	Yes	No	N/A
D. When the auditee believes the audit findings are no longer valid or do not warrant further action, are the reasons for this position described in the summary schedule? (See A-133 for valid reason requirements.)	___	___	___
E. Does the schedule also include audit findings reported in the prior audit's summary schedule of prior audit findings unless not warranted? [A-133, §.315 (b)]	___	___	___

Corrective Action

14. Has the auditee prepared a corrective action plan to address each audit finding included in the current year auditor's reports? [A-133, §.315 (c)]	___	___	___
15. Does the corrective action plan provide the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date? [A-133, §. 315 (c)]	___	___	___
16. If the auditee does not agree with the audit findings or believes corrective action is not required, does the corrective action plan include an explanation and specific reasons? [A-133, §. 315 (c)]	___	___	___

Management Decision

17. Have adequate management decisions been issued concerning all audit findings within six months after receipt of subrecipient's audit report? Each individual state agency that passes federal funds to a subrecipient is required to issue a management decision concerning any related audit findings. If an audit finding affects programs of more than one federal agency, the audit agency is responsible for coordinating a management decision among the separate agencies. Management decisions shall clearly state whether the audit finding s sustained, the reasons for the decision, and the expected auditee action to repay disallowed costs, make financial adjustments, or take other action. Audit findings shall include the reference numbers assigned by the auditor. [A-133, §. 315 (b); §. 400(c) (5); §. 400 (d) (5); and §. 405]	___	___	___
18. Has subrecipient taken appropriate and timely corrective action concerning each audit finding? [A-133, §. 400 (d) (5)]	___	___	___

GRANT TRACKING MODULE

Review - Used for Federal Grants Only

Grantee Vendor ID: 0000001121 Planned Parenthood of Northern New

Federal Grantee Fiscal Year End Month: 12

Audit Section

Rev.

☑ Subrecipient Annual Report Received ☐ 01/23/2015 ☐ Delinquent Fiscal Year: 2014

☐ Annual Report Extension Granted Ext. date:

Audit Required? Yes

Comments 2

Comments 1

Primary Pass-Through: 03420 Health

Comments on Findings

Audit received by IAG mm

Dates

☑	Audit Received	09/17/2015
☑	Audit Reviewed	10/08/2015
☑	Audit Accepted	10/08/2015
☐	Mgt. Decision Letter Issued	
☐	Audit Contains Findings/Issues	
☐	Corrective Action Plan Requested	
☐	Corrective Action Plan Received	

Expenditures Section

CFDA Number	Granting Agency	Grant Number	Expended Amount
			0.00

Total Amount

Save | Return to Search | Notify

GRANTEE AUDIT ROUTING

GRANTEE: Planned Parenthood

PRIMARY PASS THRU: Health

AUDITED YEAR: 2014

VISION #: 1121

REPORT RECEIPT

mm [✓] AUDIT REPORT RECEIVED, DATE STAMPED AND ENTERED INTO VISION — DATE: 9/17/15

mm [✓] FORWARD COPIES TO REVIEWER — INITIALS: mm

mm [✓] CONTACT ANY SECONDARY PASS-THROUGH ENTITY

REPORT REVIEW NOTES:

(A) AUDITOR'S REPORTS FOR GAAP WAS:
- [✓] UNMODIFIED
- [ ] MODIFIED
- [ ] ADVERSE

(B) AUDITOR'S REPORT FOR MAJOR PROGRAMS WAS:
- [✓] UNMODIFIED
- [ ] MODIFIED
- [ ] ADVERSE
- [ ] NOT A-133

(C) AUDITEE QUALIFIED AS LOW RISK: [✓] YES [ ] NO [ ] NOT A-133

(D) IF HIGH RISK : REASON WITHIN THE CURRENT AND PRIOR **TWO** YEARS AUDITEE HAD:

CIRCLE APPLICABLE REASON

A) SINGLE AUDITS NOT PERFORMED ANNUALLY
B) OPINIONS OTHER THAN UNQUALIFIED
C) MATERIAL DEFICIENCIES IN INTERNAL CONTROL
D) FEDERAL TYPE A PROGRAMS HAD FINDINGS

(E) FINANCIAL STATEMENT FINDING BRIEF: NO Findings

(F) FEDERAL AWARD FINDING BRIEF: NO Findings

AUDIT COMPLETION:

THE FOLLOWING ARE REQUIRED IN ORDER FOR THE AUDITEE TO BE IN COMPLIANCE WITH 2CFR CHAPTER 1, CHAPTER II,PART 200-UNIFORM ADMINISTRATIVE REQUIREMENTS, COST PRINCIPALS, AND AUDIT REQUIREMENTS FOR FEDERAL AWARDS /UNIFORM GUIDANCE (CHECK OFF FOR SUBRECEPIENTS - IF NOT APPLICABLE USE N/A)

- [✓] REPORT ON MAJOR PROGRAM COMPLIANCE
- [✓] REPORT ON INTERNAL CONTROL COMPLIANCE
- [✓] SEFA
- [N/A] IF FINDINGS - CORRECTIVE ACTION PLAN RESPONSE
- [N/A] IF FINDINGS - MANAGEMENT DECISION LETTER SENT TO DEPARTMENT COMMISIONER FOR SIGNITURE AND MAILED TO ORGANIZATION.
- [✓] ALL SECTIONS OF ATTACHED REVIEW ARE COMPLETE AND SATIFY COMPLIANCE WITH 2CFR CHAPTER 1 AND CHAPTER II,PART 200

REVIEWED BY: INITIALS: RSR DATE: 10/7/15

mm [✓] REPORT ENTERED INTO VISION AS COMPLETED REVIEW AND TOTAL PACKAGE SCANNED INTO SYSTEM INTO SYSTEM UNDER A-133 AUDIT REPORTS

mm [✓] VISION UPDATED FOR AUDIT ACCEPTANCE AND COPY SCANNED WITH AUDIT REPORT

mm [ ] SIGNED COPY OF MDL SCANNED WITH AUDIT REPORT N/A

mm COMPLETED BY: INITIALS: MM DATE: 10/8/15

STATE OF VERMONT

Review for Compliance with Office of Management & Budget Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations"

Auditee: Planned Parenthood of Northern New England
Audit Period: 12/31/14
Conclusion:

In my opinion, this auditee:

[✓] has materially complied with OMB Circular A-133.
[ ] has not materially complied with OMB Circular A-133.

R Roberts
Signature of Reviewer

10/7/15
Date

CHECKLIST

The following checklist is meant as a *guide* to assist the reviewer in determining if the auditee has complied with the Office of Management and Budget (OMB) Circular A-133. The questions listed below are based on requirements included in OMB Circular A-133, generally accepted government auditing standards (GAGAS), and generally accepted accounting principles (GAAP). The checklist applies only to subrecipients that expend federal awards of at least $300,000 per year (this threshold has been increased to $500,000, effective for fiscal years ending after December 31, 2003) and are required to have an audit in accordance with OMB Circular A-133.

General

	Yes	No	N/A
1. Unless a longer period is previously agreed upon were the required reports submitted the earlier of: (a) no later than 9 months from the end of the audit period; or (b) no later than 30 days after the receipt of the auditor's report(s) to the auditee? [A-133, §. 235 (c) (1) and §. 320 (a)].	✓		
2. Does the audit cover only one year? If there was a biennial audit, have both years been audited and does the organization meet the restrictions on which organizations are allowed to have a biennial audit? [A-133, §. 220]	✓		

	Yes	No	N/A
Auditor's Report on the Financial Statements			
3. Is the auditor an independent licensed CPA or a public accountant licensed on or before December 31, 1970? [GAGAS, Yellow Book, §3.10, e. 2.]	✓		
Scope Paragraph			
4. Does the report state that the audit was conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS)? [Yellow Book, Section 5.11; A-133, §. 500 (e)]	✓		
5. Is the report free from any identified scope limitation?	✓		
6. If the auditor refers to the work of another auditor, does the report indicate the division of responsibility and the magnitude of the portion of the financial statements examined by the other auditor?			✓
Opinion and Explanatory Paragraphs			
7. If the financial statements are intended to be presented in accordance with GAAP, does the report contain an opinion on whether the financial statements present fairly, in all material respects, the financial position and the results of operations and are in conformity with GAAP? If not, does the report include an assertion that an opinion cannot be expressed?	✓		
8. If the financial statements are intended to be presented in accordance with another comprehensive basis of accounting:			
A. Is there a separate explanatory paragraph or note which describes the basis of presentation and how the basis differs from GAAP?			✓
B. Does the report contain a disclaimer on whether the financial statements are fairly presented in accordance with the basis of accounting described?			✓
9. If a disclaimer of opinion is issued, are the reasons stated?			✓
10. Are there separate explanatory paragraphs disclosing each substantive reason for withholding an unqualified opinion?			✓

	Yes	No	N/A
Schedule of Expenditures of Federal Awards			
11. Does the Schedule of Expenditures of Federal Awards [A-133, §.310 (b)]:			
A. List individual federal programs by federal agency? List individual federal programs included in a cluster of programs, if applicable? List R&D total federal awards expended by either individual award or by federal agency and major subdivision within the federal agency?	✓		
B. For federal awards received as a subrecipient, the name of the pass-through entity and identifying number assigned by the pass-through entity?	✓		
C. Provide total awards expended for each individual federal program and the Catalog of Federal Domestic Assistance (CFDA) number or other identifying number when the CFDA number is not available?	✓		
D. Include notes that describe the significant accounting policies used in preparing the schedule?	✓		
E. To the extent practical, identify the total amount from pass-through entities provided to subrecipients from each federal program?	✓		
F. Include, in either the schedule or a note to the schedule, the value of federal awards expended in the form of noncash assistance, the amount of insurance in effect during the year, and loans or loan guarantees outstanding at year-end?		✓	
Audit Reporting			
12. The auditor's report(s) may be in either combined or separate reports. Does(Do) the report(s) include the following [A-133, §.235 (b) (4) and §.505]:			
A. An opinion on whether the schedule of expenditures of federal awards is presented fairly in all material respects in relation to the financial statements taken as a whole?	✓		

	Yes	No	N/A
B. A report on internal control related to the financial statements and major programs? This report shall describe the scope of testing of internal control and the results of the tests, and, where applicable, refer to the separate schedule of findings and questioned costs.	✓		
C. A report on compliance with laws, regulations, and the provisions of contracts or grant agreements, noncompliance with which could have a material effect on the financial statements? Does this report also include an opinion as to whether the auditee complied with laws, regulations, and the provisions of contracts or grant agreements which could have a direct and material effect on each major program, and, where applicable, refer to the separate schedule of findings and questioned costs?	✓		
D. A schedule of findings and questioned costs, which include the following three components:			
1) A summary of the auditor's results, which shall include:			
a) The type of report the auditor issued on the financial statements (i.e., unqualified, qualified, adverse, or disclaimer of opinion)?	✓		
b) Where applicable, a statement that reportable conditions in internal control were disclosed by the audit of the financial statements and whether any such conditions were material weaknesses?			✓
c) A statement as to whether the audit disclosed any noncompliance which is material to the financial statements of the auditee?			✓
d) Where applicable, a statement that reportable conditions in internal control over major programs were disclosed by the audit and whether any such conditions were material weaknesses?			✓
e) The type of report the auditor issued on compliance for major program (i.e., unqualified, qualified, adverse, or disclaimer of opinion)?	✓		
f) A statement as to whether the audit disclosed any audit findings that the auditor is required to report?			✓

	Yes	No	N/A
g) An identification of major programs?	✓		
h) The dollar threshold used to distinguish between Type A and Type B programs?	✓		
i) A statement as to whether the auditee qualified as a low-risk auditee?	✓		
2) Findings related to the financial statements that are required to be reported in accordance with GAGAS?			✓
3) Findings and questioned costs for federal awards?			
a) Are audit findings (e.g., internal control findings, compliance findings, questioned costs, or fraud) which relate to the same issue presented as a single audit finding?			✓
b) Are audit findings that relate to both the financial statements and federal awards reported in both sections of the schedule? (One schedule may be in summary form if the other is in detail.)			✓
E. Does the schedule of audit findings and questioned costs include:			
1) Reportable conditions in internal control over major programs? The auditor shall identify reportable conditions that are individually or cumulatively material weaknesses.			✓
2) Material noncompliance with the provisions of laws, regulations, contracts, or grant agreements related to a major program?			✓
3) Known questioned costs and likely questioned costs that are greater than $10,000 for a type of compliance requirement for a major program?			✓
4) Known questioned costs that are greater than $10,000 for a federal program that is not audited as a major program but comes to the attention of the auditor?			✓

	Yes	No	N/A
5) The circumstances concerning why the auditor's report on compliance for major programs is other than an unqualified opinion, unless reported elsewhere?			✓
6) Known fraud affecting a federal award unless such fraud is otherwise reported as an audit finding in the schedule of findings and questioned costs for federal awards?			✓
7) Instances where the results of audit follow-up procedures disclosed that the summary schedule of prior audit findings prepared by the auditee materially misrepresents the status of any prior audit findings?			✓
8) Do audit findings include the following, if applicable: (a) federal award identification (such as a CFDA number); (b) criteria for finding; (c) condition found; (d) identification of questioned costs and how computed; (e) information for judging prevalence and consequences of findings; (f) cause; (g) recommendations; (h) views of responsible officials?			✓

Summary Schedule of Prior Audit Findings

13. The summary schedule of prior audit findings shall report the status of all audit findings included in the prior audit's schedule of findings and questioned costs relative to federal awards. [A-133, §.315 (b)]			✓
A. When audit findings were fully corrected, does the summary schedule list the audit findings and state that corrective action was taken?			✓
B. When audit findings were not corrected or were partially corrected, does the summary schedule describe the planned corrective action as well as any partial corrective action taken?			✓
C. When corrective action taken is significantly different from corrective action previously reported in a corrective action plan or in the federal agency's or pass-through entity's management decision, does the summary schedule provide an explanation?			✓

	Yes	No	N/A
D. When the auditee believes the audit findings are no longer valid or do not warrant further action, are the reasons for this position described in the summary schedule? (See A-133 for valid reason requirements.)	___	___	✓
E. Does the schedule also include audit findings reported in the prior audit's summary schedule of prior audit findings unless not warranted? [A-133, §.315 (b)]	___	___	✓

Corrective Action

14. Has the auditee prepared a corrective action plan to address each audit finding included in the current year auditor's reports? [A-133, §.315 (c)]	___	___	✓
15. Does the corrective action plan provide the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date? [A-133, §. 315 (c)]	___	___	✓
16. If the auditee does not agree with the audit findings or believes corrective action is not required, does the corrective action plan include an explanation and specific reasons? [A-133, §. 315 (c)]	___	___	✓

Management Decision

17. Have adequate management decisions been issued concerning all audit findings within six months after receipt of subrecipient's audit report? Each individual state agency that passes federal funds to a subrecipient is required to issue a management decision concerning any related audit findings. If an audit finding affects programs of more than one federal agency, the audit agency is responsible for coordinating a management decision among the separate agencies. Management decisions shall clearly state whether the audit finding s sustained, the reasons for the decision, and the expected auditee action to repay disallowed costs, make financial adjustments, or take other action. Audit findings shall include the reference numbers assigned by the auditor. [A-133, §. 315 (b); §. 400(c) (5); §. 400 (d) (5); and §. 405]	___	___	✓
18. Has subrecipient taken appropriate and timely corrective action concerning each audit finding? [A-133, §. 400 (d) (5)]	___	___	✓

CONFIDENTIAL

BerryDunn

Board of Trustees
Planned Parenthood of Northern New England, Inc.

We have audited the consolidated financial statements of Planned Parenthood of Northern New England, Inc. (PPNNE) for the year ended December 31, 2014, and have issued our report thereon dated April 28, 2015. Professional standards require that we communicate to you the following information related to our audit.

REQUIRED COMMUNICATIONS

Our Responsibility under U.S. Generally Accepted Auditing Standards, *Government Auditing Standards* and U.S. Office of Management and Budget (OMB) Circular A-133

As stated in our engagement letter dated October 22, 2014, our responsibility, as described by professional standards, is to express an opinion about whether the consolidated financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles (U.S. GAAP). Our audit of the consolidated financial statements does not relieve you or management of your responsibilities.

In planning and performing our audit, we considered PPNNE's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the consolidated financial statements and not to provide assurance on the internal control over financial reporting. We also considered internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with U.S. Office of Management and Budget (OMB) Circular A-133.

As part of obtaining reasonable assurance about whether PPNNE's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grants, noncompliance with which could have a direct and material effect on the determination of consolidated financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit. Also, in accordance with OMB Circular A-133, we examined, on a test basis, evidence about compliance with the types of compliance requirements described in the OMB Circular A-133 *Compliance Supplement* applicable to each of its major federal programs for the purpose of expressing an opinion on PPNNE's compliance with those requirements. While our audit provides a reasonable basis for our opinion, it does not provide a legal determination on PPNNE's compliance with those requirements.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by PPNNE are described in Note 1 to the consolidated financial statements. In 2014, PPNNE adopted Financial Accounting Standards Board (FASB) *Accounting Standards Update (ASU)* 2012-05, *Not-for-Profit Entities: Classification of the Sale Proceeds of Donated Financial Assets in the Statement of Cash Flows.* FASB *ASU* 2012-05 requires cash receipts from the immediate sale of donated financial assets (such as stock) be classified as cash inflows from operating activities, unless the donor restricted the use of the contributed resources to long-term purposes. The application of existing policies was not changed. We noted no transactions entered into by PPNNE during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the consolidated financial statements in the proper period.

Accounting estimates are an integral part of the consolidated financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most significant estimates affecting the financial statements were:

- Management's estimates of allowance for uncollectible accounts and allowances for contractual adjustments based on historical data and current contracted reimbursement rates,
- Management's estimate of the value of the beneficial interest in trusts based on current market rates and actuarially determined life expectancy tables,
- Management's estimate of depreciable lives on capital assets held based on industry standards, and
- Management's estimates of cost allocations based on estimated utilization of support services by functional cost centers.

We evaluated the key factors and assumptions used to develop the estimates in determining that they are reasonable in relation to the consolidated financial statements taken as a whole.

The financial statement disclosures are neutral, consistent and clear.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated April 28, 2015.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Company's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as PPNNE's auditor. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters

With respect to the schedule of expenditures of federal awards, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with U.S. GAAP, the method of preparing it has not changed from the prior period, and the information is appropriate and complete in relation to our audit of the consolidated financial statements. We compared and reconciled the schedule of expenditures of federal awards to the underlying accounting records used to prepare the consolidated financial statements or to the consolidated financial statements themselves.

INTERNAL CONTROL MATTERS

In planning and performing our audit of the consolidated financial statements of PPNNE as of and for the year ended December 31, 2014, in accordance with U.S. GAAP, we considered PPNNE's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of PPNNE's internal control. Accordingly, we do not express an opinion on the effectiveness of PPNNE's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of PPNNE's consolidated financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

****

We sincerely appreciate the cooperation, courtesy and working environment provided to our personnel by management and the employees of PPNNE during the engagement.

This communication is intended solely for the information and use of the Budget and Finance Committee, Board of Trustees, management and others within PPNNE, and is not intended to be, and should not be, used by anyone other than these specified parties.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
April 28, 2015

CONFIDENTIAL

BerryDunn

[redacted]

Planned Parenthood®
of Northern New England

AUDITOR'S REPORTS AS REQUIRED BY
U.S. OFFICE OF MANAGEMENT AND BUDGET (OMB) CIRCULAR A-133
AND *GOVERNMENT AUDITING STANDARDS* AND RELATED INFORMATION

Year Ended December 31, 2014

[redacted]

CONFIDENTIAL

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.

A-133 Compliance

Year Ended December 31, 2014

BerryDunn

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Trustees
Planned Parenthood of Northern New England, Inc.

We have audited, in accordance with U.S. generally accepted auditing standards and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Planned Parenthood of Northern New England, Inc. (PPNNE), which comprise the consolidated statement of financial position as of December 31, 2014, and the related consolidated statements of activities, cash flows and functional expenses for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated April 28, 2015.

Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered PPNNE's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of PPNNE's internal control. Accordingly, we do not express an opinion on the effectiveness of PPNNE's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of PPNNE's consolidated financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether PPNNE's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of PPNNE's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering PPNNE's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
April 28, 2015

BerryDunn

INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM; REPORT ON INTERNAL CONTROL OVER COMPLIANCE; AND REPORT ON THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS REQUIRED BY OMB CIRCULAR A-133

Board of Trustees
Planned Parenthood of Northern New England, Inc.

Report on Compliance for Each Major Federal Program

We have audited Planned Parenthood of Northern New England, Inc.'s (PPNNE) compliance with the types of compliance requirements described in the OMB Circular A-133 *Compliance Supplement* that could have a direct and material effect on each of PPNNE's major federal programs for the year ended December 31, 2014. PPNNE's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its major federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of PPNNE's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with U.S. generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about PPNNE's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of PPNNE's compliance.

Opinion on Each Major Federal Program

In our opinion, PPNNE complied, in all material respects, with the requirements referred to above that could have a direct and material effect on each of PPNNE's major federal programs for the year ended December 31, 2014.

Report on Internal Control Over Compliance

Management of PPNNE is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered PPNNE's internal control over compliance with requirements that could have a direct and material effect on each major federal program in order to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of PPNNE's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this communication is not suitable for any other purpose.

Schedule of Expenditures of Federal Awards

We have audited the consolidated financial statements of PPNNE as of and for the year ended December 31, 2014, and have issued our report thereon dated April 28, 2015, which contained an unmodified opinion on those consolidated financial statements. Our audit was performed for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by OMB Circular A-133 and is not a required part of the consolidated financial

statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with U.S. generally accepted auditing standards. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
April 28, 2015

CONFIDENTIAL

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.

Schedule of Expenditures of Federal Awards

Year Ended December 31, 2014

Federal Grantor Program Title Pass-Through Grantor	Federal CFDA Number	Contract/Pass-Through Identifying Number	Federal Expenditures
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)			
Family Planning Services (Title X)			
Direct:			
Family Planning Services 12/31/2013 - 12/30/2014	93.217	6FPHPA016064-01-01	$ 656,200
Family Planning Services 09/1/2013-08/31/2014	93.217	6FPHPA016125-01-01	167,271
Passed-through:			
State of Vermont, Department of Health, Agency of Human Services			
Family Planning Services 01/01/2014 - 12/31/2014	93.217	03420-6297S	744,231
Family Planning Association of Maine			
Family Planning Services - Clinical 07/01/2013 - 06/30/2014	93.217	FPA-2014-07	179,441
07/01/2014 - 06/30/2015	93.217	FPA-2015-07	198,588
Family Planning Services - Health Insurance Enrollment Program 09/1/2014-08/31/2015	93.217	FPA-ENROLL-PPNNE	4,687
Total Family Planning Services (Title X)			1,950,418
Social Services Block Grant			
Passed-through:			
State of Vermont, Department of Health, Agency of Human Services			
Social Services Block Grant 07/01/2013 - 06/30/2014	93.667	03420-6129S	150,822
07/01/2014 - 06/30/2015	93.667	03420-6358S	156,728
Total Social Services Block Grant			307,550

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.

