services. More importantly, they can pass illness on to patients.

The Maryland Partnership for Prevention (MPP), the Maryland Department of Health and Mental Hygiene, and other partners are working together to increase vaccination rates among healthcare workers. To support this campaign, MPP is providing selected healthcare facilities 2-for-1 Vaccine Matching Grants to assist in efforts to improve Tdap, varicella, and zoster coverage among healthcare workers.

What is the Maryland Health Care Workers Immunization Initiative?

An initiative designed to raise awareness about the importance of vaccinations among healthcare workers and provide health care administrators resources to support efforts to increase vaccination rates among their employees and volunteers.

What types of assistance will be provided through this initiative?

Participants in the Maryland Healthcare Workers Immunization Initiative will receive resources that have been developed to help healthcare facilities implement strategies and programs to increase influenza rates among their employees. Some facilities will receive grants to help support these activities.

Who is eligible for the 2-for-1 matching grants and how does it work?

Any healthcare facility that completed the Healthcare Workers Influenza Initiative Registered Partners Survey prior to October 2009 is eligible. This may include hospitals, skilled nursing facilities, mental health facilities, substance abuse programs, and other providers of health services. For each dose of vaccine that is purchased by a facility, the grant will provide two doses. Therefore, if a hospital purchases 50 doses of Tdap, the grant will provide 100 doses. Note that there is a limit to the number of doses that will be matched. This will be based on the type of vaccine requested and available grant resources.

Applicants must use the form provided. Please use 10 point font or larger. This application is an electronic form that can be completed in Adobe Acrobat Reader. Mailed applications (one original and three copies) must be **postmarked by March 24, 2010** and received no later than March 29, 2010. For receipt confirmation, enclose a self-address, stamped envelope. Proposals may be emailed to hcwinfo@immunizemaryland.org and must be **received by 5 p.m. EDT on March 24**. Faxed applications WILL NOT be accepted.



Proposal Application:
Healthcare Workers 2-for-1 Vaccine Matching Program

Organization Name _____ Division/Department _____

Address _____ City, State ZIP _____

Contact Name _____ Title/Position _____

Phone Number _____ Fax Number _____ Email _____

Type of Facility: Hospital (≤ 200 beds) Hospital (≥ 201 beds) Local Health Department
 Long Term Care Facility Outpatient Clinic Other _____

Print or type responses in the space provided. If necessary, continue on page 2.

1. Briefly describe your past practices for promoting and/or administering vaccinations to your employees.

2. Please describe your **current** plans (without MPP grant funding) to promote and/or deliver immunizations to healthcare workers in your facility.

3. Describe how you will use the grant to increase vaccination rates among healthcare workers in your facility. Include the vaccines you intend to administer, methods of promotion, number targeted, vaccination rate tracking method(s), and how you will measure the effectiveness of your project.

Organization Name _____ Contact Number _____

Use this section to continue responses to questions from first page. Remember to include question number.

VACCINE PRODUCT REQUEST

Vaccine	Product / Manufacturer	# of Doses*
Tdap	_____	_____
Varicella	_____	_____
Zoster	_____	_____
Other _____	_____	_____

* # of Doses refers to the number of doses you would like to receive through the grant.

Signature _____

Date _____

Return one original and THREE copies of completed application to:

HCW Immunization Initiative Grants Committee
Maryland Partnership for Prevention, Inc.
P. O. Box 702
Owings Mills, MD 21117
410-902-4677

Applications must be postmarked by March 24, 2010 and received in our office by March 29.