Schedule of Expenditures of Federal Awards (Concluded)

Year Ended December 31, 2014

Federal Grantor Program Title Pass-Through Grantor	Federal CFDA Number	Pass-Through Identifying Number	Federal Expenditures
Other Grants			
Passed-through:			
State of Vermont, Department of Health, Agency of Human Services			
Preventive Health Services - Sexually Transmitted Diseases Control Grants			
07/01/2013 - 06/30/2014	93.977	03420-6119S	17,130
07/01/2014 - 06/30/2015	93.977	03420-6355S	17,130
Total Preventive Health Services Sexually Transmitted Diseases Control Grants			34,260
Centers for Disease Control and Prevention - Investigations and Technical Assistance			
04/25/05 - open ended	93.283	N/A	1,684
Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchange			
07/3/2013 - 06/30/2014	93.525	03410-1155-14	36,455
07/3/2014 - 06/30/2015	93.525	03410-1155-15	42,773
Total Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchange			79,228
Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges			
08/15/2013 - 08/14/2014	93.750	1NAVCA130057-01-00	81,191
New Hampshire Department of Health and Human Services			
Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges			
10/01/2013-06/30/2014	93.750	N/A	187,227
07/01/2014-02/28/2015	93.750	N/A	149,843
Total Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges			418,261

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.

Schedule of Expenditures of Federal Awards (Concluded)

Year Ended December 31, 2014

Maine Department of Health and Human Services			
Cooperative Agreements for State-Based Comprehensive Breast and Cervical Cancer Early Detection Programs 07/01/12 - 06/30/15	93.919	CDC-13-1383	7,205
Total Other Grants			540,638
Total DHHS and Total Federal Awards Expended			$ 2,798,606

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.

Notes to Schedule of Expenditures of Federal Awards

Year Ended December 31, 2014

1. Basis of Presentation

The accompanying schedule of expenditures of federal awards (the Schedule) includes the federal grant activity of Planned Parenthood of Northern New England, Inc. (PPNNE) under programs of the federal government for the year ended December 31, 2014. The information in this Schedule is presented in accordance with the requirements of Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Because the Schedule presents only a selected portion of the operations of PPNNE, it is not intended to and does not present the financial position, changes in net assets or cash flows of PPNNE.

2. Summary of Significant Accounting Policies

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in OMB Circular A-122, *Cost Principles for Non-profit Organizations*, wherein certain types of expenditures are not allowable or are limited as to reimbursement. Pass-through entity identifying numbers are presented where available.

3. Program Descriptions

Programs subsidized by Title X consist of the following:

Family Planning Program

Comprehensive reproductive health services and counseling, including federally-mandated Title X services, provided to approximately 31,612 women and men at 19 sites in Maine, New Hampshire, and Vermont.

Education Program

Education program provided to teens on topics related to sexuality and reproductive health.

Public Information Program

Informs the public about the activities and programs provided by PPNNE.

Programs not subsidized by Title X consist of the following:

Family Planning Program

Comprehensive reproductive health services and counseling provided to approximately 6,143 women and men at two sites in Vermont.

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.

Notes to Schedule of Expenditures of Federal Awards (Concluded)

Year Ended December 31, 2014

Abortion

Medical and surgical abortion services to patients at the Portland, Maine; Barre, Bennington, Burlington, Rutland, Williston, and White River Junction, Vermont; and Keene, West Lebanon and Manchester, New Hampshire sites.

Lobbying and Advocacy

Includes input on legislative issues, which are of vital interest to PPNNE, and information to the public about these issues.

CONFIDENTIAL

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC.

Schedule of Findings and Questioned Costs

Year Ended December 31, 2014

Section I **Summary of Auditor's Results**

Consolidated Financial Statements

Type of auditor's report issued:	Unmodified	
Internal control over financial reporting:		
Material weakness(es) identified?	____yes	__x__no
Significant deficiency(ies) identified not considered to be material weaknesses?	____yes	__x__none reported
Noncompliance material to financial statements noted?	____yes	__x__no

Federal Awards

Internal control over major programs:		
Material weakness(es) identified?	____yes	__x__no
Significant deficiency(ies) identified not considered to be material weaknesses?	____yes	__x__none reported
Type of auditor's report issued on compliance for major programs:	Unmodified	
Any audit findings disclosed that are required to be reported in accordance with Circular A-133, Section 510(a)?	____yes	__x__no

Identification of Major Programs:

CFDA Numbers	Name of Federal Program or Cluster
93.217	Family Planning Services - Title X
93.750	Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges

Dollar threshold used to distinguish between Type A and Type B programs:	$300,000	
Auditee qualified as low-risk auditee?	__x__yes	____no

Section II **Findings Related to the Financial Statements Which are Required to be Reported in Accordance with *Government Auditing Standards***

NONE

Section III **Findings and Questioned Costs for Federal Awards**

NONE

CONFIDENTIAL

[redacted]

[redacted]

From:	Spottswood, Eleanor
To:	Moino, Peter
Subject:	RE: Planned Parenthood of Northern New England (PPNNE) A-133 Audits
Date:	Friday, July 20, 2018 1:54:00 PM

Yes, if you could send me the actual audit reports for 2014 and 2013, that would be ideal.
Thanks for your help.
Ella

From: Moino, Peter
Sent: Friday, July 20, 2018 1:52 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: RE: Planned Parenthood of Northern New England (PPNNE) A-133 Audits

For older than 2015, if you click on the "Form" link and go to the second tab entitled "Audit Info", you'll get the audit information you're looking for. If you need the actual audit report, I do have PPNNE audit reports going as far back as FY 2013.
Peter

From: Spottswood, Eleanor
Sent: Friday, July 20, 2018 1:43 PM
To: Moino, Peter <Peter.Moino@vermont.gov>
Subject: RE: Planned Parenthood of Northern New England (PPNNE) A-133 Audits

Peter,
Thank you, that worked for 2015, 2016, and 2017. Should I assume you don't have anything older than that?
Ella

From: Moino, Peter
Sent: Friday, July 20, 2018 1:32 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: Planned Parenthood of Northern New England (PPNNE) A-133 Audits

Hi Ella,
After the conclusion of our phone call, I remembered a better way of getting what you're looking for….
For a complete listing of A-133 audits for PPNNE, go to the Federal Audit Clearinghouse:
https://harvester.census.gov/facdissem/SearchResults.aspx
Let me know if you have any questions.
Peter

VERMONT
Peter G. Moino CPA, CGMA, CIA
Director of Internal Audit
Agency of Human Services – Office of the Secretary
280 State Drive, Waterbury, VT 05761
802-241-0446
peter.moino@vermont.gov

From:	Moino, Peter
To:	Spottswood, Eleanor
Subject:	RE: Planned Parenthood of Northern New England (PPNNE) A-133 Audits
Date:	Friday, July 20, 2018 1:51:47 PM

For older than 2015, if you click on the "Form" link and go to the second tab entitled "Audit Info", you'll get the audit information you're looking for. If you need the actual audit report, I do have PPNNE audit reports going as far back as FY 2013.
Peter

From: Spottswood, Eleanor
Sent: Friday, July 20, 2018 1:43 PM
To: Moino, Peter <Peter.Moino@vermont.gov>
Subject: RE: Planned Parenthood of Northern New England (PPNNE) A-133 Audits

Peter,
Thank you, that worked for 2015, 2016, and 2017. Should I assume you don't have anything older than that?
Ella

From: Moino, Peter
Sent: Friday, July 20, 2018 1:32 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: Planned Parenthood of Northern New England (PPNNE) A-133 Audits

Hi Ella,
After the conclusion of our phone call, I remembered a better way of getting what you're looking for….
For a complete listing of A-133 audits for PPNNE, go to the Federal Audit Clearinghouse:
https://harvester.census.gov/facdissem/SearchResults.aspx
Let me know if you have any questions.
Peter

VERMONT
Peter G. Moino CPA, CGMA, CIA
Director of Internal Audit
Agency of Human Services – Office of the Secretary
280 State Drive, Waterbury, VT 05761
802-241-0446
peter.moino@vermont.gov

From:	Spottswood, Eleanor
To:	Moino, Peter
Subject:	RE: Planned Parenthood of Northern New England (PPNNE) A-133 Audits
Date:	Friday, July 20, 2018 1:43:00 PM

Peter,
Thank you, that worked for 2015, 2016, and 2017. Should I assume you don't have anything older than that?
Ella

From: Moino, Peter
Sent: Friday, July 20, 2018 1:32 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: Planned Parenthood of Northern New England (PPNNE) A-133 Audits

Hi Ella,

After the conclusion of our phone call, I remembered a better way of getting what you're looking for….

For a complete listing of A-133 audits for PPNNE, go to the Federal Audit Clearinghouse:

https://harvester.census.gov/facdissem/SearchResults.aspx

Let me know if you have any questions.

Peter

VERMONT

Peter G. Moino CPA, CGMA, CIA
Director of Internal Audit
Agency of Human Services – Office of the Secretary
280 State Drive, Waterbury, VT 05761
802-241-0446
peter.moino@vermont.gov

From:	Moino, Peter
To:	Spottswood, Eleanor
Subject:	Planned Parenthood of Northern New England (PPNNE) A-133 Audits
Date:	Friday, July 20, 2018 1:32:14 PM

Hi Ella,

After the conclusion of our phone call, I remembered a better way of getting what you're looking for….

For a complete listing of A-133 audits for PPNNE, go to the Federal Audit Clearinghouse:

https://harvester.census.gov/facdissem/SearchResults.aspx

Let me know if you have any questions.

Peter

VERMONT

Peter G. Moino CPA, CGMA, CIA
Director of Internal Audit
Agency of Human Services – Office of the Secretary
280 State Drive, Waterbury, VT 05761
802-241-0446
peter.moino@vermont.gov

From:	Spottswood, Eleanor
To:	Swartz, Kimberly
Cc:	Livingston, Shayla
Subject:	RE: More FP documents
Date:	Friday, July 20, 2018 10:09:00 AM

Ok, thank you.

From: Swartz, Kimberly
Sent: Friday, July 20, 2018 10:08 AM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Cc: Livingston, Shayla <Shayla.Livingston@vermont.gov>
Subject: RE: More FP documents

Hi Ella,

I'm not sure if these exist , and if so, where they would be housed. I will consult with one of my colleagues here in MCH to see if she knows.

My reference to AHS was for PPNNE financial audits that are submitted to AHS annually to the internal audit group.

Best, Kim

From: Spottswood, Eleanor
Sent: Friday, July 20, 2018 9:55 AM
To: Swartz, Kimberly <kimberly.swartz@vermont.gov>
Subject: RE: More FP documents

Hi Kim,

All of the OPA program review reports are so helpful, I am hoping we can dig out some that are even older. Did you say you thought they would be stored at AHS (maybe in Waterbury)? Who should I speak to over there to try to find them? I'm happy to go digging through files if I know where they are (and/or bring my intern to do so).

Thank you for all your help.

Ella

From: Swartz, Kimberly
Sent: Thursday, July 19, 2018 12:19 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: More FP documents

Hi Eleanor,

Please find attached:

- 2013 OPA program review report and VT's response
- 2010 OPA program review report and response

These go back as far as I could identify.

I am also attaching our most recent family planning needs assessment, which was conducted in 2015 in preparation for our competitive 2015 application.

Best, Kim

Kim Swartz, MHSc
Director, Preventive Reproductive Health
Division of Maternal and Child Health
Vermont Department of Health

(802)-652-4184
kimberly.swartz@vermont.gov
http://healthvermont.gov/

From: Swartz, Kimberly
To: Spottswood, Eleanor
Cc: Livingston, Shayla
Subject: RE: More FP documents
Date: Friday, July 20, 2018 10:08:10 AM

Hi Ella,
I'm not sure if these exist , and if so, where they would be housed. I will consult with one of my colleagues here in MCH to see if she knows.
My reference to AHS was for PPNNE financial audits that are submitted to AHS annually to the internal audit group.
Best, Kim

From: Spottswood, Eleanor
Sent: Friday, July 20, 2018 9:55 AM
To: Swartz, Kimberly <kimberly.swartz@vermont.gov>
Subject: RE: More FP documents
Hi Kim,
All of the OPA program review reports are so helpful, I am hoping we can dig out some that are even older. Did you say you thought they would be stored at AHS (maybe in Waterbury)? Who should I speak to over there to try to find them? I'm happy to go digging through files if I know where they are (and/or bring my intern to do so).
Thank you for all your help.
Ella

From: Swartz, Kimberly
Sent: Thursday, July 19, 2018 12:19 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: More FP documents
Hi Eleanor,
Please find attached:

- 2013 OPA program review report and VT's response
- 2010 OPA program review report and response

These go back as far as I could identify.
I am also attaching our most recent family planning needs assessment, which was conducted in 2015 in preparation for our competitive 2015 application.
Best, Kim
Kim Swartz, MHSc
Director, Preventive Reproductive Health
Division of Maternal and Child Health
Vermont Department of Health
(802)-652-4184
kimberly.swartz@vermont.gov
http://healthvermont.gov/

From:	Swartz, Kimberly
To:	Spottswood, Eleanor
Subject:	More FP documents
Date:	Thursday, July 19, 2018 12:19:08 PM
Attachments:	2013 VDH Review Report Summary, VDH response.pdf 2013 VDH Review Rpt.pdf 2010 VDH Review Rpt FINAL.pdf 2010 Review VT Plan with RO Response.pdf Title X Family Planning Needs Assessment- 2015.pdf

---

Hi Eleanor,

Please find attached:

- 2013 OPA program review report and VT's response
- 2010 OPA program review report and response

These go back as far as I could identify.

I am also attaching our most recent family planning needs assessment, which was conducted in 2015 in preparation for our competitive 2015 application.

Best, Kim

Kim Swartz, MHSc
Director, Preventive Reproductive Health
Division of Maternal and Child Health
Vermont Department of Health
(802)-652-4184
kimberly.swartz@vermont.gov
http://healthvermont.gov/

Vermont Response to Program Review with Regional Office Comments

Grantee: Vermont Department of Health
Delegate: Planned Parenthood of Northern New England
Date of Review: February 16-19, 2010

GENERAL FINDINGS:

Finding #1 (Overall) VDH is not adequately carrying out monitoring responsibilities. Title X Guidelines state "…the grantee is responsibly for the quality, cost, accessibility, reporting and performance of grant-funded activities provided by delegate/contract agencies and the performance of grant funded activities provide by delegate/contract agencies." (Title X Guidelines: Section 1.6; 45 CFR Part 92, Subpart C, Sections 92.40-44, OMB A-133-400(d))

Grantee Response:
The grantee summarizes the Title X oversight and monitoring plan as below. This plan will be included in the Title X oversight manuals maintained on site at VDH.

Administrative Systems

- Monthly meetings with PPNNE Grants Administrator with documentation of meeting content in writing. These meetings will include topics such as general oversight, review of systems for data collections, review training and educational development plans, and Title X program operations.
- Other contact with PPNNE Grants Administrator as needed for smooth oversight and program planning via in-person meetings, email, and phone.
- VDH will participate in decision making process for choosing training programs supported by RTC and will formally approve all training choice so as to best meet the needs of personnel working at Vermont health centers.

Fiscal

- Requested monthly payments by invoice are presently reviewed, compared to amounts allotted by Title X grant, and approved by VDH Title X Family Planning Coordinator.
- Quarterly Fiscal Reports are submitted by grantee and are reviewed by the VDH Title X Family Planning Coordinator. This practice will be revised to include quarterly review by the VDH Business Office in communication with the Title X Family Planning Coordinator. In this review, the requested payments by the grantee will be reviewed and validated.

Information/Educational Review/Community Involvement

- VDH will review and review and approve method specific consents and patient information sheets in the meetings between the VDH MCH Director and the PPNNE Medical Director. In addition, a general materials review will be ongoing by the VDH Family Planning Coordinator in consult with the VDH MCH Director.

Vermont Response to Program Review with Regional Office Comments

Clinical

- The VDH MCH Director reviews for approval and sign off of the PPNNE Clinical Protocols. The VDH MCH Director is a Pediatrician and is employed within a state leadership position that requires an MD credential. This review will be scheduled twice yearly. This review session will be conducted with the PPNNE Medical Director and meeting minutes will be recorded. Other agenda will include discussions on such items as program and medical policies and coordination with VDH district offices. (Note, the VDH MCH Director met with the PPNNE Medical Director on June 4 and approved the PPNNE clinical protocols. Another meeting will be scheduled for six months from this date.)
- Review of educational materials by MCH Director will be scheduled at the same time as the clinical protocol reviews between the MCH Director and the PPNNE medical director. Ad hoc reviews will be scheduled as needed per initiation by VDH Family Planning Coordinator.
- Review and approval of method specific consents and patient information sheets will be scheduled at the same time as the clinical protocols review between the VDH MCH Director and the PPNNE medical director.
- VDH Title X Family Planning Coordinator will accompany PPNNE CQI Coordinator to at least two Title X health center sites annually. The visits will follow a protocol of reviewing overall clinical procedures to insure compliance with Title X regulations and guidelines.

Regional Office Response - This plan shows intent to improve oversight by the Vermont Department of Health of your delegate. However, there are still some gaps which should be addressed. We will want to review your oversight manuals as well as the notes from your meetings with PPNNE so that we can fully understand the new monitoring system. The following additions should be made to your oversight plan:

- Overall, your oversight should include all items that are included in the Title X Review tools. These tools outline all the requirements for compliance with statute and regulations. Here are some specific areas that are not included in your plan, but which are part of your oversight responsibility.
- For **Administrative Systems**, in some case, on site reviews will be needed to assure compliance with facility requirements, but you should be able to deal with this via the on site reviews that you will participate in. You should also include review of data consistency via audits which can be done by PPNNE and reviewed at your level.
- For **Fiscal** operations, you should periodically review of the billing/collections practices of the delegate, including annual review of fee scales and periodic review of the cost analysis.
- For **Information/Ed** your plan to review consents and patient education sheets is a good start. You will also want to be sure that I&E review is conducted appropriately on all educational materials. Your participation in the I&E committee will help in this matter.
- **Clinical** review should include assurance that all Title X specific requirements are met including parental involvement counseling, objective options counseling, counseling on coercion and the use of evidence based guidelines to inform agency protocols.

Vermont Response to Program Review with Regional Office Comments

ADMINISTRATIVE:

A. Voluntary Participation

There were no findings in this section of the review

B. Confidentiality

There were no findings in this section of the review

C. Conflict of Interest

There were no findings in this section of the review

D. Insurance Coverage

There were no findings in this section of the review

E. Human Subjects Clearance

There were no findings in this section of the review

F. Prohibition of Abortion

Administrative Recommendation #1: Vermont Department of Health should add a stand alone provision to its family planning services contract that states that the delegate agency must operate in compliance with the Title X statue, Section 1008.

Grantee Response:
The VDH will add a stand alone provision to the Title X grant to PPNNE stating that the delegate agency must operate in compliance with the Title X Statute, Section 1008.

Regional Office Response This is a constructive step in assuring that the contractual relationship between VDH and the delegate is compliant with Title X. Please send a copy of the revised contract to the Regional Office when it is completed.

Administrative Recommendation #2: Since PPNNE plans to move its West Lebanon New Hampshire operations to Vermont, and because this facility will provide abortion as well as Title X services, prior to the move, the Department of Health must secure a copy of PPNNE's policy for the separation of abortion services from Title X and review it for compliance. In addition VDH must send a copy of the separation policy to the Regional Office.

Grantee Response:
Due to a variety of factors, the plan for moving the PPNNE West Lebanon Health Center to Vermont is no longer being considered for the near term at this time. However, should any Vermont PPNNE Title X sites plan to provide abortion services in the future the Vermont Department of Health will obtain and review the PPNNE policy for the separation of abortion services from Title X services. Because PPNNE

already has such policies in place and currently operates co-located Title X and abortion services in its other two states, the VDH does not anticipate any issue with PPNNE's understanding of or compliance with separation requirements.

Regional Office Response: This is an adequate response. Please keep the Regional Office posted on any changes in the situation with regard to the collocation of abortion service with Title X services at any Vermont site.

G. Structure of the Grantee/Sub-recipient

Administrative Recommendation #3 The grantee should restructure its contract with PPNNE to provide more specificity and detail regarding expectations for the grantee, including the expectation of active monitoring by the grantee. The review team recommends the New Hampshire Department of Health and Human Service as a model. This document has been favorably reviewed and including similar content would significantly enhance VDH's contract.

Grantee Response:
Several of the regulations and manuals listed in this federal review are on file at the VDH, such as Title X guidelines, Program Instructions, FPAR instructions, and Title X Priorities, Key Issues, and Legislation. This information will be updated with a more detailed description of the reporting and monitoring mechanisms that are employed by VDH to assure compliance to acceptable standards by the delegate agency. This system of oversight will be summarized in appropriate language and included in the VDH language of the VDH grant to PPNNE. The suggested language from the New Hampshire Department of Health will be used as reference for the VDH grant revision.

Regional Office Response: Your response addressed the recommendation and the Regional Office will want to review the relevant documents during the 2011 Site Visit to VDH.

H. Governance

Administrative Recommendation #4 The committee that handles the nomination of board members should be elected by the Board and not appointed which is the current procedure. Election of the nominating committee is a common practice and facilitates keeping the process objective.

Grantee Response
PPNNE reports they will take this recommendation under advisement.

Regional Office Response: Since this is a recommendation rather than a finding, no action is required, but we appreciate the consideration given to this matter.

Vermont Response to Program Review with Regional Office Comments

I. Planning and Evaluation

There were no findings in this section of the review

J. Facilities and Accessibility of Services

Administrative Recommendation #5 The Bennington site should have electrified exit signs as opposed to card board signs because they cannot be seen in a heavy black smoke environment. Also, an additional exit sign pointing to the front door should be placed in the hallway outside the waiting room.

Grantee Response:
PPNNE reports that the Bennington Health Center manager will work with the landlord to have an electrified exit sign installed and to install an additional exit sign in the hallway outside the waiting room.

Regional Office Response: This is an appropriate response to the recommendation and should increase the safety at the site.

Administrative Recommendation #6 The Safety and Security Protocol manual calls for bi-annual fire and disaster drills. This should be changed to annual drills which would reflect the current practice.

Grantee Response:
PPNNE reports that the PPNNE Safety and Security manual recommends twice yearly drills. Each site undergoes an internal risk and quality management review once per year during which the date of the last drill is reviewed. The internal review tool will be modified to include the dates of the two drills in keeping with the twice yearly recommendation in the manual.

Regional Office Response: This is an appropriate response.

Administrative Recommendation #7 To assure that clients are aware of the availability of discounts, a sign should be placed in front desk area at each site stating that the fees are based on the patient's ability to pay.

Grantee Response:
PPNNE responds that all patients are informed of the PPNNE fee structure via the Financial Agreement form that is reviewed and signed by each patient. PPNNE has chosen to not post a notice such as the one recommended for the following reasons: (1) the Financial Agreement form provides a necessary level of detail that is simply not possible in a waiting room sign; detail that eliminates possible confusion regarding fees that may be incurred for non-Title X services, (2) providing information about the fee scale and payment policy individually and personally to each patient ensures that each patient is aware of it – unlike a sign, which may or may not be read and understood; (3) PPNNE staff have consciously tried to limit the number of signs and posters on the walls of the waiting rooms in order to avoid

inundating patients with visual "clutter" and portray a more professional atmosphere. In addition, information on the PPNNE website for each of the Health Centers includes the following statement, "Fees for services are based on your household income." For these reasons, PPNNE feels that a sign is redundant and potentially confusing.

Regional Office Response: VDH appears to have assured that PPNNE has given careful consideration to assuring that clients are aware of the fee requirements. The posting of signage has been a traditional way of assuring that clients are aware that they will not be denied services due to inability to pay. As long as this principle is upheld, the signage is not required.

K. Personnel

Administrative Recommendation # 8 It is generally good practice to have some form of written personnel reviews on an annual basis and this practice seems to be generally followed at PPNNE and VDH. Therefore, both organizations should complete the reviews that are overdue. In addition a system should be set up to assure that subsequent evaluations are completed on a timely basis consistent with applicable personnel policies.

Grantee Response:
PPNNE personnel policies include a provision for an annual employee development plan. The annual development plan provides an opportunity for each employee to work with their supervisor to consider their professional growth needs on an annual basis and beyond. Although the plan is designed to be focused on the coming year, rather than past performance, the collaborative development of the plan between the supervisor and employee provides an opportunity to address any challenges with performance on an annual basis, as applicable. In addition to the annual employee development plan, PPNNE advanced practice clinicians are evaluated annually either by direct observation or chart review by the Medical Director, CQI Director, or a peer evaluator. Evaluations may cover clinical skills, documentation, adherence to the Medical Protocol, coding practices, and/or adherence to quality standards. Performance feedback may occur either by discussion and/or in written form.

VDH will renew attention to its practice of annual personnel evaluations. Regular personnel evaluations are a standard VDH personnel policy and are designed to enhance communications with employees, set annual performance goals, and foster personal and professional growth.

Regional Office Response: This response is adequate and addresses the concern in the recommendation for regular review of employee performance.

L. Training and Technical Assistance

Administrative Recommendation #9 The Vermont Department of Health should be actively involved in choosing training supported by the RTC and should formally approve all training choices so that the training that is chosen meets the needs of the Vermont program.

Grantee Response:
VDH Family Planning Coordinator will begin a more active oversight role in planning for training support by participating in the annual planning meeting between JSI and PPNNE in September 2010, at which time training and technical assistance plans will be reviewed and approved. VDH will follow up on the status of these trainings via regular oversight meetings with the PPNNE Grants Administrator and by review of the quarterly progress reports.

Regional Office Response: More active participation by VDH in the planning of training and technical assistance should assure that these activities meet Vermont specific needs.

L. Reporting Requirements

Finding # 2 neither (Administrative) Neither VDH nor PPNNE is adequately validating the data which is submitted for the FPAR report regarding client income. In addition, the system for capturing race/ethnicity does not always include a self report, but rather appears to be based on assessment or assumptions made by intake staff. Finally, services delivered by health care assistants (HCAs) were not accurately attributed. (45 CFR, 74:51; Title X Guidelines: Section 6.7. FPAR Forms and Instructions)

Grantee Response:
Client Income Reporting: PPNNE has traditionally entered 9999 in the income block for patients who refuse to provide their income information – thereby declining reduced fee services. Because fee scale level is automatically calculated based on the income figure entered into the practice management software program, entering income at 9999 appropriately assigns the patient to the full fee level. In order to more accurately report income, PPNNE will translate records in which the income field is 9999 to missing/unknown prior to sending data to the Region I data system.

Race/ethnicity: PPNNE patients self-report their race and ethnicity on a form given to them during the intake process. PPNNE Intake forms are currently undergoing revision. As pert of the training on these new forms (to be implemented in the fall of 2010,) staff will be reminded of the importance of patient self report when collecting race/ethnicity data.

HCA only visits: For insurance billing purposes, all visits must be associated with a licensed provider. PPNNE does have an "in house" code for brief/low complexity

HCA visits, "99211HCA". However, when data are transmitted to the Region I data system, this code must be translated to 99211, which could be an HCA-only or a practitioner visit. Prior to transmitting data to the Region I data system, PPNNE will revise the primary provider field to "Counselor/CHE" for those records for which the 99211HCA code is used.

VDH will coordinate with PPNNE to conduct data consistency audits once these changes have been implemented.

Regional Office Response: The changes described here are responsive to this finding and should assure that the data concerns raised in the review are addressed. A the time of the 2011 site visit, the Regional Office will review data submissions and audit reports to confirm that the changes have achieved their intent. In addition, if PPNNE interprets the refusal to provide income information as a client's indication that they do not want or need to be considered for a discount, this must be clearly articulated to the clients.

M. Publications

There were no findings in this section of the review

O. Federal Assurances

There were no findings in this section of the review

FISCAL:

1. Budgetary Controls

Finding # 3 Fiscal The delegate budget and expenditure reports include an advertising line item that appears to describe an unallowable expense. (45 CFR 74.21 (6); 2CFR 230 –Appendix B (paragraph 1))

Grantee Response:
PPNNE has changed its budget and expenditure reports to eliminate the marketing and miscellaneous categories.

Regional Office Response: This is an appropriate response to the finding. The Regional Office will review current grant budgets to assure that the changes have been made.

2. Accounting Systems and Reports

Finding #4 (Fiscal) PPNNE's accounting manual does not include a section on the procedures for determining reasonableness, allocability and allowability of costs in accordance with Federal cost principles. (Ref: 45 CFR 74.21 (b) (6))

Grantee Response:
The PPNNE Accounting Manual was revised to include a section on the determining the reasonableness, allocability, and allowability of costs. This section is attached**.**

Regional Office Response: Thank you for including the actual policy document addressing this finding. It would be helpful if the policy include a system for how costs are allocated. The current policy indicates that joint costs are allocated "using a base most appropriate to the particular cost prorated." Some explanation of how this base is determined would be helpful. Please consider this in your review of delegate budgets.

Finding #5 (Fiscal) Responsibilities for physical security/custody of assets is not adequately separated from record keeping/accounting for those assets and unauthorized access to assets and accounting records is not fully prevented. (Ref: 45 CFR 92.20; Accepted Internal Control Procedures)

Grantee Response:
PPNNE policy on the use of courtesy and other fee adjustments by Health Center staff is attached. There are designated staff at each Health Center authorized to use such adjustments and they must seek supervisor approval. All instances of courtesy or other discounts on top of the sliding fee adjustment are reviewed by the V.P. of Health Center Operations and the Associate V.P. of I.T. and Revenue process.

Regional Office Response: Again, thank you for submitting the actual policy document. The new policy addresses the application of discounts and therefore satisfies this finding. We would expect that the delegate has provided staff training on this new policy and it would have been helpful to have had a description of that process.

Fiscal Recommendation #1 The Grantee should establish a process to instruct new staff on how to report accurately on the Federal Reporting forms (both the SF-269 and the new Federal Financial Report (FFR) – SF-425).

Grantee Response:
Reporting procedures on the federal reporting forms will be reviewed for accuracy and consistency with OGM guidelines during the quarterly meeting between the VDH Family Planning Coordinator and the VDH Business Office. The need for orientation of new staff will be identified during these meetings or during ad hoc communications between the Family Planning Coordinator and the VDH Business Office.

Regional Office Response: This is an appropriate response which should result in clarification of the proper procedures.

3. Charges, Billing and Collections Procedures

Finding #6Fiscal) The application of the schedule of discounts to established fees is not implemented in full accordance with Title X expectations and in some cases Title X clients with incomes below 100% FPL are being charged for services required in providing required family planning care (42 CFR 59.5 (a) (8); Title X Guidelines: Section 6.3)

Grantee Response:
PPNNE has modified its Title X fee schedule to include "Hemoglobin for provision of birth control method," "Hematocrit for birth control method," "lab handling fee-family planning," and "surgical tray for provision of birth control method." Note that these services will slide to zero in accordance with the Title X schedule of discounts only when provided in conjunction with a Title X service. The revised fee schedule is attached.

Regional Office Response: These changes meet the requirement to assure that all Title X required services are discounted appropriately.

Fiscal Recommendation #2 The Grantee should work with the sub recipient to insure the cost of pharmaceuticals is reduced to a level that is supported by a cost analysis and creates a pricing structure that allows those at the low end of the SOD an ability to obtain services.

Grantee Response:
VDH and PPNNE are undertaking an analysis of this issue.

Regional Office Response: This is an appropriate response. The Regional Office will continue to monitor fee scales. Please let us know if there are changes.

4. Procurement/Inventory Control/Property Management

Finding #7 (Fiscal) Grantee does not have adequate safeguards for assuring that supplies purchased through the Federal Drug Pricing Program (340B) are provided only to clients served in the Title X project. (Veterans Health Care Act of 1992)

Grantee Response:
This finding has been removed per notification by Region 1 RPC on July 22, 2010.

Regional Office Response: Despite the fact that the policy regarding purchase of contraception by sites certified as 340B eligible under 318 has been clarified by HRSA with a statement that this is allowable if the certifying agency agrees that these drugs are within the scope of the 318 work, it is still important that the purchasers maintain auditable records regarding the purchase and use of 340B medications.

INFORMATION AND EDUCATION REVIEW AND COMMUNITY INVOLVMENT:

A. Information and Educational (I&E) Materials

Finding #8 (Community Participation, Education and Promotion) VDH is not in compliance with Title X requirements for review of educational materials. (Title X Statute, Section 1006 (d), 42CFR 59.6; Title X Guidelines: Section 6.8)

Grantee Response:
PPNNE replies that the specific materials to which this finding refers are clinical information sheets that are provided to the patient in the context of a one-on-one conversation with their provider. These are not meant to be broadly distributed materials nor are they made available in PPNNE waiting rooms. Rather, they are given to the patient either per medical protocol and/or when the provider feels that written information/instructions will be beneficial to that particular patient. Furthermore, these clinical information sheets are developed and required by Planned Parenthood Federation of America as part of the Planned Parenthood medical protocol and are reviewed and approved for clinical accuracy. They are not created by – nor can they be modified by – PPNNE.

For these reasons, VDH and PPNNE respectfully request that the materials in questions be exempt from the materials review process.

Regional Office Response: Title X statute and regulations require review of all educational materials that are part of a Title X project by a committee whose composition and purpose are defined in 42 CFR, Section 59.6. The Regional Office has determined, in consultation with Central Office, OPA that the materials described here fall under this requirement and that the requirement cannot be waived.

As we discussed during this Review, the review process should be able to be streamlined by including a notification to the review team of the fact that these documents are certified as medically accurate by PPFA.

Recommendation # 1 (Community Participation, Education and Project Promotion) PPNNE can improve their materials review process by adding the publication date and review date to their reviewed materials list and by adding a policy for periodic review of materials on a cyclical basis to assure currency.

Grantee Response:
VDH and PPNNE will take this recommendation under advisement for materials to be reviewed in the future.

Regional Office Response: This is an appropriate response.

3. Project Promotion

There were no findings in this section of the review

CLINICAL MANAGEMENT AND SERVICES:

A. Client Services

Finding #9 (Clinical) PPNNE's clinical protocols have not been reviewed and signed off by the Medical Director of the grantee organization, Vermont Department of Health (Ref: Title X Guidelines Sections 6.5 and 7.1 and Office of Population Affairs (OPA), Program instruction Series, OPA 09-01). *Please note that this finding was made in the previous review and has not yet been addressed.*

Grantee Response:
The VDH MCH Director, who is a physician and pediatrician, met with the PPNNE Medical Director on June 4, 2010 and approved the PPNNE Clinical Protocol Manual. These meetings will continue to be scheduled twice yearly. See also Section "General Findings, Finding #1."

Regional Office Response: This response addresses this finding. It appears that the monitoring plan described earlier in the VDH response, which includes semi annual meetings between the Grantee medical director and PPNNE should assure that all protocol changes are reviewed and approved by the Grantee in the future.

Clinical Recommendation #1 As a part of VDH's oversight of the PPNNE Title X program, it is recommended that the VDH Medical Director and the PPNNE Medical Director meet semi-annually for program and medical policy discussion. This has been recommended in the past and the review team believes that it would be useful in assuring that VDH is well informed on the clinical operations at PPNNE. Minutes of these meetings should be taken and maintained and should be available for review by the Regional Office.

Grantee Response:
The VDH MCH Director, who is a physician and pediatrician, will begin meeting at least twice yearly with PPNNE Medical Director to review clinical protocols and for program and medical policy discussion. Minutes of these meetings will be kept and maintained with the Title X manuals and records of the Family Planning Coordinator.

The first of these meetings for 2010 was held on June 4th. See also Section General Finding, Section #1.

Regional Office Response: The monitoring plan described earlier in the VDH response addresses this concern.

B. Service Plan and Protocol and C. Procedural Outline

Finding # 10 (Clinical) PPNNE charts do not clearly document the offer of general exams for many clients and often fail to document contraceptive counseling for male patients who present for STI screening and are reported as Title X Clients. (Ref: Title X Guidelines 8.3).

Grantee Response:
Offer of general exams: PPNNE reports that the Hormonal Option without Pelvic Exam Medical Record form has been revised to encourage practitioners to indicate the date by when a physical exam is recommended. The revised form is attached.

In addition, the PPNNE practice management system has a recall function that allows practitioners to indicate when a return visit is indicated and for what purpose, including for an annual exam. This then automatically generates patient letters reminding them to return for that service. Health Center staff were recently reminded of the requirement to complete these fields when indicated in order to ensure appropriate reminders are sent to patients.

Contraceptive counseling for male users: PPNNE reports that the male physical exam form was revised to include documentation that contraceptive options were reviewed. The revised form is attached.

Regional Office Response: The alterations to the medical history forms address these recommendations and should assure that all client visits that are part of the Title X program both include discussion of contraceptive needs and plans and provided appropriate anticipatory guidance with regard to recommended schedules for preventive health service.

D. Emergencies

There were no findings in this section of the review

E. Referrals and Follow-Up

Clinical Recommendation #2 In addition to cost provisions, referral lab contracts should include quality provisions such as volume, certifications/approvals/quality assurance mechanisms. In addition to the assessments the Medical Director has made in selecting the lab, PPNNE should include formal periodic review of referral contracts through their QI program that includes patient satisfaction.

Grantee Response:
PPNNE reports that the recommended provisions are already included per PPFA requirements.

Regional Office Response: The review team did not review the PPFA requirements in this area, but having such provisions in place will ensure that the quality of referral resources is assessed regularly.

Clinical Recommendation #3 PPNNE should continue the work they have already begun on improving referral and follow-up documentation. Copies of follow-up letters should be kept in patient records. Consults and records from outside sources should be separated in PPNNE patient records. Notes and plans should not be written on lab reports.

Grantee Response:
PPNNE reports that the referral and follow-up protocols have recently been updated and strengthened. Training has been provided to all PPNNE practitioners and Health Center staff. The referral and follow-up protocol is attached.

Regional Office Response: The new system and policy is very clear about the need for thorough follow up on required referrals.

Clinical Recommendation #4 PPNNE is reminded that confidentiality and sliding fee provisions must be provided by labs billing directly to patients.

Grantee Response:
PPNNE reports that the contracted laboratories do not bill patients directly.

Regional Office Response: Thank you for this clarification.

F. Required Services

Clinical Recommendation #5 VDH as grantee should review and approve method specific consents and patient information sheets. These materials were not included in the manual available for review at the VDH office. This is included in the overall findings about monitoring above.

Grantee Response:
VDH has arranged for PPNNE to provide materials for review on a regular basis by the VDH Family Planning Coordinator. In addition, method specific consents and patient information sheets will be reviewed by the VDH MCH Director in the twice yearly clinical review meetings held with the PPNNE Medical Director. (See General Finding #1.) These forms will be included in the Title X manual kept on file at VDH.

Regional Office Response: This response deals well with the recommendation.

G. Client Education and H. Counseling

There were no findings in this section of the review

I. History, Physical Assessment and Lab Testing

Recommendation #6 Continue recent initiative to add allergy sticker alert to patient medical record cover; the alert should be used only when an allergy is identified. Allergy histories are documented consistently within the record.

Grantee Response:

PPNNE reports that they plan to continue this initiative.

Regional Office Response: This is a good practice and the Regional Office is glad to hear it will be continued.

Recommendation #7 Add Vitamin D intake to dietary/prevention history and influenzas to vaccination record history on initial and annual patient history formats.

Grantee Response:

PPNNE reports that the annual update to the PPFA Medical Protocol, which often precipitates changes to medical forms, was released in June and is currently under review at PPNNE. PPNNE will consider the recommended forms changes per Title X as future changes are incorporated into medical forms.

Recommendation #8 PPNNE should consider adding HIV test to Health Maintenance list on Problem List format. Access to HIV testing following CDC standards has been greatly enhanced. All patients were offered testing during patient care observations, this review.

Grantee Response:

PPNNE reports that the annual update to the PPFA Medical Protocol, which often precipitates changes to medical forms, was released in June and is currently under review at PPNNE. PPNNE will consider the recommended forms changes per Title X as future changes are incorporated into medical forms.

Recommendation #9 Add BP to DMPA Flow Chart. The clinical consultant reinforced the standard of obtaining BP at every clinical visit in discussions with PPNNE. At St. Albans, the consultant observed careful attention to BP measurement. A further suggestion is made for staff to review current BP screening criteria.

Grantee Response:

The annual update to the PPFA Medical Protocol, which often precipitates changes to medical forms, was released in June and is currently under review at PPNNE.

PPNNE will consider the recommended forms changes per Title X as future changes are incorporated into medical forms.

Regional Office Response Recommendations 7 -9: The plans for considering changes to forms based on protocol are very sensible.

J. Fertility Regulation
There were no findings in this section of the review

K. Infertility Services
There were no findings in this section of the review

L. Pregnancy Diagnosis and Counseling
There were no findings in this section of the review

M. Adolescent Services
There were no findings in this section of the review

N. Identification of Estrogen-Exposed Offspring
There were no findings in this section of the review

N. Optional Related Services
There were no findings in this section of the review

P. Special Counseling and Q. Genetic Information and Referral
There were no findings in this section of the review

R. Health Promotion/Disease Prevention
There were no findings in this section of the review

S. Postpartum Care
There were no findings in this section of the review

T. Equipment and Supplies

Clinical Recommendation #10 PPNNE should consider securing sharps containers to the wall and should investigate the use of magnetic locks for supply cabinets and drawers. Computer or key punch locks for pharmacy closets would also help to ensure that these areas are always secured during the clinic day.

Grantee Response:
PPNNE reports that they are currently focused on making their Health Centers more modern, welcoming and appealing to teens and young adults, with the goal of renovating or relocating every Health Center over the next three years. As Health Center renovations and relocations are planned, these recommendations will be included in the plans.

Regional Office Response: The Regional Office is glad to hear that VDH has encouraged PPNNE to consider these safety related recommendations as they make changes at their centers.

U. Pharmaceuticals

Recommendation #11 Documentation of pharmaceuticals dispensed should be made in patient medical records. Providers should document drugs dispensed next to original prescription order or in a log in patient medical records. This issue should be considered, and can probably be resolved with the adoption of electronic medical records, but PPNNE should keep it in mind and should have a resolution to assure that dispensing follows prescriptions for the interim.

Grantee Response:
PPNNE reports that their staff currently document pharmaceuticals dispensed on a pharmaceutical log that is signed by the patient and also in Vision, PPNNE's practice management software. When PPNNE makes the transition to electronic medical records, this documentation will automatically be part of the patient record.

Regional Office Response: The ability to track dispensing via the EHR will address this recommendation.

V. Medical Records

Recommendation #12 Social Security numbers must not be used in patient records. Currently, they appear on the data form and sliding fee application.

Grantee Response:
PPNNE reports that they will consider this recommendation. However, at present, Social Security number remain the only available truly unique patient identifier.

Regional Office Response: The Regional Office appreciates that VDH is working with PPNNE on consideration of this recommendation.

Recommendation #13 PPNNE should continue to work with staff on legibility issues. Some records at the St. Albans site were difficult to read.

Grantee Response:
PPNNE reports that the legibility of patient records will be addressed, as needed, at PPNNE annual internal quality improvement audits.

Regional Office Response: Internal quality improvement audits are a good way to address legibility issues. The adoption of the EHR should resolve this problem in any case.

W. Quality Improvement/Assurance

There were no findings in this section of the review

Comprehensive Program Review
Vermont Department of Health
Date: February 16-19, 2010

Sites Reviewed:

- Vermont Department of Health – 108 Cherry Street, Burlington, Vermont
- Planned Parenthood of Northern New England Administrative Office – Williston Administrative Offices – 183 Talcott Road, Suite 101, Williston, Vermont
- Planned Parenthood of Northern New England Parenthood Northern New England (PPNNE), Bennington site, 23 Mansfield Avenue, Burlington, Vermont
- Planned Parenthood of Northern New England Parenthood Northern New England (PPNNE), St. Albans Health Center, 80 Fairfield Street, St Albans, Vermont
- Visited: Office of the PPNNE Medical Director, 23 Mansfield Avenue, Burlington, Vermont

Review Team: Kathy Desilets, Regional Program Consultant, and Team Leader and I & E/Community Involvement Reviewer
Rita Pope, Clinical Reviewer
Steve White, Administrative Reviewer
Gerry Christie, Fiscal Reviewer

Persons Interviewed:

Vermont Department of Health
Sally Kershner, Vermont Department of Health Family Planning Coordinator
Tracy Dolan, Chief Public Health Planning
Patrick Burke, VDH Business Office

Planned Parenthood Administration
Steve Trombley, President and CEO
Kelly Dougherty, Director of Government Grants and Planning
Dawn Touzin, Vice President for Public Policy and Government Affairs
Ellen Starr, VP of Health Center Operations
Carolynn Ernst, Regional Director
Karen Landry, VP of Human Resources
Sarah Weisman, Director HCO Training Team
Becky Levasseur, Director of Clinical Quality Improvement
Catriona McHardy, VP Education

Planned Parenthood of Northern New England – Bennington
Sara LaShay, Site Manager
Becky Levasseur, CQI Director
Roxanne Karter, Regional Director
Jennifer Appleman, Health Care Associate

Planned Parenthood of Northern New England – St. Albans
Pamela Polhemus, Site Manager
Becky Levasseur, CQI Director
Carolyn Ernst, Regional Director

Note: Throughout this review, the citation "Guidelines" refers to Program Guidelines for Project Grants for Family Planning Services, January 2001, Office of Family Planning, U.S. Department of Health and Human Services.

Overview

The Vermont of Health (VDH) has been funded as a Title X grantee for over 40 years and is the sole grantee for the state of Vermont. The program is administratively located in the Maternal and Child Health Division of the health department, where one staff person dedicates part of her time to the program. Additional administrative and fiscal support is available from a limited number of financial and contract management staff members at the department of health. VDH contracts for all Title X services with Planned Parenthood of Northern New England (PPNNE), an affiliate of the Planned Parenthood Federation of America. It is notable that VDH passes the vast majority of Title X funds to the delegate, retaining only a very small proportion to cover its own costs.

PPNNE currently provides services at eleven (11) sites across the state of Vermont, nine (9) of which are part of the Title X program. Vermont provides additional support to PPNNE through the Social Services Block Grant and the Global Commitment for Health. The latter is a fund created under a Medicaid 1115 waiver that allows the state broad discretion in how it uses Medicaid funds. The waiver sets a capped amount that can be spent and allows the state to use funds that are not spent on basic Medicaid expenses to support programs that are determined to benefit the state's overall heath or to save money. In addition, the state funds PPNNE to deliver STD Control and HIV Prevention Services so that the PPNNE clinics are the state's STD and HIV clinics. The Vermont Department of Health views PPNNE as a valued and close partner and this can be seen in a variety of collaborations between the state and PPNNE.

Currently PPNNE serves approximately 8500 Title X users annually and in the first year of the current Title X grant expects to maintain that user number. User numbers have dropped each year since 2004 and the reasons for the decrease in numbers or not entirely clear. Demographic changes and competition from Community Health Centers which have increased their reach in Vermont are two possible reasons for the change. Teen user numbers also dropped between 2004 and 2008, as did teens as a proportion of users, but in 2009, there was a 12% increase in the number of teen users from the prior year. This could be a result of PPNNE outreach efforts. The proportion of users who were teens generally been between 24% to 28% and the agency projects that 30% of 2010 users will be teens. Male user numbers have been relatively steady and the proportion of users who are male has increased gradually since 2005 to its current level of 7% of total users. While the state unemployment rate is exceptionally low, the major user group, 20 -29 years of age, called the millennial age group is most affected by the current recession i.e., they have fewer jobs, they are

behind in earnings and they experience housing cost problems. Fifty percent of users in the coming year are projected to be at or below 100% of poverty, but the proportion of reported clients in this income category has ranged from 33 – 39% over the past five years, a lower proportion that most Title X clinics. Approximately 55% report that they have access to some public or private insurance coverage, but it is not always clear to what extent this insurance will cover family planning visits, devices or pharmaceuticals.

Vermont is a rural state with less than one million population. Planned Parenthood and the state of Vermont have decided to concentrate Title X funding in areas they have identified as high need.

The VDH has experienced the same kind of funding challenges that are common nationally in the current economy and has seen significant cuts to staff over the last two years. The state continues to show commitment to provide comprehensive family planning services to residents through their support of PPNNE. While the state has provided generously in safety-net resources for its citizens and with the uninsured rate reported at a surprisingly low 7%, PPNNE remains in a difficult financial state. Clearly, the PPNNE is affected by increasing costs and declining utilization. They have made some reductions in clinical staff and have also shifted to generic drugs. In addition PPNNE now maintains a smaller pharmaceutical supply than in the past. Cost saving measures being considered include consolidation of smaller clinical sites. This will result in moving a site that is currently in New Hampshire to Vermont. This move will have added significance because the site provides abortion services collocated with Title X, a situation that has not existed in Vermont where abortion services have, to date, been provided in non-Title X sites. These changes were announced slightly after the submission of the currently funded application.

In the application, PPNNE described plans to further implement their electronic practice management system and to begin implementation of an electronic health record (EMR). They also plan to continue their work of translating materials, although at this point, the Vermont centers see no LEP clients, suggesting that this work will be of more benefit to the agency's health Centers in Maine and New Hampshire, which also receive Title X funds. The program goals also include increasing STD/HIV offerings, refinement of adolescent protocols and strengthening parental involvement for adolescent users. PPNNE also plans to use outreach strategies to maintain teen utilization. They hope to increase fee revenue but have not outlined any specific activities. VDH and PPNNE are cautioned to assure that fees are not a barrier to care.

Since the last Title X Review, the long term PPNNE President/CEO, Nancy Mosher, who had worked in various roles at the agency before becoming CEO, retired. Immediately prior to the review, the new President/CEO, Steve Trombley began work. He is new to PPNNE, but has held a number of positions in Planned Parenthood affiliates in other parts of the country. Mr. Trombley's arrival will likely bring about significant changes in the organization. Another significant staff change was the retirement of the Quality Assurance Director who has been replaced by a qualified NP who has a long history with the organization and significant institutional knowledge.

This review was guided by the Title X Program Review Tool (7/2009) and the report follows the outline of the tool. Members of the review team consulted a variety of documents, interviewed staff and observed clinical care at the clinical sites. The review found the Vermont Department of Health to be in general compliance with Title X law, regulations and guidelines. This report contains ten (10) findings which indicate areas where VDH must take action to come into full compliance with Title X. Most significant are monitoring of PPNNE by VDH and compliance with 340B regulations. For each finding, a corrective action plan is proposed. These recommended remedial actions reflect the opinions of the reviewers on how the grantee can come into closer compliance with Title X. The grantee may have other mechanisms to come into compliance. In any case, the grantee must respond within 90 days of receipt of this report with a remedial action plan addressing each of the findings. If actions have already been taken when the plan is submitted, appropriate documentation should be included. Where actions have not been taken, the plan should clearly outline actions to be taken and indicate clearly when the required actions will be completed. Where findings relate to the delegate, it is the responsibility of the grantee to assure that the delegate takes appropriate remedial action. In addition to the findings, the report contains a number of recommendations. These recommendations are provided by the consultants in an effort to provide helpful suggestions to the grantee for improving practice. The Regional Office welcomes grantee response to all of these recommendations, but response to recommendations is **required** only if this is explicitly noted in the report. A response is required where the recommendation is such that a failure to take some action could result in a finding in the future.

General Findings

VDH and PPNNE have a very cordial and collaborative relationship, which is an asset to the program. However, as the grantee, the VDH is responsible for formal oversight of the activities of its delegate agency. During this review, the extent and thoroughness of this monitoring was found to be limited and, because this effects all aspects of the grantee/delegate relationship and of the operation of the program, it is cited here as a general finding. It appears likely that the limits in monitoring activities are related to the small amount of funding VDH takes from the grant and the subsequent limitations on staff available to carry out these activities. It would be difficult if not impossible for one staff person, whose time is only partially dedicated to the Title X program, to carry out all of the needed monitoring. Each of the other two programs in Region I where the state is the grantee have at least 2 FTE staff dedicated to the program.

This said, monitoring is not completely lacking. Given the staff limitations, there is significant contact between the grantee and delegate. The VDH Family Planning Manager meets monthly with the PPNNE Grants specialist and VDH requires reporting from PPNNE on grant goals. A review of the minutes of the meetings and discussions between VDH and PPNNE indicate that the primary focus of these sessions is on collaborative activities and general operational business. In addition, the record of the meetings does not provide detail of the discussion or of actions taken, but rather is a listing of topics discussed. There does not appear to be any systematic review of grantee quality assurance results, fiscal operations

or clinical operations. A number of examples of places where more oversight is needed include:

- VDH monitors fiscal operations of the sub recipient via desk audit of PPNNE's A-133 audit. The Grantee reports a lack of staff to provide on-site monitoring. Based on internal audit practices the sub recipient is considered low risk. However, it is not clear that essential oversight is provided by the Grantee. For instance, there is no process for having the sub recipient submit any valid back up material to support the vouchers submitted for payment.
- There appears to be no on site monitoring of PPNNE's activities and VDH does not review Quality Assurance Reports from the delegate nor do they require quality audits specifically to consider issues of importance to Title X.
- It does not appear that either the grantee or the delegate has a system for regular validation of the data submitted for FPAR.
- PPNNE's clinical protocols, chart templates and handouts have not been reviewed and signed off on by the VDH Medical Director. This was a finding in the previous review and has not yet been remedied. It appears that the contact between the VDH Medical Director and the PPNNE Medical Director with regard to Title X requirements is quite limited. This may be a result of staffing challenges at VDH, but it must be addressed.

Finding #1 (Overall) VDH is not adequately carrying out monitoring responsibilities. Title X Guidelines state "…the grantee is responsibly for the quality, cost, accessibility, reporting and performance of grant-funded activities provided by delegate/contract agencies and the performance of grant funded activities provide by delegate/contract agencies." (Title X Guidelines: Section 1.6; 45 CFR Part 92, Subpart C, Sections 92.40-44, OMB A-133-400(d))

Recommended Remedial Action Finding #1 VDH must present, as part of its response to this review, a concrete plan for monitoring all aspects of the operations of the grantee. The plan should include review of administrative systems, fiscal performance, and clinical performance. This plan should include a method for validating requested payments by the sub recipient, a sign off on clinical protocols by the VDH medical director and some plan for reviewing other operational issues including data collections, clinical care, materials review.

Administrative

The intent of the administrative section of the review is to assure that the grantee and delegate have administrative systems and processes consistent with Title X and other federal grant requirements.

Both Vermont DPH and PPNNE have mature administrative systems that are generally working in accordance with Title X regulations. Contracts are in place for services, facilities are well maintained and attractive. As noted above, there are concerns about monitoring of PPNNE by VDH.

A. Voluntary Participation

The Grantee fully complies with the required elements in this section.

B. Confidentiality

Observations during this visit indicated that the VDH and PPNNE were in full compliance with the requirements of this section. The consultant noted that PPNNE's sensitivity to privacy issues and to the provisions of the Privacy Act and the fact that the front desk patient care staff was well trained and highly skilled made it clear that ensuring patient confidentiality was a priority throughout the organization.

C. Conflict of Interest

As a state health department, VDH has appropriate provisions to prevent conflict of interest and
PPNNE has a thorough conflict of interest statement for board and staff.

D. Insurance Coverage

PPNNE has appropriate and adequate insurance coverage for medical malpractice, general liability, fire and disaster, employee dishonesty and officers and directors liability. Their insurance is through the Planned Parenthood Federation of America.

E. Human Subjects Clearance (Research)

Neither the VDH nor PPNNE conducts research involving Title X clients. Should they plan any such research activities, PPNNE is aware of their responsibility to use proper research protocols validated by an Institutional Review Board and to inform the Regional Office in writing.

F. Prohibition of Abortion

As far as could be observed at this visit, PPNNE is operating in compliance with section 1008 prohibiting abortion as a method of family planning. Since none of the sites reviewed perform abortion, meeting this requirement in the context of the review tool was unambiguous. However during the review, PPNNE disclosed its intent to move a site which is currently in New Hampshire and which performs abortions to Vermont. In addition, PPNNE provides abortions at non Title X sites in Vermont.

Administrative Recommendation #1 Vermont Department of Health should add a stand alone provision to its family planning services contract that states that the delegate agency must operate in compliance with the Title X statue, Section 1008.

Title X clearly prohibits funding of any program that uses abortion as a method of family planning. To the extent that abortion services are provided in the same site as Title X funded services, diligence must be exercised to assure that there is adequate separation of these services. (Title X Statute, Section 1008; 42 CFR 59.5 (a) (5); Title

X Guidelines, Section 3.30; Federal Register / Vol. 65, No. 128 / Monday, July 3, 2000 / Notices)

Administrative Recommendation #2 – **Response Required** Since PPNNE plans to move its West Lebanon New Hampshire operations to Vermont, and because this facility will provide abortion as well as Title X services, prior to the move, the Department of Health must secure a copy of PPNNE's policy for the separation of abortion services from Title X and review it for compliance. In addition VDH must send a copy of the separation policy to the Regional Office.

G. Structure of the Grantee/Sub-recipient

VDH has a signed annual contract for its grant award with PPNNE which outlines the Title X programmatic and fiscal requirements. Unlike the 2008 and 2009 contracts, the 2010 contract referenced the appropriate CFR Subparts. However, the current contract does not reference the Title X Guidelines, Section 6.1. Any subcontract initiated by the sub-recipient must be approved by the Grantee. Although, the contract with PPNNE is adequate, it could be expanded and more explanatory.

The Grantee uses the policy and procedure manual prepared by PPNNE, the delegate agency. PPNNE provides all clinical services and, as long as they are in full compliance with Title X requirements, the clinical guidelines could be adopted by VDH. However, VDH should have a its own manual that includes at minimum the Title X Guidelines, and Program Instructions, the FPAR instructions, and the current Title X Priorities, Key Issues and Legislative Manuals as well as the contract with PPNNE, and a description of the reporting and monitoring mechanisms that are used by the state to assure conformance to the applicable standards by PPNNE. The development of this manual should be part of the plan developed in response to this report.

Administrative Recommendation #3 The grantee should restructure its contract with PPNNE to provide more specificity and detail regarding expectations for the grantee, including the expectation of active monitoring by the grantee. The review team recommends the New Hampshire Department of Health and Human Service as a model. This document has been favorably reviewed and including similar content would significantly enhance VDH's contract.

H. Governance

PPNNE's by-laws fully meet IRS requirements for nonprofit organizations and documentation of this status is on file. The Board of Director's minutes were reviewed for the 2009/10 time period. They are well written, thorough and convey a clear sense of the deliberations. The major issue the board was dealing with during this period, besides finances, was hiring a new CEO to replace a long tenured CEO. The new CEO, Steve Trombley, was hired shortly prior to this review and he was on hand for relevant discussions. Mr. Trombley has a long history of work with Planned Parenthood affiliates.

In summary, PPNNE has a sophisticated governance system that readily meets requirements for a legal entity with not-for-profit status. The following recommendation suggests a revision to the PPNNE by-laws.

Administrative Recommendation #4 The committee that handles the nomination of board members should be elected by the Board and not appointed which is the current procedure. Election of the nominating committee is a common practice and facilitates keeping the process objective.

I. Planning and Evaluation

Both VDH and PPNNE comply with the requirements in this section. VDH has a planning process for the Maternal and Child Health Block Grant that includes a number of goals that are related to family planning. PPNNE has conducted research focusing on the preferences and tendencies of generation Y (18-30 years olds) and generation X (30-40 year olds) individuals. The insights they gain from this process will be applied to the delivery of their services. The end result will be, they hope, a clinical network that will be in sync with the wants and wishes of this age group and, in turn, assure the future of their agency. One result of this research is a series of pamphlets entitled "Good Chemistry" which deal with topics such as secondhand smoke, pesticides and cleaning products. This environmentally focused initiative is meant to appeal to both generation Y and X individuals. The initial client response has been favorable but any affect this has on either client recruitment or retention has yet to be determined.

J. Facilities and Accessibility of Services

The review included visits to PPNNE sites in Bennington and St. Albans. Both sites are well maintained and appear inviting to patients. The facilities are accessible to those with mobility handicaps and have some evening hours. Despite the fact that few non-English speakers are seen, each site has written policies for persons with Limited English Proficiency. They have written fire and emergency plans and document the fire and disaster drills. All exits appeared to be free from barriers. The review team has three recommendations regarding the facilities.

Administrative Recommendation #5 The Bennington site should have electrified exit signs as opposed to card board signs because they cannot be seen in a heavy black smoke environment. Also, an additional exit sign pointing to the front door should be placed in the hallway outside the waiting room.

Administrative Recommendation #6 The Safety and Security Protocol manual calls for bi-annual fire and disaster drills. This should be changed to annual drills which would reflect the current practice.

Administrative Recommendation #7 To assure that clients are aware of the availability of discounts, a sign should be placed in front desk area at each site stating that the fees are based on the patient's ability to pay.

K. Personnel

The Grantee meets the requirements related to personnel with the exception that written performance evaluations were delayed for some staff both at the grantee and the delegate. The most recent evaluation completed for the VDH Family Planning Coordinator was in 2006, largely because of staff turnover and vacancies at the VDH. The PPNNE Site Manager in Bennington had not been formally reviewed since 2007, which was also largely related to turnover. Both VDH and PPNNE have formal grievance mechanisms.

> Administrative Recommendation # 8 It is generally good practice to have some form of written personnel reviews on an annual basis and this practice seems to be generally followed at PPNNE and VDH. Therefore, both organizations should complete the reviews that are overdue. In addition a system should be set up to assure that subsequent evaluations are completed on a timely basis consistent with applicable personnel policies.

While the diversity of the staff is limited, this is reflective of the population in Vermont which is reported at only 2 % non-white residents. PPNNE and VDH should both keep pay close attention to changes in the demographics of the state. If the diverse populations currently resident in Massachusetts and New Hampshire move to Vermont in significant numbers, changes in staffing may be needed.

.

The Grantee and the Sub-recipient have organizational charts which clearly define lines of authority. All have written job descriptions and personnel records are kept confidential. PPNNE has a system to ensure that professional licenses are current.

L. Training and Technical Assistance

The review team found the Vermont Title X project to be in compliance with training requirements. PPNNE has a continuing education and evaluation program carried out by a separate department within the agency. VDH offers a number of in- service training opportunities but it is up to each employee whether or not to attend the sessions. PPNNE puts a lot of emphasis on staff orientation and training for the first four months (with the option of extending this to 6 months) of employment. Those that do not successfully complete the first 4 to 6 months of employment are terminated. The idea is to not extend the employment of those individuals that are not doing well in the orientation period. The agency believes that this early intervention approach saves them a lot of subsequent employee problems.

During the visit, the RPC discussed the fact that in Vermont, PPNNE has been active with the Regional Training Center's process to choose training and technical assistance. VDH has not been as actively involved and in some cases, it appears that the trainings that PPNNE chose were more relevant to their system overall than to the Vermont situation in particular.

Administrative Recommendation #9 The Vermont Department of Health should be actively involved in choosing training supported by the RTC and should formally approve all training choices so that the training that is chosen meets the needs of the Vermont program.

L. Reporting Requirements

The Vermont Title X project generally complies with Title X reporting requirements. PPNNE has policies for mandated reporting of child abuse, child molestation, sexual abuse, rape or incest. They also have written Information System policies to maintain and secure records in both electronic and hard copy formats. PPNNE submits service data to the Region I family planning data system and uses reports from the system to prepare the Family Planning Annual Report (FPAR). PPNNE appears to be capturing and validating appropriate patient visit data with one exception. PPNNE staff routinely uses a system for dealing with clients who do not report income that puts both Medicaid and private insurance clients at the top of the fee scale, i.e. 250%. This results in inaccurate reporting of client income which is a required element of the FPAR. Additional concerns were noted during the data validation check including the fact that provider type is reported incorrectly in cases where an HCA provides services at the visit. PPNNE explained that all visits default to the clinical provider in their data system because the clinician has final responsibility and is the billable entity. Service delivery by an HCA is relatively infrequent in the PPNNE system, but nonetheless, PPNNE should make an attempt to capture this data since it is reportable in FPAR. In addition, the system for capturing race/ethnicity does not always include a self report, but rather appears to be based on assessment or assumptions made by intake staff. In 6 of 15 charts reviewed there was no entry to validate the ethnicity reported on the family planning encounter record.

Finding # 2 (Administrative) Neither VDH nor PPNNE is adequately validating the data which is submitted for the FPAR report regarding client income. In addition, the system for capturing race/ethnicity does not always include a self report, but rather appears to be based on assessment or assumptions made by intake staff. Finally, services delivered by health care assistants (HCAs) were not accurately attributed. (45 CFR, 74:51; Title X Guidelines: Section 6.7. FPAR Forms and Instructions)

Recommended Remedial Action Finding # 2 PPNNE should discontinue using code 9999 to record income for Medicaid and private insurance clients and devise an alternative system that will accurately place these clients in the appropriate FPAR income category. In addition, training and support should be offered to staff at PPNNE sites regarding appropriate systems of collecting race/ethnicity data and an effort should be made to accurately capture the situations where HCAs are the service provider for a visit. Once changes have been made, the VDH or PPNNE should conduct data consistency audits to assure that the problems identified have been rectified.

M. Publications

Neither VDH nor PPNNE currently uses any Title X grant funds for publications. The VDH Family Planning Coordinator is a member of the PPNNE materials review committee.

O. Federal Assurances

VDH has signed appropriate Title X Assurances as a part of the most recent grant application. Assurances prohibiting discrimination based on race, color, national origin, handicap, age and gender are part of the 2009 contract between VDH and PPNNE and are on file at the Grantee office. The contract gives the VDH appropriate access to records and documents related to the Title X program.

Fiscal

The purpose of the financial review is to assess whether the Grantee has an appropriate financial management system that includes budgetary control procedures, accounting systems and reports, charges, billing and collection procedures, purchasing procedures and property management, and compliance with Federal laws and regulations noted in the application assurances, including standards set forth in Subpart C of 45 CFR Part 74 and Subpart C of 45 CFR Part 92 as well as any requirements noted in the Notice of Grant Award (NGA).

The following report provides a narrative of the findings of the fiscal review for this Title X Grantee. The report is based on observations made at the Grantee's central office and at one (1) delegate agency sites. The review team identified the following strengths:

- Staff at the VDH and PPNNE show commitment to the project and are knowledgeable about the family planning needs in the state.
- The grantee has established a methodology to submit their Cost Allocation Plan on a quarterly basis.
- The delegate has established an excellent cost analysis methodology that should provide accurate information.
- There are excellent internal controls for fiscal activities in place at both the Grantee and Delegate.

Areas where improvement is either required to meet Title X standards or recommended to strengthen the program are listed below.

1. Budgetary Controls

The State of Vermont has established excellent controls to insure that PPNNE meets accepted standards and procedures. Both the VDH and PPNNE maintain separate budgets for Title X funds. The reviewers found no evidence that clients are denied services or subjected to variation in quality of services because of the inability to pay. Accounting systems and reports are consistent with Title X and other federal requirements. The Grantee and sub recipient monitor the approved Title X budget expenditures.

Neither the VDH nor the sub recipient has an approved indirect cost rate. A review of the state cost allocation plan methodology confirms that the included costs are appropriate. The cost allocation plan is updated on a quarterly basis. PPLM also uses a cost allocation plan for the distribution of administrative costs. This is based on the percent of salary paid by each program and meets the requirements for Title X. The Grantee has instituted an appropriate methodology to track and report time and effort that complies with the standards establish in 2 CFR 225 App. B. 8 h (6). The sub recipient has a system to track and report time and effort that complies with the standards established in 2 CFR 230 App. B. 8 m.

Both the grantee and the delegate include "advertising" as a line item on their budget and expense reports. In addition, the delegate uses a "miscellaneous" category on their budget. It is important to note that advertising costs are, generally, an unallowable expense. There are certain exceptions to this when the advertising is solely for: 1) the recruitment of personnel required for the performance by the organization of obligations arising under a sponsored award; 2) The procurement of goods and services for the performance of a sponsored award; 3) The disposal of scrap or surplus materials acquired in the performance of a sponsored award (with a limited exception); 4) Other specific purposes necessary to meet the requirements of the sponsored award. Grantee activities appear to meet these exceptions, but this is not fully clear with the delegate.

In most instances, the program is involved in public and community relations activities dedicated to maintaining the image of the organization or maintaining or promoting understanding and favorable relations with the community or public at large. As long as the public relations costs are specifically required by the sponsored programs (as is the case with Title X) or are related to the promotion of sponsored programs(also the case with Title X) , any reasonable advertising media, including magazines, newspapers, radio, television, direct mail, exhibits, and the like, can be used and its costs are allowable.

As a budget category, miscellaneous does not meet the requirements for insuring expenditures are reasonable or allowable. The program should identify all costs and cost centers to insure the funds expended are reasonable, allocable, and allowable to the Title X program.

Finding # 3 Fiscal The delegate budget and expenditure reports include an advertising line item that appears to describe an unallowable expense. (45 CFR 74.21 (6); 2CFR 230 – Appendix B (paragraph 1)**)**

Recommended Remedial Action #3 At least for VDH, the actual expenses incurred are probably allowable, but the way in which they are reported is not. In their next budgets, both the grantee and the delegate should identify their activities that are for "program promotion" and insure funds that are expended in these activities are allowable. They should also identify the proposed expenditures in the "miscellaneous" budget category and assign them to appropriate cost centers.

2. Accounting Systems and Reports

VDH and PPNNE have internal controls that meet Federal and Title X requirements. As noted above, the grantee has not established an onsite review at the sub recipient to insure their compliance with these requirements. Both VDH and PPNNE have clear separation of duties and systems are in place at both agencies that allow for proper review and reconciliation of grant funds. Draw downs from the Payment Management System (PMS) are consistent with Federal Guidelines.

PPNNE has a fiscal policy and procedure manual and most of the established policies meet the applicable requirements. The manual lacks a section on procedures for determining reasonableness, allocability and allowability of costs in accordance with Federal cost principles. These written policies are required under Federal cost principles outlined in 45 CFR 74.21 (b) (6) as follows: "Recipients' financial management systems shall provide for ... Written procedures for determining the reasonableness, allocability and allowability of costs in accordance with the provisions of the applicable Federal cost principles and the terms and conditions of the award." Definitions for these terms may be found in *2 CFR 230 App .A, Section A, (2), (3), and (4).*

Finding #4 (Fiscal) PPNNE's accounting manual does not include a section on the procedures for determining reasonableness, allocability and allowablility of costs in accordance with Federal cost principles. (Ref: 45 CFR 74.21 (b) (6))

Recommended Remedial Action #4 As a part of the action plan required in response to this report, VDH must provide to the Regional Office a copy of the sub recipient's fiscal policy and procedure regarding the determination of reasonableness, malleability, and allow ability consistent with Federal Guidelines.

A review at two (2) separate clinic sites indicates a lack of control over cash receipts at the checkout point. Staff is allowed to change the amount of the billing calculated by the computer by over-riding the final amount. This is done at times to provide a courtesy discount. However, there do not appear to be guidelines as to when this discount is or should be provided and how much it should be. Changes can be made by any staff without supervisor approval. This appears to create the potential for malfeasance by the individual collecting a higher amount from the client and then posting a lower amount (as a courtesy discount) after the client is gone. A review indicates that approximately twenty five percent (25%) of client receipts are cash which suggests that this rises to the level of materiality.

Finding #5 (Fiscal) Responsibilities for physical security/custody of assets is not adequately separated from record keeping/accounting for those assets and unauthorized access to assets and accounting records is not fully prevented. (Ref: 45 CFR 92.20; Accepted Internal Control Procedures)

Recommended Remedial Action Finding #5 As a part of the action plan in response to this report, VDH must provide to the Regional Office the sub recipient's plan to ameliorate this problem. Plans should assure that changes are made within 90 days.

The Financial Status Report (SF-269) has been submitted on time. However, the information being reported is not in compliance with OGM guidelines and requirements. The fiscal consultant provided the grantee with technical assistance regarding the proper reporting on: line "g," program income used in cost sharing alternative; line "h," all other recipient outlays; line "q," disbursed income on lines "c" and "g"; line "r," disbursed income using the addition alternative; and the "remarks" section.

Fiscal Recommendation #1 The Grantee should establish a process to instruct new staff on how to report accurately on the Federal Reporting forms (both the SF-269 and the new Federal Financial Report (FFR) – SF-425).

3. Charges, Billing, and Collection Procedures

PPNNE has policies and procedures in place for billing and collecting client fees and has established a framework for cost analysis that allows them to establish fees for services based on the "reasonable cost" of providing those services. A review of all the schedule of discounts (SOD) indicates appropriate proportionality and sufficient steps. However, in trying to tie the fees to the SOD it was discovered that the percentage breaks for the fees did not correspond to the percentage breaks on the SOD. Discussion with PPNNE indicated that the discounted amounts were not calculated from the "full fee" (level 35) but from a separate amount not on the fee table but calculated as the "reasonable cost" of providing the service. The full fee should reflect the reasonable cost of providing services and the calculation of discounted fees should be transparent.

A review of the fee schedule at the sub recipient reveals that some Title X services are not discounted in accordance with the SOD. Some lab fees that may be required in the provision of certain contraceptives are not identified as such on the fee schedule. It is imperative that any test associated with the provision of a Title X service be discounted in accordance with the SOD.

Finding #6Fiscal) The application of the schedule of discounts to established fees is not implemented in full accordance with Title X expectations and in some cases Title X clients with incomes below 100% FPL are being charged for services required in providing required family planning care (42 CFR 59.5 (a) (8); Title X Guidelines: Section 6.3)

Recommended Remedial Action Finding # 6 The grantee must obtain an updated fee schedule from the sub recipient that meets the discount requirements and clearly show that labs required for contraceptive management are appropriate discounted and forward it to the Regional Office along as part of its action plan in response to this report.

Most billing and collection procedures meet the intent of Title X and insure the sub recipient is maximizing the use of Title X funds. The sub recipient has entered into a number of contracts with third party payers.

Fees for clinical services and laboratory services at the sub recipient have been established via a cost analysis. However, the pharmaceutical fees have not been the subject of the same kind of analysis. The price of pharmaceuticals at level 35 is quite high. The sub recipient would have a difficult time justifying these prices as the "reasonable cost" of providing these services, especially when 340B prices are taken into consideration. This in turn leads to fees at level 32 (20% of full fee) that are still much higher than the cost paid by the agency. The cost of a single pack of pills at this (20%) level is at least twelve dollars ($12). This raises the question if the program "ensures that the inability to pay is not a barrier to the receipt of services."

> Fiscal Recommendation #2 The Grantee should work with the sub recipient to insure the cost of pharmaceuticals is reduced to a level that is support by a cost analysis and creates a pricing structure that allows those at the low end of the SOD an ability to obtain services.

4. Procurement /Inventory Control/Property Management

While in general, procurement inventory and property management systems were adequate, questions arose during review of the use of the 340 B program by PPNNE. In trying to insure that 340B supplies purchased under the Title X program are provided only to Title X clients, the reviewer requested the CFO and the Director of Finance to provide copies of purchase orders and distribution logs of 340B supplies. The staff at the sub recipient was reluctant to immediately provide documentation regarding those purchases and requested that the reviewer wait for one day to speak directly to the CEO regarding the use and purchase of 340B supplies. In subsequent discussion the CEO indicated that PPNNE believes that providing contraceptive methods to clients under their Section 318 agreement is consistent with the scope of work of that agreement. He discussed their role as a "covered entity" and the definition of a "patient" within the context of the "covered entity." They further stated that they felt CDC would approve of the purchase of contraceptive methods as part of their scope of work for the STD program. The RPC and fiscal consultant disagreed with this interpretation and the RPC agreed to investigate further. This further review lead to the conclusion that PPNNE's purchase of contraceptives is outside the scope of the STD Section 318 certification for 340B. The National Family Planning and Reproductive Health Association (NFPRHA) worked with the Office of Pharmacy Affairs (HRSA) and published a document in February 2008 (The 340b Drug Pricing Program: *What Family Planning Clinics Need To Know)*. This document states: "Under the current "patient" definition, clinics may provide 340B-purchased drugs to patients of the Title X grant project, and the types of drugs purchased should be consistent with the scope of the grant project. Family planning clinics have typically considered their patients to be women who receive "a range of

services," meaning the provision of what the World Health Organization has called "dual protection" for their patients: an integrated package of sexually transmitted infection (STI) prevention services and family planning services that is consistent with the services for which grant funding was made available under Title X. **Entities eligible for the 340B program only via their Section 318 funding should only purchase STI-related drugs – contraception is not generally considered to be consistent with the scope of the grant**."(Emphasis added). This document goes on to state, "Dispensing 340B-purchased drugs to individuals not defined in the section above could be considered illegal "drug diversion." In addition, **purchasing drugs through the 340B Program that are to be used for services outside of the scope of the grant project also could fall within the definition of "drug diversion."** A "covered entity" found to be diverting drugs could be required by Pharmacy Affairs to pay back all discounts to the manufacturer and could lose its eligibility to participate in the 340B Program." (Emphasis added).

The Title X program nationally has worked over the years with the Office of Pharmacy Affairs, the division of the Health Services Resource Administration (HRSA) which is responsible for the 340B program to assure appropriate access to discounted prices for Title X programs. Only Title X Programs and other programs that explicitly include the provision of contraception as part of their official scope of work (e.g. Federally Qualified Community Health Centers) are eligible to purchase contraception under the 340B program.

Finding #7 (Fiscal) Grantee does not have adequate safeguards for assuring that supplies purchased through the Federal Drug Pricing Program (340B) are provided only to clients served in the Title X project. **(Veterans Health Care Act of 1992)**

Recommended Remedial Action #7 Assurance that the provisions of the Veterans Health Care Act are being followed could be considered outside of the scope of the Title X program except as it applies to Title X service sites. However, the identification of improper use of 340 B discounts by entities funded under Title X, even if the 340B medications are being improperly purchased by a site within the grantee's network that is not a certified Title X site, is an area of great concern. This is because the practice could create a threat to overall Title X access to the program. Therefore, the VDH must immediately notify the sub recipient that they are participating in the unauthorized diversion of 340B medications. The Grantee should also meet with the State of Vermont STD program to review the 340 B program rules with regard to purchasing under Section 318. If VDH cannot provide a signed statement from PPNNE describing corrective action in this matter as a part of the action plan submitted within 90 days of this report, the Title X Program will notify the HRSA Office of Pharmacy Affairs about the concern identified in this visit.

Information and Education Review and Community Involvement

This section of the review considers the degree to which the grantee/delegate(s) are taking steps to assure that key communities are aware of and able to provide input to the Title X

project. In addition, it evaluates compliance with Title X requirements for review of educational materials.

A. Information and Educational (I& E) Materials

VDH delegates the responsibility for I& E review to PPNNE. This is an appropriate delegation, and VDH monitors the I & E process to some extent because the VDH staffer responsible for the family planning program serves on the I&E Committee. PPNNE has an appropriate review committee and provided a list of materials that had been reviewed. In the on site review, it appeared that most pamphlets, etc. in general use were on the list. However, clinical information sheets, which are given to clients during their visits, did not appear on the list and appear not to have been reviewed. The material review requirements, which are included in the Title X statute and further explained in the regulations and guidelines, require review of all educational and informational materials.

Finding #8 (Community Participation, Education and Promotion) VDH is not in compliance with Title X requirements for review of educational materials. (Title X Statute, Section 1006 (d), 42CFR 59.6; Title X Guidelines: Section 6.8)

Recommended Remedial Action – Finding #8 VDH needs to work with PPNNE to assure that all materials are reviewed, including the clinical handouts. This could likely be accomplished simply by creating a packet of clinical materials with a checklist of its contents and sending it to the I & E Committee as one review item.

The list that PPNNE keeps of reviewed materials is in alphabetic order and includes the title and publisher of each item. The list does not, however, show the publication dates of the items nor did it note the date of the I&E review. This creates a risk that materials that are out of date could go unnoticed. PPNNE should have a policy for periodic re-review of all materials to assure that they are still timely and relevant to the audiences. In addition, either the staff member responsible for the list or the committee should scan the list at least annually to look for items that may be out of date, even if these items are not yet scheduled for periodic reconsideration. Some examples where timely review is needed include times when guidelines or agency protocols change so that the information in a brochure or fact sheet is no longer accurate. In recent years, cancer screening guidelines and some guidance on method use (e.g. only women with a baby can use an IUD/IUS) has changed and older materials would not likely reflect these changes.

Recommendation # 1 (Community Participation, Education and Project Promotion**)** PPNNE can improve their materials review process by adding the publication date and review date to their reviewed materials list and by adding a policy for periodic review of materials on a cyclical basis to assure currency.

2. Community Education

PPNNE has a strategic plan for community education that has a primary focus on healthy sexuality. Among the initiatives that come under this umbrella are parent-child

communication and sexuality education for developmentally delayed individuals. Creative initiatives include home based parent education and the development of a manual for educators working with developmentally delayed individuals.

In addition, as a direct outgrowth of the research that PPNNE did on dealing with Gen X and Gen Y, a series of pamphlets were developed to be used in the waiting rooms of the clinics that focus on environmental health and safety including topics like, cosmetics, secondhand smoke, lead exposure, and toxins in foods. While these efforts are not funded by the Title X grant, they work to promote project services.

The current Title X grant work plan includes exploration of the racial, ethnic and linguistic diversity of service areas, as these users remain low even when compared with low state and regional population statistics. These efforts were not fully assessed in this review and need further follow up.

3. Project Promotion

Staff at the sites that were visited described efforts to reach out to key community partners. These efforts target schools, colleges and other agencies in the communities. In some cases, project promotion efforts could be enhanced. For example, at one of the sites, the staff had not been in contact with the community health center. Each site would probably benefit from a strategic outreach plan with specific, defined goals and targets.

In addition to their health center based outreach, PPNNE, with non-Title X funding, has developed a web based outreach strategy including the use of Facebook and Twitter, a dedicated website for the Good Chemistry campaign and other on line sites.

Clinical Management and Services

The clinical review considers the all aspects of care provided at the sites, including clinical, laboratory and pharmacy policies and procedures, medical oversight, medical documentation, referrals and follow up and the actual delivery of care to determine whether these practices are consistent with Title X and other relevant laws, regulations and guidelines.

The clinical review included review of policies and procedures at the grantee and delegate sites, interviews with clinical leaders, medical directors and others involved in clinical care, a review of charts at each of the sites and observation of client services at two (2) sites.

The clinical services delivery model at PPNNE is well established with experienced practitioners and full time physician direction and oversight. Health Care Assistant (HCA)'s who have been internally trained support healthcare providers and provide educational services as well as some front desk functions. Practitioner turnover is extremely low and currently there are no recruitment problems. HCA turnover is relatively high and PPNNE has responded to this by devoting significant resources to orientation and in-service training of these vital staff members. PPNNE has recently adopted open access scheduling and the

system seems to have decreased wait times and substantially reduced no show rates. Staff adjustment to the new system is good.

Longstanding Quality Improvement (QI) activities continue. The committee responsible for QI reports through the recently implemented Board/Administration Risk Management Committee. Clinician pre-service credentialing, orientation, mentoring, training and performance review continues with appropriate provision for positions subject to periodic clinical skills review. PPNNE and VDH staff are active participants in the Chlamydia Project, Regional Training and Clinical Advisory networks as well as a variety of relevant local and national professional organizations.

Clinical service sites reviewed were well prepared for our review. Documentation reviews, staff interviews and site and patient care observations were carried out as scheduled.

A. Client Services

PPNNE provides all expected Title X family planning clinical and patient education services at its service sites. The health centers are fully staffed and have some evening, but no Saturday hours. STI/HIV screening and treatment services are fully integrated. The addition of Colposcopy and the continuation of well-established full-time gynecological consultation and after-hours triage/consultation make this service very comprehensive. The grantee (VDH) and PPNNE collaborate on a number of screening and treatment initiatives – infertility prevention, STI/HIV services, breast and cervical cancer prevention, Well Woman Care, WIC and other nutrition programs; these initiatives and programs are administered through VDH district offices, extend FP clinical program offerings and are of great value and convenience to health center users.

Medical direction and oversight is provided full time by Cheryl Gibson MD, a superbly prepared long term staff member. Her responsibilities include a unique clinical consultation/mentoring and staff performance review program that is highly regarded by PPNNE practitioner staff and by the broader family planning community. Review and adoption of PPFA medical standards and protocols is a continuous process and is accomplished in collaboration with PPNNE Director of Quality Improvement. Face-to-face collaboration, review and written agreement on medical standards and policies by the grantee, VDH, has not occurred as planned.

PPNNE is exploring cost saving and efficient models of care. Staff interviewed (characteristic of all PPNNE staff), are well prepared and have both high experience levels and institutional memory. The reviewer observed close collaboration among practitioners and HCAs with sufficient time allocated for required patient education and counseling. HCA pre- and in-service trainings and day to day supervision has certainly paid off, as HCAs observed at sites reviewed are functioning at an exceptionally high level and expressed positive job satisfaction.

The two clinical facilities reviewed are accessible to service area users and are well maintained and located in rural and high need areas. The grantee has in place appropriate

communication procedures for persons with LEP and has some translated materials. Appropriate and well organized patient education materials were found on site. While well located, professional and well maintained, the St. Albans site is handicap accessible only on the first floor; a non clinical program office is staffed on the second floor.

On-site laboratory service is available for some moderate complexity and CLIA waived tests. All PPNNE outside lab work is now contracted through a single lab, with an up-to-date contract. Conventional and newer lab testing technologies are ordered. In March, 2009 when a PPNNE site was part of a New Hampshire program review, concerns arose about a two tiered system of offering some tests and methods. PPNNE has since offered assurances medical and lab standards and protocols will be consistent for all clients with sliding fee made available for liquid cervical cytology tests where appropriate. Reviewers found no evidence of a two-tiered system of care in patient records reviewed. All staff interviewed stated they have ample clinical resources on site and for needed referrals. Contraceptive supplies are available and distributed on site in sufficient amounts to meet patient needs.

PPNNE Health Clinical Guidelines are extensive, up-to-date and appropriately reviewed, signed and distributed among agency staff. The QA Manager, an experienced RN, manages clinical and program evaluation. Clinical Quality Improvement includes an appropriate committee structure, clinical policy development, formulary discussion and review, as well as occurrence reporting.

PPNNE has adjusted their formulary to include lower cost generic drugs; at this time all expected methods are available on a sliding fee basis, including the Mirena IUS. PPNNE staff report that an increasing number of clients express preference for IUD/IUSs and Nuva ring. Implanon will not be provided at this time. Medical oversight is available and PPNNE can provide colposcopy at the majority of sites with small sites providing inter- office referrals.

The only major concern in this section is related to the issue of oversight of the PPNNE program by the Vermont Department of Health.

Finding #9 (Clinical) PPNNE's clinical protocols have not been reviewed and signed off by the Medical Director of the grantee organization, Vermont Department of Health (Ref: Title X Guidelines Sections 6.5 and 7.1 and Office of Population Affairs (OPA), Program instruction Series, OPA 09-01). ***Please note that this finding was made in the previous review and has not yet been addressed.***

Recommended Remedial Action Finding #9 Prior to submitting a response to this review, VDH should assure that the medical director reviews and concurs in writing with the PPNNE clinical guidelines.

PPNNE clinical standards and protocols are extensive and have been competently prepared (some of the best this reviewer has seen) and should not pose a problem with

grantee approval. PPNNE is sensitive to the Title X clinical service program requirements.

Clinical Recommendation #1 As a part of VDH's oversight of the PPNNE Title X program, it is recommended that the VDH Medical Director and the PPNNE Medical Director meet semi-annually for program and medical policy discussion. This has been recommended in the past and the review team believes that it would be useful in assuring that VDH is well informed on the clinical operations at PPNNE. Minutes of these meetings should be taken and maintained and should be available for review by the Regional Office.

The reviewers found that several previously reported client service concerns have been resolved (e.g. variation in availability of liquid based paps and some IUDs based on ability to pay). The team commends PPNNE for making these changes that support THE key principle that Title X programs cannot discriminate in client service offerings on the basis of a patient's ability to pay. If a drug or devise is in the formulary or protocol and has been prescribed, it must be made available regardless of the patient's fee scale status.

B. Service Plan and Protocol and C. Procedural Outline

PPNNE's service plan is the grantee service plan. The current plan while not extensive, follows Title X priorities. There is good understanding of Title X program requirements and appreciation of and use of state and national health care standards (CDC, ACS, ASCCP). Careful attention has been given to melding PPFA and Title X program requirements.

Two areas of practice require clarification or changes in protocol for full Title X compliance. The first involves women who present for contraceptive services. In many cases (some teens, HOPE, Well Women Care) charts show no plans for comprehensive health exams. In view of the fact that many clients do not have other clinical care, Title X guidelines call for an extensive history and a physical exam including height and weight, examination of the thyroid, heart, lungs extremities, breasts, abdomen, pelvis and rectum. Excellent and extensive family and personal health and social histories ARE documented and cervical cancer screening protocols are current. Documentation of education and counseling received is vastly greater than often found in Title X programs. Health Maintenance screening and management protocols appear to generally follow nationally accepted standards. It appears, however, that routinely deferring or omitting exams is the normal practice at sites reviewed. Protocols include language that Title X requirements may differ from PPNNE and that exams may be required

Current Title X Program Instructions (OPA 09-01) call for the use of nationally accepted protocols and this will generally support deferral of the pap, pelvic and breast exam for women. PPNNE has up to date protocols for breast, colon and cervical cancer screening that follow acceptable schedules as well as prompts and evidence of counseling, referrals and follow up. The rapidly changing national clinical recommendations for cancer screening have created some confusion with regard to exams, but there is no reason to

abandon the general elements of the exam. In addition, clients should be educated about cancer screening schedules the offer of the exam should be noted in the medical chart.

It appears that male users who present for STI screening are being counted as Title X users, but their records do not document the offer of a general exam. This is especially true regarding physical assessments beyond genital/urinary screening exams. In addition, reviewers found minimal documentation of contraceptive education and counseling in male patient records reviewed. Some attention to family planning should be included in medical chart documentation of all clients counted as Title X users.

Finding # 10 (Clinical) PPNNE charts do not clearly document the offer of general exams for many clients and often fail to document contraceptive counseling for male patients who present for STI screening and are reported as Title X Clients. (Ref: Title X Guidelines 8.3).

Recommended Remedial Action Finding # 10 VDH should work with PPNNE to clarify the Title X Guidelines with regard to physical assessment of males and females. During the review, the clinical consultant proposed the following system. "Practitioners should document a plan for initiating or completing physical exams in the patient medical record that specifies a time frame for completing the work." Prompts are already in place under "Assessment" and "Plan" in the current (5/09) Female Physical Exam format. PPNNE should also consider adding an electronic reminder /prompt generated through the current practice management system (Vision) that will track and remind practitioners of the plan.

PPNNE has a chart prompt to track the amount of time spent in education and counseling as a percentage of total practitioner time. This data, collected consistently, could be valuable in assessing changes in practice as exam time is in some cases replaced by education. If PPNNE conducts an analysis of this information, the Regional Office would appreciate being seeing the results.

The chart reviews included a few cases of older women (beyond reproductive age) being reported as Title X users. VDH and PPNNE are reminded that individuals may be counted as Title X users only if the content of the visit includes family planning services. Post menopausal women by definition are not Title X users. Although it is completely appropriate that PPNNE should provide care for these women, this care should be considered separate from the Title X program.

D. Emergencies

Written protocols for emergencies are current and inclusive of medical and other emergencies, disasters, violent behaviors, etc. Equipment and supplies are complete and maintained appropriately at the all sites reviewed. CPR and advanced training is provided and reviewed on an annual basis. PPNNE staffers at the site were familiar with their role in emergencies. PPNNE has medical emergency services through 24 hour on-call provider service. There are no findings or recommendations in this section of the review.

E. Referrals and Follow-up

PPNNE staff provides required clinical and patient education/counseling and basic laboratory tests on site. PPNNE contracts with referral labs. Recently the organization reviewed available laboratories and selected a single lab for referrals from all clinical sites; an up-to-date centrally executed contract is in place. The clinical reviewer observed quality improvement efforts to improve the timeliness of lab report review and documentation of follow-up plans. The fact that the clinical providers are experienced and have medical consultation available minimizes the number of outside gynecological referrals. Optimum inter-office and outside referral processes are in place that include consent, counseling and careful attention to follow-up and tracking. PPNNE expects to expand their electronic lab practice management tracking system to cover all labs and consults. Sufficient staff time has been allocated for follow-up with appropriate medical management responsibilities.

The agency obtains appropriate referral consents and documents excellent care plans and follow-up. Up-to-date referral resources lists are maintained at each site. The clinical consultant offers the following recommendations to strengthen laboratory systems.

Clinical Recommendation #2 In addition to cost provisions, referral lab contracts should include quality provisions such as volume, certifications/approvals/quality assurance mechanisms. In addition to the assessments the Medical Director has made in selecting the lab, PPNNE should include formal periodic review of referral contracts through their QI program that includes patient satisfaction.

Clinical Recommendation #3 PPNNE should continue the work they have already begun on improving referral and follow-up documentation. Copies of follow-up letters should be kept in patient records. Consults and records from outside sources should be separated in PPNNE patient records. Notes and plans should not be written on lab reports.

Clinical Recommendation #4 PPNNE is reminded that confidentiality and sliding fee provisions must be provided by labs billing directly to patients.

F. Required Services

General and method specific consent processes and formats are appropriate. Patient information materials including patient instruction sheets are well written, factually correct and up-to-date. Some translated materials are available and interpreter service is available. PPNNE currently has an initiative to review language needs. The clinical consultant observed complete counseling regarding required consents. The consultant discussed the importance of assuring voluntary consent from special needs students receiving services at the St. Albans site with Planned Parenthood staff.

PPNNE does not currently offer sterilization services.

Clinical Recommendation #5 VDH as grantee should review and approve method specific consents and patient information sheets. These materials were not included in the manual available for review at the VDH office. This is included in the overall findings about monitoring above.

G. Client Education and H. Counseling

Patient records that were reviewed included excellent documentation of patient education and counseling by HCA and practitioners. Patient care observed at the Bennington and St. Albans sites included complete education and counseling. In addition to basic reproductive health and contraception information and counseling, considerable preventive health information is included in client counseling. STI/HIV risk assessment, counseling, voluntary rapid HIV testing and universal Chlamydia screening of young women are noteworthy. Also of note is a recent environmental health provider training and development of educational materials. Parental involvement counseling and abuse prevention are covered as required. All patient record formats prompt inquiries re parental involvement for patients under 18 years old. Return schedules are appropriate and high return rates were noted. With the decrease in exam components practitioners expect to devote more time to counseling patients.

I. History, Physical Assessment and Lab Testing

Male and female medical histories are comprehensive, capturing all required elements with extensive family, gynecological and immunization histories. . There is excellent use of problem lists and health maintenance and immunization records regularly include documentation of review and updating. Prompts are utilized and formats revised and used, sometime with additional information, to capture Title X required items. The following items of documentation were discussed with PPNNE staff and are suggested to further complete medical histories.

Recommendation #6 Continue recent initiative to add allergy sticker alert to patient medical record cover; the alert should be used only when an allergy is identified. Allergy histories are documented consistently within the record.

Recommendation #7 Add Vitamin D intake to dietary/prevention history and influenzas to vaccination record history on initial and annual patient history formats.

Recommendation #8 PPNNE should consider adding HIV test to Health Maintenance list on Problem List format. Access to HIV testing following CDC standards has been greatly enhanced. All patients were offered testing during patient care observations, this review.

Recommendation #9 Add BP to DMPA Flow Chart. The clinical consultant reinforced the standard of obtaining BP at every clinical visit in discussions with PPNNE. At St. Albans, the consultant observed careful attention to BP measurement. A further suggestion is made for staff to review current BP screening criteria.

The content of comprehensive physical assessments follows Title X guidelines. The practice found reduces the number and periodicity of physical exams at PPNNE sites reviewed, and otherwise PPNNE is following manufacturer's requirements for contraceptive methods. PPNNE procedure is for full exams for males but allowing for targeted histories and limited exams for those presenting for STI/HIV screenings. Otherwise, all required health maintenance screenings are provided and appropriate national standards are followed. Revisit schedules are appropriate with high return rates noted.

Lab tests ordered and reported are appropriate in patient records reviewed and no missing reports were noted during the review. It was clear that providers were looking at all results was evident, however the clinical consultant observed a practice of writing notes on reports. This practice has been considered by PPNNE as part of their QI and a plan is in process for utilizing a stamp to document the dates lab results were received and reviewed. Follow up plans were appropriately documented in patient records reviewed. Careful attention is paid to patient notification and follow-up, with a number of paper and electronic systems in place.

Laboratory testing is readily available through on-site labs, certified for CLIA waived and moderate complexity testing. Lab procedure manuals are undergoing revision and were not reviewed. External quality controls are performed on pregnancy tests and Hemocue. Lab equipment maintenance contracts are in place and reviewers noted up-to-date maintenance. Staff proficiency in lab procedures including wet mount microscopy is reviewed. The array of testing available includes full STI screening and testing.

J. Fertility Regulation

Contraceptive methods provided are consistent with Title X expectations. Prospective EC prescription is standard. Condom use is encouraged and distribution is liberal. Sterilization services are not provided at this time.

K. Infertility Services

Level I and limited Level II infertility service is available on-site, otherwise by referral.

L. Pregnancy Diagnosis and Counseling

PPNNE provides pregnancy testing and counseling on same to one day scheduled basis and will accommodate a walk-in consistent with Title X regulations. Excellent protocols are in place as is inter-office medical consultation for early pregnancy issues. The clinical reviewer observed patient care and found well prepared practitioner staff, appropriate referrals and referral resource lists. Physical exam is not routine at the time of a pregnancy test. Sufficient local referral resources are available for prenatal care, adoption and abortion services Options counseling provided follows Title X requirements.

As noted elsewhere, PPNNE is spearheading an environmental health initiative with recent provider training and new patient education brochures. These materials can be seen as a part of reproductive life planning in that they advise clients on ways to avoid exposure to environmental toxins. The agency has had training on adoption counseling.

Because PPNNE is an abortion provider at their non-Title X supported sites, reviewers cautioned against any appearance of self-referral in patient education materials and noted that Title X prohibits direct referral, beyond the provision of a list of provider names.

M. Adolescent Services.

Open access scheduling has eliminated excessive wait times for teens along with other clients. Facilities visited are ideally located for access by teens. Approximately 30% of users are teens. PPNNE offers and documents expanded teen histories, risk based assessments and enhanced counseling going well beyond required Title X elements. Policies and documentation are excellent for support of parental involvement. The agency has identified referral resources that cater to teens. A review of grantee policy regarding assessment for and reporting of child/sexual abuse indicated a knowledgeable staff with appropriate reporting.

N. Identification of Estrogen-Exposed Offspring.

Histories for female and male for born between 1940 and 1971 show assessment of whether there was DES exposure before birth. Cervical cancer screening protocols add additional screening.

N. **Optional/Related Services**

Experienced clinical staff provides assessment and treatment for common, minor gynecological concerns and integrated STI/STD services on-site. Staff understands the state disease reporting requirements and STDs are reported and followed up in collaboration with the other state programs.

P. Special Counseling and Q. Genetic Information and Referral.

PPNNE has improved risk assessments and counseling throughout the clinical program, especially for teens. Providers identify areas where clients have behavioral risks and document risk reduction plans developed through counseling which is initiated on a wide variety of concerns. Documentation for follow up is especially complete and high compliance rates noted in patient records reviewed. Patients in need of genetic counseling are referred to resources at Dartmouth-Hitchcock and Fletcher Allen Hospitals.

R. Health Prevention/Disease Prevention

PPNNE has works in strong collaboration with VDH's preventive health programs and has used the health department's needs assessments in program development. PPNNE program staff members are very well versed regarding the health and education needs of service area populations. Many local programs are utilized for referral.

S. **Postpartum Care**.

PPNNE provides postpartum services, primarily contraceptive care, on site when it is requested. They make referrals to community resources and other VDH programs.

T. Equipment and Supplies

Both sites that the team visited on this review are attractive in appearance, are well maintained and supplied and have appropriate modern equipment. PPNNE staff are oriented to and updated on infection control policies that include OSHA BB Pathogen control.

Clinical Recommendation #10 PPNNE should consider securing sharps containers to the wall and should investigate the use of magnetic locks for supply cabinets and drawers. Computer or key punch locks for pharmacy closets would also help to ensure that these areas are always secured during the clinic day.

U. Pharmaceuticals.

PPNNE's formulary is very complete and exceeds Title X program requirements. Recent use of generic contraceptives appears acceptable to providers and patients. Providers interviewed stated they had an appropriate array of pharmaceuticals available to them. Based on a review of patient records and observations on site, it appears that patients are prescribed and receive adequate drugs and supplies, sliding fees are applied including to high cost IUS/Mirena. Some appropriate scripts are made, but it is clear that the practice at sites reviewed is to dispense adequate pharmaceutical supplies on-site.

An "Easy Scripts Plan" provides 90 day drug supplies by mail and is reported to be a popular option for patients. PPNNE dispensing procedures include using a computerized dispensing record that presently cannot be included in patient medical records. Site managers or practitioners can review an electronic listing or printout of drugs dispensed, but there is no documentation of drug supplies dispensed to the patient unless the provider queries the dispensing log on a computer that is not readily available. In the future it is expected that the proposed EMR will provide a computerized system for practitioner review. This is a best practice to assure the accuracy of dispensing.

Recommendation #11 Documentation of pharmaceuticals dispensed should be made in patient medical records. Providers should document drugs dispensed next to original prescription order or in a log in patient medical records. This issue should be considered, and can probably be resolved with the adoption of electronic medical

records, but PPNNE should keep it in mind and should have a resolution to assure that dispensing follows prescriptions for the interim.

V. Medical Records.

PPNNE has well organized medical records with appropriate maintenance and security. There were no problems with confidentiality observed at sites visited. General and specific consents are consistently signed and witnessed. Formats are perpetually updated and revised and are comprehensive in content. There is a high level of continuity of care and patient compliance with care plans documented in patient records reviewed. Formats designed for referral and tracking are numerous. Record release consent policies and formats are appropriate. (Section I above includes recommendations for allergy alerts and the addition of assessment items to chart formats.)

Recommendation #12 Social Security numbers must not be used in patient records. Currently, they appear on the data form and sliding fee application.

Recommendation #13 PPNNE should continue to work with staff on legibility issues. Some records at the St. Albans site were difficult to read.

W. Quality Improvement/Assurance

The longstanding and comprehensive quality improvement program at PPNNE is under the direction of a well qualified nurse director who works closely with the full time medical director, the QI committee and the Risk Management committee. All structural reviews, focused audits, clinical staff credentialing, orientation, mentoring, and training are coordinated and of high quality. PPNNE is commended for their careful attention to medical policies and protocols and for their recent QI initiatives including: further development and streamlining of the tracking and follow-up systems, research and preliminary credentialing for contracting with a new referral lab, review and proposed revision of on-site laboratory manual and updated approaches to patient access through marketing and scheduling, and improved adolescent services.

.

Comprehensive Program Review
Vermont Department of Health
Date: July 16 – 19, 2013

Sites Reviewed:

- Vermont Department of Health – 108 Cherry Street, Burlington, Vermont
- Planned Parenthood of Northern New England Administrative Office – 128 Lakeside Ave, Burlington, Vermont
- Planned Parenthood of Northern New England Parenthood Northern New England (PPNNE), Barre Health Center, 90 Washington St, Barre, Vermont
- Planned Parenthood of Northern New England Parenthood Northern New England (PPNNE), St. Johnsbury Health Center, 501 Portland St, St. Johnsbury, Vermont

Review Team: Kathy Desilets, Regional Program Consultant, and Team Leader and I & E/Community Involvement Reviewer
Beverly McGuire, Clinical Reviewer
Robin Lane, Administrative Reviewer
Joe Alifante, Fiscal Reviewer

Persons Interviewed:

Vermont Department of Health
Ilisa Stalberg, Vermont Department of Health, Director Preventive Reproductive Health
Harry Chen, MD, Health Commissioner
Breena Holmes, MD, MCH Director
Patrick Burke, VDH Business Office
Karen Kelley, Grants Program Specialist
Kevin O'Connell, Grants and Contracts Chief
Roberta Downs, IT

Planned Parenthood Administration
Meagan Gallagher, Interim Co-CEO, Senior VP for Business Operations
Heather Bushey, Interim Co-CEO, CFO
Helen Reid, Director of Health Center Operations
Becky Levasseur-Oettinger, ARNP, Field Surveyor

Planned Parenthood of Northern New England – St. Johnsbury
Kate Plummer, CNM, St. Johnsbury Health Center
Maureen Sullivan, Site Manager, St. Johnsbury Health Center
Michelle Emerson, Health Care Associate, St. Johnsbury Health Center

Planned Parenthood of Northern New England – Barre
Amy Borgman, PA, Barre Health Center
Sara Graves, Site Manager, Barre Health Center
Emily Therrein, Health Care Assistant

Note: Throughout this review, the citation "Guidelines" refers to Program Guidelines for Project Grants for Family Planning Services, January 2001, Office of Family Planning, US Department of Health and Human Services.

Overview

The Vermont of Health (VDH) has been funded as a Title X grantee for over 40 years and is the sole grantee for the state of Vermont. The program is administratively located in the Maternal and Child Health Division of the health department, where one staff person dedicates part of her time to the program. Since the last review, the position which oversees the Title X Program has been restructured under the new title, Director of Preventive Reproductive Health Services. The incumbent, Ilisa Stalburg oversees a variety of programs including Teen Pregnancy Prevention, Violence Prevention and other related programs. Additional administrative and fiscal support is available from financial and contract management staff members at the department of health. The Maternal and Child Health Director is also actively involved with the family planning program and is a strong advocate for reproductive health services. VDH contracts for all Title X services with Planned Parenthood of Northern New England (PPNNE), an affiliate of the Planned Parenthood Federation of America. VDH passes the vast majority of Title X funds to the sub-recipient, retaining only a very small proportion to cover its own costs.

VDH has a unique and strong relationship with PPNNE. In addition to Title X funds the state supports the agency through STD grants and two distinct contracts supported by an 1114 Medicaid waiver. One contract supports outreach, education and infrastructure and the other funds the new Vermont Access Program. This program operates like a Medicaid family planning waiver or state plan amendment, supporting the cost of a wide range of reproductive health services for clients with incomes under 200%. For administrative reasons, the Vermont Medicaid program was not prepared to manage a broad-based family planning waiver or amendment, so the Access Program is being piloted with PPNNE as the only provider. The state expects to expand the Access Program in the future to include other providers.

Vermont is moving forward to implement its healthcare Marketplace under the ACA and has an initiative underway to come as close as possible to having a single payer healthcare system. The Vermont Blueprint for Health is working to develop medical homes for Vermont consumers which include linkages with community social services and substance abuse and mental health treatment with a focus on management of chronic diseases aimed to reduce health care costs. A state health information infrastructure including EMRs, hospital data sources, a health information exchange, and a centralized registry will allow the state to collect and measure data to support services, guide quality improvement and determine program impact. PPNNE is a full partner in these efforts.

In addition to supporting PPNNE's services VDH has a broad range of other programs related to reproductive health including an MCH performance measure on pregnancy intention, a home visiting program, and an evidence-based teen pregnancy prevention initiative. To increase their impact, these programs are focused on groups in greatest need. In a relatively new effort, Vermont is working with primary care providers to implement the One Key Question Project. Based on a model developed in Oregon, the project encourages and supports primary care providers to ask all female clients if they are planning a pregnancy in the next year. This one key question opens the door to discussion of preconception care and/or contraception depending on the client's needs and interests.

Vermont is a rural state with less than one million residents and until recently a significant area of the state did not have Title X services as Planned Parenthood and the state of Vermont concentrated Title X funding in areas they have identified as high need. Over the years between 2005 and 2011, Vermont saw annual losses in the number of individuals served in the Title X project. These losses accelerated in 2010 and 11 and between 2008 and 2011, there was a 30% drop in the number of annual users. In 2012, VDH and PPNNE recognized the need for statewide services and added two existing PPNNE sites to the Title X project. The Barre site, visited during this review, was one of the newly added sites and staff there expressed gratitude at having Title X support to assist their low income users. This change, along with the reopening of the site in St. Johnsbury, which was closed in 2010 due to low utilization, resulted in a significant increase in users in 2012 which is expected to continue. Community distress at the loss of the St. Johnsbury site was a key factor in the decision to reopen. To support this site and another low volume northern Vermont site, this year PPNNE with support from VDH initiated a telemedicine program. In this program one provider works at the two sites and is on site in each location for part of the week. When the provider is not on site, clients can schedule telemedicine visits conducted over a secure video link. PPNNE has found that clients, who are asked to complete a survey at the end of each visit, are very satisfied with the telemedicine service.

VDH is in the first year of a three year grant period. In preparation for the competitive application, the grantee conducted a thorough needs assessment regarding family planning services in the state both considering both Title X services and broader issues impacting the state as a whole. The assessment led the state to consider formation of a family planning workgroup and identified the following focus areas for the group's consideration:

- Educating the health care workforce – in particular a provider group interviewed for the assessment noted the need to assure that the primary care work force is engaged in reproductive health. The current adoption of the One Key Question initiative has the potential to be an opening for this kind of training.
- Sexual and reproductive health education via a comprehensive health education curriculum.
- Assuring access to family planning services for teens, even in non-Title X service sites. There were specific concerns about provision of LARCs because key informant in non-Title X sites indicated that these methods create a financial burden for providers. There was a strong belief among informants that PPNNE is an important asset to the state.
- Recognition of and work to address barriers to care including transportation, clinic hours, cultural attitudes and high co-pay for health care.
- The need for performance indicators and benchmarks for the VT family planning system to allow qualitative and quantitative monitoring of services and improvement.
- The need for enhanced linkages among family planning providers and other providers to enhance services, prevention and education.

In 2012 VDH, though its sub-recipient PPNNE served almost 8,000 Title X users (up from just under 6,000 in 2011) and utilization is continuing to increase with the goal of services to over 11,000 users in 2013. Individuals under 25 years of age make up 52% of the Vermont Title X caseload and there have been modest increases in the number of users in their thirties and forties. Male user numbers have increased gradually since 2005 to its current level of 7% of total users. In 2012, users under 100% of federal poverty level increased significantly from 32% in 2011 to 40%

in 2012, with the majority of users (83%) reporting either public or private health insurance. Reflecting the makeup of the state, Vermont users are predominantly white and non-Hispanic.

Since the last Title X Review, PPNNE has had a change in leadership. The CEO who was new to the agency at the time of the last review has departed and currently executive management responsibilities are being shared between two incumbents, the CFO and the Senior VP for Business operations, while the agency conducts a search for a permanent replacement. The departing CEO led a significant change process at PPNNE, including streamlining and modernization of systems, rebranding to enhance the look and feel of the health centers and an aggressive development strategy. At the time of this visit, the system had absorbed these changes and morale appeared high at all sites visited with little anxiety in evidence about the current changes.

PPNNE has adopted a new electronic practice management (EPM) system and is currently transitioning to a full EHR with implementation expected to be complete across the agency's three-state service area by the end of 2014. PPNNE, like many Planned Parenthood affiliates nationally will use the NexGen System. The initial transition to EPM which was completed very quickly had some glitches, but systems are now firmly in place and include some elements of the EHR. Full EHR implementation is planned as a site by site process which will allow sites that are later adopters to learn from the experience of those who have gone before.

This review was guided by the Title X Program Review Tool (3/2011) and the report follows the outline of the tool. Members of the review team consulted a variety of documents, interviewed staff and observed care at the clinical sites. The review found the Vermont Department of Health to be in general compliance with Title X law, regulations and guidelines. This report contains three (3) findings which indicate areas where VDH must take action to assure full and continuing compliance with Title X. For each finding, a corrective action plan is suggested. These recommended remedial actions reflect the opinions of the reviewers on how the grantee can come into closer compliance with Title X. The grantee may have other mechanisms to come into compliance.

In any case, the grantee must respond within 90 days of receipt of this report with a remedial action plan addressing each of the findings. If actions have already been taken when the plan is submitted, appropriate documentation should be included. Where actions have not been taken, the plan should clearly outline actions to be taken and indicate clearly when these actions will be completed. Where findings relate to the sub-recipient, it is the responsibility of the grantee to assure that the sub-recipient takes appropriate remedial action.

In addition to the findings, the report contains a number of recommendations. These recommendations are provided by the review team in an effort to provide helpful suggestions to the grantee for improving practice. The Regional Office welcomes grantee response to all of these recommendations, but response to recommendations is **required** only if this is explicitly noted in the report. Only one of the recommendations in this report **requires** response.

Administrative

The goals of the administrative review are:

1. *To assure that the program is in compliance with Federal and other appropriate laws and regulations.*
2. *To assure that the organizational, management, and administrative structure of the program is sufficient to implement the project in its service areas.*
3. *To determine if the program operates in a properly constituted organization.*
4. *To determine if the program has a sound organizational structure.*

Overall Vermont Department of Health and its sub-recipient Planned Parenthood of Northern New England are providing quality family planning and related services in administrative compliance with Title X regulations and guidelines. The partnership that exists between the VDH and PPNNE is a model of public health/health care collaboration deserves to be commended. Integration of the Title X Family Planning Program, MCH initiatives and the Vermont Access Plan benefits the patients and demonstrates the strength of this partnership as does the commitment to patient care and patient access. Staff members who are responsible for this program at both VDH and PPNNE bring energy, creativity and commitment to their work and this is reflected throughout the service network.

Findings and recommendations for improvement are noted below with the full confidence that the VDH and PPNNE will take necessary corrective action to be in full compliance with Title X Regulations.

A. Voluntary Participation

The grantee and the sub-recipient agency fully comply with the required elements in this section. The reviewer observed the intake process at both health centers and all services are provided voluntarily. There is no indication that clients are subject to coercion in use of any particular method of family planning

B. Confidentiality

The grantee and sub-recipient were in full compliance with the requirements of this section. PPNNE's sensitivity to privacy issues and to the provisions of the Privacy Act and the fact that the front desk patient care staff was well trained and highly skilled ensured that patient confidentiality was a priority throughout the organization. PPNNE's Administrative Policy and Procedures Manual includes policies regarding the agency's compliance with the Privacy Act. Both the grantee and sub-recipient collect required family planning data elements in a manner that ensures client confidentiality.

C. Conflict of Interest

Both the grantee and sub-recipient have established policies to prevent employees, consultants, or members of the governing/advisory bodies from using their positions for private gains as required by Title X.

D. Insurance Coverage

The grantee VDH provided a copy of their liability policy. The sub-recipient, PPNNE, has appropriate and adequate insurance coverage for medical malpractice, general liability, fire and disaster, employee dishonesty and officers and directors liability. Their insurance is through the Planned Parenthood Federation of America.

E. Human Subjects Clearance (Research)

There was no evidence of any research projects being conducted at the grantee, sub-recipient or health center sites. VDH's grant application contained all necessary assurances and confirmed compliance with all requirements in this area.

F. Prohibition of Abortion

VDH and PPNNE are operating in full compliance with section 1008 prohibiting abortion as a method of family planning. Policies and procedures at PPNNE clearly state that no Title X funds will be used in programs where abortion is a method of family planning. During a detailed review of all systems and facilities at Barre Health Center, where abortions are provided, the reviewer observed all required separations between abortion services and Title X Family Planning services. Review of the personnel records of the staff at Barre Health Center showed data on specific allocation of payroll funds for that employee to the different programs including distinct and separate allocations to the Title X program and abortion services in all files.

G. Structure of the Grantee/Sub-recipient

VDH has a signed annual contract for its grant award with PPNNE which outlines the Title X programmatic and fiscal requirements. VDHVDH provides an opportunity for maximum participation by the sub recipient in the ongoing policy decision making of the project. This is accomplished with ongoing, scheduled monthly meetings and additional conference calls as needed between the grantee and the sub recipient.

The sub-recipient, in collaboration with the grantee, does an excellent job of clinical and facility monitoring of its health centers. However some of the administrative and fiscal requirements are not addressed in these tools. These requirements must be included, and the grantee must conduct the monitoring of the health centers where Title X services are delivered.

Finding # 1 (Administrative)

The grantee must have a system to monitor and ensure sub-recipient performance conforms to the terms, conditions and specifications of the sub recipient agreement, Title X regulations and other Federal Regulations (Ref: 45 CFR Part 92.37). This requirement includes fiscal and administrative as well as clinical review.

Recommended Remedial Action Finding #1
The grantee must develop and implement systems to monitor the sub-recipient to ensure its compliance to Title X Regulations on a routine and systematic basis. Some of the required administrative and fiscal review might be done efficiently through a desk audit by VDH staff of other reviews which have been completed of the sub-recipient (i.e. PPFA review) with follow up on any findings. In addition, the grantee must assure that all Title X specific issues are addressed and the Federal Review Tools used in this review can provide guidance on these items. The Regional Office will share formats used by other grantees to conduct this type of administrative review with VDH as examples.

H. Governance

The grantee, Vermont Department of Health, is a Public State Government agency.

PPNNE's by-laws fully meet IRS requirements for nonprofit organizations and documentation of this status is on file. All required documentation for the IRS 501 (c) (3) status was reviewed and found to be in compliance. Review of the Board of Director's meeting minutes confirmed that the Governing Board is appropriately constituted and in compliance with all Title X Regulations.

I. Planning and Evaluation

The grantee and sub-recipient both comply with the requirements in this section. Vermont Department of Health has a planning process for the Maternal and Child Health Block Grant that includes goals related to family planning. Upon review of the grant applications, the goals are based on a needs assessment, have specific objectives that are measurable, and are consistent with Title X regulations. They relate to Title X priorities and OPA key issues. During the review, both grantee and sub-recipient sites demonstrated commitment and attention to the work plans which are based on a format and set of measures developed by the grantee.

J. Facilities and Accessibility of Services

The review included visits to VDH and PPNNE administrative offices as well as PPNNE sites in St Johnsbury and Barre. Both sites are well maintained, comfortable and clean, and assure privacy for the patients. The facilities are accessible to patients with disabilities and/or limited mobility. The facilities are geographically accessible to the population served. In fact, PPNNE should be commended for their reopening of their St. Johnsbury site which had been closed for some time. They clearly recognized the need and responded to a significant community response to its closing. Both St Johnsbury and Barre Health Centers have written fire and emergency plans, in fact posted in every room. All exits appeared to be free from barriers. The reviewer has three recommendations regarding the facilities.

Recommendation #1 (Administrative)
Every clinical site requires specific exit routes. An additional exit sign pointing to the exit routes should be placed in the hallway outside the exam rooms.

There was no documentation of fire drills in either clinical site. Reviewer recognizes that fire drills do take place, as explained in staff interviews, however there needs to be a specific log for fire drills.

Recommendation #2 (Administrative)
VDH should encourage PPNNE to maintain logs of fire drills indicating the date of the drill, the time to evacuate and outlining any issues that should be considered for future drills.

OSHA requires every place of business to have two exit routes (29 CFR 1910 33-39 Subpart E). St. Johnsbury has only one exit route. During staff interviews it was noted that the local fire marshal inspected the facility, noted that there was only one exit route, but gave approval to the site.

Recommendation #3 (Administrative) – Response Required
The review team strongly recommends that an additional exit be created, in order to ensure safety for staff in case the front exit is blocked due to fire or violence and as well to permit prompt evacuation of employees and patients from the building.

K. Personnel

The Personnel Policies and Procedures Manuals at the grantee and sub-recipient are in excellent shape and in compliance with Title X Regulations. Both VDH and PPNNE have formal grievance mechanisms. The manuals contain policies regarding nondiscrimination in recruitment, performance evaluations and disciplinary procedures. Both the grantee and sub-recipient have organizational charts showing clear lines of authority.

PPNNE should be commended for its practice of promoting from within the organization. At both health centers, the center manager was formerly the Health Care Associate. This practice of advancement provides an environment of recognition and reward for good work.

Review of PPNNE's personnel records showed that they included documentation of all required trainings, and all licensure was up to date. The records are kept confidential, and written job descriptions for all positions are in place. Performance evaluations were current except for two records, where the performance evaluations are overdue. At VDH there was a complex process to access the personnel records, including consultation with the office of labor relations, so the personnel records at VDH were not reviewed. However Title X Coordinator who has been in her current position for slightly more than a year, stated during an interview that she had not yet received a formal performance evaluation so the reviewer recommends that be done as soon as possible.

Recommendation #4 (Administrative)
Written personnel performance reviews should take place on an annual basis and this practice seems to be generally followed at PPNNE. Both organizations should complete the

reviews that are overdue. In addition a system should be set up to assure that subsequent evaluations are completed on a timely basis consistent with applicable personnel policies.

L. Training and Technical Assistance

The reviewer found the Vermont Title X project to be in compliance with training requirements. PPNNE has a continuing education and evaluation program carried out by a separate department within the agency. PPNNE puts a lot of emphasis on staff orientation and training and the fruits of this training/orientation were evident in observations at the clinic sites.

M. Reporting Requirements

The Vermont DOH Title X project complies with Title X reporting requirements including all FPAR requirements. Written policies are in place for the reporting of child abuse, child molestation, sexual abuse, rape or incest, as well as human trafficking. Reviewers found evidence of the training on this requirement in the personnel records at PPNNE administrative offices. Upon interviewing of key staff, it was apparent that all requirements are adhered to and followed regarding these policies. They also have written information system policies to maintain and secure records in both electronic and hard copy formats.

PPNNE submits service data to the Region I family planning data system and uses reports from the system to prepare the Family Planning Annual Report. A review of consistency between the records on site and the data in the region system revealed some discrepancies. A significant number of records from the data system showed a source of reimbursement that was different from what was recorded in the client charts. Since all data is sent to the regional system via export from the sub-recipients electronic systems, it may be that the data was pulled from an inappropriate part of these records. In any case, since the insurance status of clients is of special interest in tracking changes as a result of the ACA and state changes in availability of insurance, VDH should assure that PPNNE is providing correct data for the FPAR report. Also, contraceptive method at the end of the visit was often inconsistently reported so that the data system reports did not reflect the methods shown in the client charts. This is an important data element in that it is used to evaluate the degree to which clients leave the clinic with an effective method.

Finding #2 (Administrative)

Data reported for the purposes of the Family Planning Annual Report did not completely match data in client records for insurance status and contraceptive method and as a result the accuracy of this reporting cannot be assured (Ref: 45 CFR 74.51; 45 CFR 92.40; Grants Policy Statement 2007, II-86-II-89)

Recommended Remedial Action Finding #2

VDH must work with PPNNE to assure that all data reported to FPAR is accurate. A review of the mapping of data from PPNNE's electronic systems to the files submitted to the regional data system to assure that the proper data is being captured and a periodic review of on-site records against the data system should be helpful in this assurance. It would be worthwhile particularly to check how contraceptive method data and insurance data are collected and reported.

N. Publications

Neither VDH nor PPNNE currently uses any Title X grant funds for publications. The VDH Family Planning Coordinator is a member of the PPNNE materials review committee.

O. Federal Assurances

Review of the grant applications, as well as grantee and sub-recipient policies, made it evident that the grantee is in compliance with all Federal Assurances and Certifications. The grantee and PPNNE health centers provided free access to examine all records, books, papers and documents related to the title X funding award.

Systems and qualified personnel are in place to ensure proper planning, management and completion of the project as described in the award.

Fiscal

The purpose of the Title X Program financial review is to assess whether the grantee and sub-recipient agency have appropriate financial management systems, including budgetary control procedures, accounting systems and reports, and procedures for charges, billing, collections, purchasing and property management, and fiscal monitoring that are in compliance with applicable Federal laws and regulations (Subpart C of 45 CFR Part 74, or subpart C of 45 CFR Part 92, Federal Cost Principles as applicable, as well as any other requirements imposed by the Notice of Grant Award, and which complies with Federal standards to safeguard the use of Title X Project funds).

The review assesses the systems in place to reconcile grant funding from accounting records and documents and determines whether the project staff has sufficient understanding of the accounting and financial systems to verify that recorded transactions actually took place and were made in accordance with agency policy and procedures

The Vermont Department of Health (VDH) and its sub-recipient agency Planned Parenthood of Northern New England (PPNNE) appeared to have adequate financial systems and internal controls in place to assure the accurate and timely reporting and use of Title X Project funds. Budget practices and control procedures were strong. Accounting systems were well structured; with agency staff interviewed being well informed and possessing strong financial management skills and understanding to perform job responsibilities adequately.

There were no items of non-compliance found. Recommendations and comments have been presented below.

1. Budgetary Controls and & 2. Accounting Systems and Reports

The VDH had adequate financial systems and internal controls in place to accurately and appropriately reflect the use of Title X Project funds. Budget practices and control procedures

were evident and utilized. Accounting systems were generally well done, as were most financial policies and procedures. Required sub-recipient procedures for charges, billing, and collections were in place. Agency staff interviewed was well informed and had the financial management skill and understanding to perform job responsibilities adequately.

The VDH 2013 Title X Project budget reflected a Title X grant award of about $750,000, with total project revenues and expenditures of over $4 million. The Health Department's total is a minor amount of the Title X Project budget in 2013, approximately $12,000. The remaining revenues and expenditures reflected relate to the Title X costs and revenues of PPNNE, the sub-recipient service delivery agency.

The VDH amount includes 10% of the Program Administrator's time and her corresponding fringe benefits and an indirect cost utilizing VDH approved cost allocation plan. During the program review site visit it was determined that the actual costs of the Title X Project were not being accounted for in the Title X Budget and expenditure reporting. Key financial personnel such as Patrick Burke and Karen Kelly and the central financial services staff who complete the Payment Management System (PMS) quarterly Federal Financial Report (FFR) were not recorded at all in these reports. It is difficult to ascertain the "true" HD costs related to the Title X Project and grantee oversight function.

Recommendation #5 (Fiscal)
VDH should consider reflecting all costs involved in the Title X Project. At minimum, key personnel involved in the program as mentioned above, if not charged to the federal and non-federal budget totals, should have an imputed value calculated and reflected as additional "In-Kind" costs being provided by the grantee. This helps for a better basis and knowledge of the actual costs of the Title X Family Planning Project.

The VDH requires quarterly Title X Project expenditure reporting from PPNNE. These quarterly reports along with the HD's grantee costs are compiled and reviewed by financial staff and the project administrator comparing budget to actual totals, determining variances or outliers during the year. The quarterly expenditures are also utilized by the central financial services staff to generate and submit the required quarterly PMS Federal Financial Report (FFR). However, a copy of the quarterly FFR is not provided to the state's Title X project financial staff or the program administrator.

Recommendation #6 (Fiscal)
A copy of the quarterly PMS Federal Financial Reports (FFR) should be provided to HD Title X Project staff (Financial Administrator, Grants Program Specialist and Project Administrator). The PMS reports are a valued source of reconciling Title X Project award cash receipts and expenditures, and would be helpful for Title X Project staff completing the required Title X Project annual financial status report section of the FFR.

Grantees are responsible to monitor sub-recipient agencies as necessary to ensure compliance with Federal laws, regulations, and grant provisions. Internal controls over Federal programs are to be maintained that provide reasonable assurance that the grantee is managing the Federal award in compliance with applicable financial regulations and requirements. Since PPNNE's

revenues and expenditures are the overwhelming component of the VDH's Title X Project, it is important for the VDH to establish appropriate and effective monitoring tools and efforts to assure its sub-recipient agency has appropriate written financial management policies and procedures in place, the budgeting and expenditure reporting needed, and an accounting system that records transactions accurately and timely to determine Title X Project costs by direct observation and assessment by Grantee Title X Project staff.

Recommendation #7 (Fiscal)
The VDH should develop a financial management component to its sub-recipient monitoring process and review tool. This is consistent with the Administrative Program Review finding related to Grantee oversight requirements and developing an appropriate monitoring tool.

PPNNE have strong financial systems and internal controls in place to accurately and appropriately reflect the use and reporting of Title X Project funds. Budget practices and control procedures were effective, with an accounting system (General Ledger and Financial Reporting and Analysis) that included Title X Project cost center information. PPNNE's financial policies and procedures are well crafted and comprehensive. Agency staff interviewed was trained, well informed and had the financial management skill and understanding to perform job responsibilities effectively. PPNNE has implemented practices to assess Title X Program financial management compliance. It has key procedures in place that respond to Title X Project requirements such as charges, billing and collection practices, Section 1008 (Abortion Separation) staff training, policies and procedures, and a thorough understanding and effective compliance practices for HRSA Office of Pharmacy Affairs 340 B requirements.

3. Charges, Billing and Collections

PPNNE completes an annual relative value cost analysis utilizing Resource Based Relative Value System (RBRVS) data to generate service procedure costs. This annual cost analysis is used to help develop its Title X sliding fee scale procedure to set charges for self-pay patients utilizing annual federal poverty guidelines. PPNNE also generates other useful tools for patient front desk staff and Call Center personnel who have direct contact with patients. This is an impressive effort and system.

Recommendation #8 (Fiscal)
VDH should review annual changes to the Title X Project Sliding Fee Scale procedure charges and Schedule of Discounts to assure that all Title X Family Planning Project charges are proportionately discounted as required and appropriate.

4. Procurement/Inventory Control/Property Management

In general, procurement inventory and property management were adequate with written policies and procedures outlining agency practices. Accounting system reflected cost centers and account designations providing appropriate financial information and audit controls.

PPNNE has strong written procurement and inventory control policies and procedures. Monthly inventory reports are provided by all health centers to the PPNNE office in

Burlington, where a review and a reconciliation of inventory totals are completed, comparing accounting system control totals with actual quarterly inventory counts done at the health centers. During the site visits at the St. Johnsbury and Barre Health Centers, inventory practices, daily logs, monthly reports and quarterly inventory counts were reviewed. All health center staff had good training and knowledge of the inventory practices and controls in place.

At the Burlington Office, invoice testing of supply and pharmacy purchases was done reflecting proper controls, the reconciliation of the propriety and accuracy of purchases and the appropriate recording in the accounting systems and control accounts.

During the interview with Heather Bushey, CFO & Interim CO-CEO, it became evident that she has strong knowledge and understanding of the HRSA (Office of Pharmacy Affairs) 340B Program and previous program review findings related to the STD Section 318 requirements as well as the current Title X Project 340B eligibility and requirements. Agency policies and procedures had good audit controls reflecting that purchases under the 340B program are appropriate and consistent with the program requirements and use of discounted supplies for eligible Title X Project services and patients.

Information and Education Review and Community Involvement

This section of the review considers the degree to which the grantee either directly or through delegation to the sub-recipient(s) takes steps to assure that key community stakeholders are aware of and able to provide input to the Title X project. In addition it evaluates compliance with Title X requirements for review of educational materials.

VDH delegates responsibility for most aspects of Information and Education Review and Community Involvement to the sub-recipient. However, the grantee requires, as a performance measure in its contract with PPNNE, that the sub-recipient provide contraceptive updates to each of the VDH regional offices annually. This assures that the VDH district staff members are aware of the project and that they have appropriate and current information to share with clients and provider a reminder of the potential for VDH staff to make to the project. The grantee monitors the information and education materials review process by participating in the review committee. Outreach to communities to assure knowledge of the project has been robust and appropriately targeted.

A. Information and Education Review

PPNNE has reformed its education review committee and is working on the review of clinical materials. The committee has adequate community representation and the coordinator of the process sends materials to the members for review and response along with a form which specifies the scope of the review. While this process is appropriate and ongoing, the review of materials still needs to be completed.

Finding # 3 (Information and Education Review and Community Involvement)

VDH has not assured full compliance with the Title X requirement for review of all materials developed or made available under the project. (Ref: Title X Statute Section 100: 42 CFR 59.6)

Recommended Remedial Action Finding #3

VDH must assure that all materials used in the Title X project have been appropriately reviewed. The grantee should determine which materials still need review and develop a plan with anticipated times for the completion of all reviews. In addition, we recommend that the grantee secure and maintain a listing of all materials used in the project that includes titles, publication dates, publishers and review dates. This list can be used to assure a periodic re-review of materials to assure that the materials continue to reflect accurate information, to be compatible with community standards, and to reflect current policies and practices in the project.

B. Community Participation

The close relationship of VDH and PPNNE and the participation of both entities in a variety of state and community organizations offer extensive opportunities for the grantee and sub-recipient to receive and respond to community input. As noted earlier in this review report, the reopening of the St. Johnsbury Health Center by PPNNE presents a clear example of the willingness of the grantee and sub-recipient to respond to community needs. Similarly, the shared work of the two entities on the legislative process to allow telemedicine visits shows an effort to assure that articulated community needs are being met. PPNNE also reports a process of adjusting service hours at the health centers to meet community need and has recently added clinical service delivery hours at some sites.

PPNNE has been very active in community promotion of the project and each service site develops a locally specific outreach plan to inform the community of available services. PPNNE, in response to the initiation of the Access Program for Family Planning, conducted a door to door canvas in Barre with a flyer promoting both their services and the availability of the new payment support option. Other outreach targets include school nurses, community healthcare providers including mental health providers, and youth serving agencies. Cross referral arrangements have been made with a variety of partners including Vermont Cares, the statewide AIDS Service Organization, and AWARE, a support program for those experiencing intimate partner violence.

In addition to general outreach, PPNNE, with the support of VDH has recently initiated a Teen Peer Education program. The program works primarily in the Burlington area now, but is slated for possible expansion and is characterized by youth leadership and efforts to meet kids where they are. This is a progressive move to address the decrease in teen users.

Clinical

The clinical review considers the all aspects of care provided at the sites, including clinical, laboratory and pharmacy policies and procedures, medical oversight, medical documentation, referrals and follow up and the actual delivery of care. The goals for this section of the review are:

- *to determine whether clinical policies, procedures, protocols and practices are consistent with Title X and other relevant laws, regulations and guidelines*
- *to assure that clinical practice is consistent with state and local laws and evidence-based clinical guidelines*

The clinical review included review of policies and procedures of the sub-recipient and interviews with sub-recipient staff responsible for clinical care as well as a review of charts and observation of client services at two health centers. Since the last review, VDH has increased oversight of the clinical care provided through participation in reviews by the sub-recipient's Field Surveyor. In addition planned meetings between the medical directors of the grantee and sub-recipient have been held on schedule. The sub-recipient uses established, evidence-based PPFA clinical protocols and educational materials. The staffing pattern at all sites includes a provider (PA, ARNP or CNM) and one or two Health Care Assistants who work together to carry out all aspects of clinical care. A strong training program prepares Health Care Assistants for their roles, allowing them to take on the parts of the visit that do not require the time of a clinician. This has resulted in an efficient and effective system for completing all required elements of clinical service. Cordial and respectful cooperative relationships between the clinicians and the non-licensed staff were evident at both sites visited.

The clinical consultant reviewed medical records of twenty-four (24) clients ages 15-56 years in St. Johnsbury and twenty (20) medical records of clients ages 17-43 years in Barre and observed one clinical visit at each site. PPNNE demonstrated the process for telemedicine visits to the review team via a mock appointment.

A. **Client Services**

PPNNE offers all expected family planning and related health services including STD and HIV counseling and testing. Training is provided annually to ensure that providers recognize the signs and symptoms of child abuse, molestation, rape or incest. Strong referral relationships are available with community-based domestic and sexual violence support providers.

A full range of contraceptive methods are available and dispensed on site. While extensive and thorough educational materials were available at the sites, the reviewers noted that many the handouts and educational materials reviewed at the visited failed to include information on Natural Family Planning. FPAR data shows that some clients report using this method, but it is not clear what support the grantee is offering for its use.

Recommendation #9 (Clinical)

Natural family planning method must be included in the broad range of acceptable/effective FDA approved contraceptive methods and education on contraception must include this method.

B. **Service Plan and Protocol**

Medical Guidelines dated 2012 were reviewed. Changes were made to cervical cancer screening to support the use of evidence-based guidelines. Policies cover a thorough system for dealing with a myriad of situations beyond contraceptive care including:

- Systems for notification and follow-up on lab findings,
- Resources and communication regarding intimate partner violence,
- Client centered communication for sexual health,
- Prescription barriers,
- Screenings and evaluation,
- Infections,
- Men's reproductive health,
- Non-reproductive health care,
- Professional standards review,
- Limited English proficiency, and
- Emergency care.

Recommendation #10 (Clinical)

PPNNE's clinical protocols have been reviewed and signed off by the Associate Medical Director in the delivery sites in St. Johnsbury and the Barre offices. The protocols in the Department of Health have not been signed. Previous site visits included a finding to have the protocols reviewed and signed. The Department's response was to have the protocols reviewed and signed semi-annually. The Grantee needs to follow its own policy. Protocols may be reviewed annually, at a minimum, and all copies need to be signed. While this is a detail, it should be attended to so that the VDH has documentation on hand of their approval.

C. **Procedural Outline**

Observation of clinical services, chart reviews and the protocol review demonstrated appropriate content in new and return visits. Clinical documentation on all return visits was thorough, including a history update, the actual exam, any laboratory testing and needed referrals with a time line for any follow-up.

As previously noted, PPNNE in collaboration with VDH has in the past year initiated a telemedicine program and detailed protocols and procedures have been developed both to define the limits of telemedicine visits and to specify staff roles and procedures for information transfer. All telemedicine visits include data and specimen collection by lay staff well trained to provide these services followed by a video conference with the clinician.

D. **Emergencies**

Protocols and supplies for medical emergencies were available at both sites visited by the review team and staff demonstrated clear and specific knowledge of their roles in emergencies.

E. **Referrals and Follow-Up**

Written policies and procedures are in place for referrals. The medical record documentation revealed numerous referrals for a variety of services. Each clinical site maintains a locally specific referral list.

Recommendation #11 (Clinical)
PPNNE makes numerous referrals to outside provider services. It is recommended that the agency consider developing contracts and/or MOUs with the outside providers. In this ever changing health care system, it would be beneficial to be able to show formal agreements for the multitude of services that are made available to clients.

F. **Required Services**

Written consents, including method specific, were found in every medical record reviewed. Although the Vermont sites see very few English as a second language (ESL) patients and there were no patients of this category in the records reviewed, policies are in place to assure appropriate service provision.

G. **Client Education**

Client educational materials are abundant. In the two visits observed by the clinical reviewer both the Nurse Practitioner and the Health Care Assistant provided thorough and accurate education to the clients. In both instances, the providers were patient and took generous time to address any concerns.

H. **Counseling**

Providers demonstrate a knowledgeable and accurate approach to provide sufficient information to the clients. It was particularly obvious that the staff is objective and non-judgmental to the variety of client situations they encounter.

F. History, Physical Assessment, and Lab Testing

PPNNE records demonstrated that the recommendations from previous review have been followed. Current paper records are complete, meeting the requirements of Title X Guidelines. There is evidence of the physical exam and lab results, family history, medications, and immunizations. Some records included the name of the client's PCP when known. Of the male records reviewed, each client came with a concern for a STD exposure. Providers took the opportunity to review safer sex practices. Discussion with providers revealed that they are making an effort to include a discussion reproductive life plans with both females and males. PPNNE is undergoing the upgrade of documentation to an electronic medical record and is adapting the standard HER record formats to meet their own agency needs.

G. **Fertility Regulation & K Infertility Services**

All Title X requirements for information on fertility regulation are followed in the provision of clinical care.

L. Pregnancy Diagnosis and Counseling

Pregnancy diagnosis was a frequent reason for the appointment in the records reviewed. Documentation showed that the client was counseled about options, ectopic pregnancy, the need to schedule an exam as soon as possible. Good health practices are included in the information.

M. Adolescent Services

The majority of client records reviewed were of adolescents. Safer sex practices are included. There is evidence of urging parental involvement and PPNNE has made this a particular focus in their quality assurance visits. All methods, including LARCs are available to teens.

N. Related Services

Treatment is readily available for minor gynecologic problems such as vaginitis and UTIs are treated. The more common STDs are treated. Policies address the required reporting to meet state and local requirements. The most current VDH work plan includes targets for Chlamydia screening for women under 25 of age and for the provision of effective contraceptive methods. Breast and cervical cancer screening are provided in accord with evidence-based practices.

O. Special Counseling

Staff is making a concerted effort to inquire about each client's life reproductive plan. The clinical reviewer noted in her observation of care and chart reviews that counseling is provided as needed to clients to deal with specific life concerns.

At the St. Johnsbury site a significant number of clients reported mental health concerns and in some cases it was clear that the clinician had discussed mental health care. In other cases, more complete documentation of this discussion would have been beneficial. In discussion, the provider acknowledged that many clients report suffering particularly from anxiety and depression and discussed the local resources that are available for mental health referrals. This discussion suggested to the review team that discussion of these issues with clients may occur more commonly than it is charted.

P. Genetic Information and Referral

Concerns and question about genetic conditions are handled with referrals to an appropriate resource.

Q. Health Promotion/Disease Prevention

VDH, as the statewide health department, is active in community based health promotion in a variety of ways and when appropriate engages the sub-recipient in these activities. Teen pregnancy prevention and domestic violence prevention are housed within the Maternal and Child Health Program and the state is also very active in working through its district offices and centrally on improved access to health care and medical homes which link clients to a broad range of medical, social and public health services. The MCH Director is keenly aware of the linkage between health care and population health and the health department has worked to assure that its initiatives, such as the teen pregnancy prevention and home visiting programs are targeted to those most in need.

R. Postpartum Care

There were no findings or recommendations in this section of the review.

S. Equipment and Supplies

Appropriate equipment and supplies are in place. The sub-recipient site demonstrated a full understanding and practice of appropriate infection control policies. The reviewers noted that in some cases sharps containers are loose on counters.

Recommendation #12 (Clinical)

PPNNE should secure sharps containers to the wall and leave the medication cabinets and the lab door locked, allowing access only to appropriate personnel. In Barre, the lab, including medication storage cabinets was locked and inaccessible to clients. In St. Johnsbury, medication cabinets were unlocked and the lab door open. Employees explained that the lab area is always under observation but observation of the clinic activities showed opportunities for entry by others.

T. Pharmaceuticals

The supply of pharmaceuticals is adequate in amount and variety for the practice. There is a wide selection of drugs and devices to offer the client a choice.

U. Medical Records

PPNNE is currently using paper medical records with established formats, but is on the verge of converting to an EHR with staff training planned to begin immediately after this review.

The reviewers found medical records to be maintained in accordance with accepted medical standards with good clinical documentation at both sites. The clinician signs each entry. Telephone encounters are recorded. Alerts for missed appointments, visits due, etc. are included in the records. Allergies are recorded in an obvious manner. All consents, general and method specific, were present. All Title X requirements for a thorough medical record were found in the records reviewed. All records are locked during off hours.

V. **Quality Improvement/Assurance**

Since the last review, VDH has increased its monitoring of the sub-recipient, in particular by adhering to its plans for regular meetings between the MCH Medical Director and the sub-recipient medical director and also through VDH staff participation in some of the sub-recipients on site monitoring activities. In addition, the grantee has improved its monitoring records.

PPNNE educates each employee during initial orientation regarding the quality assurance processes followed in the agency. Each staff member is responsible to follow agency protocols. Quality Assurance policies and procedures include regularly scheduled visits and reports with follow up on areas in need of improvement. A peer review process is in place to evaluate clinician performance.

VERMONT
DEPARTMENT OF HEALTH

Title X Comprehensive Program Review, July 2013
RESPONSE TO: OPA Summary of Findings and Recommendations

Sites Reviewed:

- Vermont Department of Health – 108 Cherry Street, Burlington, Vermont
- Planned Parenthood of Northern New England Administrative Office – 128 Lakeside Ave, Burlington, Vermont
- Planned Parenthood of Northern New England Parenthood Northern New England (PPNNE), Barre Health Center, 90 Washington St, Barre, Vermont
- Planned Parenthood of Northern New England Parenthood Northern New England (PPNNE), St. Johnsbury Health Center, 501 Portland St, St. Johnsbury, Vermont

Review Team: Kathy Desilets, Regional Program Consultant, and Team Leader and I & E/ Community Involvement Reviewer
Beverly McGuire, Clinical Reviewer
Robin Lane, Administrative Reviewer
Joe Alifante, Fiscal Reviewer

Findings

Finding # 1 (Administrative)

The grantee must have a system to monitor and ensure sub-recipient performance conforms to the terms, conditions and specifications of the sub recipient agreement, Title X regulations and other Federal Regulations (Ref: 45 CFR Part 92.37). This requirement includes fiscal and administrative as well as clinical review.

Recommended Remedial Action Finding #1

The grantee must develop and implement systems to monitor the sub-recipient to ensure its compliance to Title X Regulations on a routine and systematic basis. Some of the required administrative and fiscal review might be done efficiently through a desk audit by VDH staff of other reviews which have been completed of the sub-recipient (i.e. PPFA review) with follow up on any findings. In addition, the grantee must assure that all Title X specific issues are addressed and the Federal Review Tools used in this review can provide guidance on these items. The Regional Office will share formats used by other grantees to conduct this type of administrative review with VDH as examples.

Grantee Response
VDH currently monitors sub-recipient performance through the following activities: 1) monthly meetings between the grantee and sub-recipient; 2) quarterly program reports, including progress on all work plan objectives and measures reviewed and signed by Program Administrator; 3) quarterly financial reports reviewed and signed by VDH Business Office; 4) 2x per year site visits and chart reviews at sub-recipient health centers; and 5) VDH MCH Director review and sign off of the PPNNE Clinical Protocols. In addition to this, VDH will implement a new sub-recipient monitoring protocol. The new protocol will consist of a site visit to the subrecipient administrative office and a review of administrative and financial systems once annually. VDH is currently developing administrative and financial audit tools, which

incorporates all items included in the Title X Review tools. Model templates have been provided to Vermont by the Regional Office and other state family planning programs. Any findings during this administrative/ fiscal site visit /audit will be reported to the sub-recipient and VDH will work with the subrecipient to identify and address barriers and develop a corrective action plan.

Finding #2 (Administrative)

Data reported for the purposes of the Family Planning Annual Report did not completely match data in client records for insurance status and contraceptive method and as a result the accuracy of this reporting cannot be assured (Ref: 45 CFR 74.51; 45 CFR 92.40; Grants Policy Statement 2007, II-86-II-89)

Recommended Remedial Action Finding #2

VDH must work with PPNNE to assure that all data reported to FPAR is accurate. A review of the mapping of data from PPNNE's electronic systems to the files submitted to the regional data system to assure that the proper data is being captured and a periodic review of on-site records against the data system should be helpful in this assurance. It would be worthwhile particularly to check how contraceptive method data and insurance data are collected and reported.

Grantee Response
PPNNE has updated their IT and RQM policies to include a review of on-site records against the data system in Q1 and Q3. PPNNE will work with VDH to ensure their participation and oversight of this audit.

Finding # 3 (Information and Education Review and Community Involvement)

VDH has not assured full compliance with the Title X requirement for review of all materials developed or made available under the project. (Ref: Title X Statute Section 100: 42 CFR 59.6)

Recommended Remedial Action Finding #3

VDH must assure that all materials used in the Title X project have been appropriately reviewed. The grantee should determine which materials still need review and develop a plan with anticipated times for the completion of all reviews. In addition, we recommend that the grantee secure and maintain a listing of all materials used in the project that includes titles, publication dates, publishers and review dates. This list can be used to assure a periodic re-review of materials to assure that the materials continue to reflect accurate information, to be compatible with community standards, and to reflect current policies and practices in the project.

Grantee Response
Shortly before the Program Review, PPNNE reconvened an I&E Committee (EMRC). The EMRC is also the advisory committee for the Peer Education Program, which is made up of professionals serving a wide range of youth and adults and includes membership from VDH. Under new program administration, PPNNE has begun to develop a listing of all materials used in the project, which will include titles, publication dates, publishers and review dates. The first set of materials has been reviewed and the next set of materials will soon be reviewed in succession. The requirement of the EMRC is under the purview of the sub-recipient, PPNNE. This requirement is outlined in the grant agreement between the two organizations and a penalty for failing to meet this requirement is attached.

Recommendations Response Required

Recommendation #3 (Administrative) – Response Required

The review team strongly recommends that an additional exit be created, in order to ensure safety for staff in case the front exit is blocked due to fire or violence and as well to permit prompt evacuation of employees and patients from the building.

Grantee Response
This recommendation is related to PPNNE's St. Johnsbury facility only. PPNNE recently relocated the health center to the Portland Street location and a fire inspection was completed by the city of St. Johnsbury prior to the facility's opening on December 27, 2012 and deemed in compliance. PPNNE is, however, assessing the cost of adding an additional exit to the back of the facility as a result of this review.

Recommendations

Recommendation #1 (Administrative)

Every clinical site requires specific exit routes. An additional exit sign pointing to the exit routes should be placed in the hallway outside the exam rooms.

Recommendation #2 (Administrative)

VDH should encourage PPNNE to maintain logs of fire drills indicating the date of the drill, the time to evacuate and outlining any issues that should be considered for future drills.

Recommendation #3 (Administrative) Response required (see above)

Recommendation #4 (Administrative)

Written personnel performance reviews should take place on an annual basis and this practice seems to be generally followed at PPNNE. Both organizations should complete the reviews that are overdue. In addition a system should be set up to assure that subsequent evaluations are completed on a timely basis consistent with applicable personnel policies.

Recommendation #5 (Fiscal)

VDH should consider reflecting all costs involved in the Title X Project. At minimum, key personnel involved in the program as mentioned above, if not charged to the federal and non-federal budget totals, should have an imputed value calculated and reflected as additional "In-Kind" costs being provided by the grantee. This helps for a better basis and knowledge of the actual costs of the Title X Family Planning Project.

Recommendation #6 (Fiscal)

A copy of the quarterly PMS Federal Financial Reports (FFR) should be provided to HD Title X Project staff (Financial Administrator, Grants Program Specialist and Project Administrator). The PMS reports are a valued source of reconciling Title X Project award cash receipts and expenditures, and would be helpful for Title X Project staff completing the required Title X Project annual financial status report section of the FFR.

Recommendation #7 (Fiscal)

The VDH should develop a financial management component to its sub-recipient monitoring process and review tool. This is consistent with the Administrative Program Review finding related to Grantee oversight requirements and developing an appropriate monitoring tool.

Recommendation #8 (Fiscal)

VDH should review annual changes to the Title X Project Sliding Fee Scale procedure charges and Schedule of Discounts to assure that all Title X Family Planning Project charges are proportionately discounted as required and appropriate.

Recommendation #9 (Clinical)

Natural family planning method must be included in the broad range of acceptable/effective FDA approved contraceptive methods and education on contraception must include this method.

Recommendation #10 (Clinical)

PPNNE's clinical protocols have been reviewed and signed off by the Associate Medical Director in the delivery sites in St. Johnsbury and the Barre offices. The protocols in the Department of Health have not been signed. Previous site visits included a finding to have the protocols reviewed and signed. The Department's response was to have the protocols reviewed and signed semi-annually. The Grantee needs to follow its own policy. Protocols may be reviewed annually, at a minimum, and all copies need to be signed. While this is a detail, it should be attended to so that the VDH has documentation on hand of their approval.

Recommendation #11 (Clinical)

PPNNE makes numerous referrals to outside provider services. It is recommended that the agency consider developing contracts and/or MOUs with the outside providers. In this ever changing health care system, it would be beneficial to be able to show formal agreements for the multitude of services that are made available to clients.

Recommendation #12 (Clinical)

PPNNE should secure sharps containers to the wall and leave the medication cabinets and the lab door locked, allowing access only to appropriate personnel. In Barre, the lab, including medication storage cabinets was locked and inaccessible to clients. In St. Johnsbury, medication cabinets were unlocked and the lab door open. Employees explained that the lab area is always under observation but observation of the clinic activities showed opportunities for entry by others.

Vermont Title X
Family Planning Needs Assessment

Prepared by JSI Research & Training Institute, Inc. for the
Vermont Department of Health

October 2015

VERMONT
DEPARTMENT OF HEALTH

Table of Contents

Executive Summary

Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. For more than 45 years, Title X-funded health centers have provided high-quality cost-effective family planning and related preventive health services to low-income, under-insured and uninsured women and men who may otherwise lack access to health care. These health centers play a critical role in ensuring access to voluntary family planning information and services for their clients based on their ability to pay.

The 2015 Vermont Title X assessment process helps to ensure that the state's safety net for sexual and reproductive health services continues to meet the needs of women 15-44 years of age, particularly the most vulnerable. The findings and considerations from the Title X Needs Assessment will guide the Vermont Department of Health (Health Department) and other stakeholders in the planning, programming, and provision of services to ensure a high quality family planning service delivery system that supports Vermont's most vulnerable populations. This report provides a demographic description of Vermont as it relates to family planning, a description of Vermont's Title X family planning system, and a description of Vermont's family planning and reproductive health services and population needs. A summary of the findings and considerations follow.

Vermont Population

- Vermont is one of the most rural states in the U.S., and one of the smallest, with about 626,630 residents in 2013.
- Over 60% of Vermonters live in rural areas of the state. By a large majority, most Vermonters are white (95%), non-Hispanic (98%).
- In 2013, 9% of the Vermont population was under 100% of the federal poverty level (FPL).

Insurance Status

- In 2014, 21% or 132,829 of Vermonters were covered by Medicaid.
- In 2014, about 3.7% or 23,000 Vermonters were uninsured.

Unintended Pregnancy & Teen Pregnancy

- About half of pregnancies among Vermonters are unintended.
- In 2013, the pregnancy rate in Vermont was 61.2 pregnancies per 1,000 women age 15 to 44. The teen pregnancy rate was 21.9 pregnancies per 1,000 women age 15 to 19 years.

Births & Infant Mortality

- In 2013, Vermont had a birth rate of 51.2 births per 1,000 women 15-44 years of age. The teen birth rate was 14.5 births per 1,000 women 15-19 years of age.
- In 2013, Vermont had a preterm birth rate of 8.1%, a low birthweight rate of 7.0%, and an infant mortality rate of 5.0%.

Sexually Transmitted Infections & HIV

- Vermont ranks 44th in rates of syphilis and 46th in rates of both chlamydia and gonorrhea among the 50 states.
- In 2012, the rate of primary and secondary syphilis was 1.0 per 100,000 Vermonters, the rate of chlamydia infections was 275.2 per 100,000 and the rate of gonorrhea was 408.1 per 100,000.
- In 2011, 12 adults and adolescents were diagnosed with HIV in Vermont. Vermont ranked 50th among the 50 states in the number of HIV diagnoses.

Title X in Vermont

The Health Department, the Title X grantee for the state of Vermont, contracts with Planned Parenthood of Northern New England (PPNNE) to provide Title X supported family planning services throughout the state, with a special focus on serving low-income and rural populations.

- In 2013, Title X family planning services helped women in Vermont avoid 2,000 unintended pregnancies, 1000 unplanned births, and 700 abortions, including 400 pregnancies to teens, 200 births to teens, and 100 abortions to teens.
- In 2014, PPNNE's Title X health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont.
    - 47% had incomes at or below 100% of the FPL
    - 77% had incomes at or below 250% of the FPL
    - 24% were uninsured
    - 21% were teens under the age of 20, and
    - 11% were men.

- In 2014, 7714 female clients not pregnant or seeking pregnancy were using the following contraceptive methods:
    - 53% Moderately effective hormonal method – pill, patch, ring, Depo
    - 16% Long-acting reversible contraception (LARC) – IUD or implant
    - 3% Permanent sterilization

- In 2014, of the 776 male clients not seeking pregnancy, 65% were using the male condom, 1% vasectomy, 1% withdrawal, and 2% relied on a female method for contraception.

Strengths & Challenges of Vermont's Family Planning Service Delivery System

- Vermont's Title X-funded health centers provide comprehensive, standardized, high-quality, timely and accessible family planning and reproductive health care throughout the state.
- Vermont's expanded Medicaid program and the Access Plan bolster access to family planning services in the state. Vermont has a relatively low proportion of uninsured individuals.
- Vermont has done good work in HIV and sexuality education within schools using research and evidence-based curricula. School Liaisons and school nurses work to coordinate with local parent child centers and providers to support student reproductive and sexual health needs.
- Energy and efforts to improve access to LARC methods in Vermont, specifically within PPNNE's network of health centers, have been successful in promoting use. Remaining challenges exist, including attitudes and beliefs on use of LARC and reimbursement barriers for providing LARC.

- Disparities in unmet family planning need and health outcomes exist in vulnerable population groups throughout the state, including individuals with low income; teens; individuals with mental health and/or substance abuse issues; lesbian, gay, bisexual, transgender and queer population; racial and ethnic minorities; and incarcerated women.

Summary & Considerations

This review of Vermont's family planning system and population needs presents a positive picture overall. The family planning system is thought to have good access with high quality, comprehensive services, and a supportive landscape. In addition to the 10 Title X funded health centers, Vermont has a broad network of safety-net providers supporting the health care needs of residents throughout the state. Key health and reproductive health indicators also present a favorable status for Vermonters. Most all Vermonters now have health insurance and Vermont's infant mortality, preterm birth, and low weight birth rates rank lower than national rates. Furthermore, the teen pregnancy rate and overall fertility rate for Vermont continue to decline while post-partum contraceptive use is high among Vermonters.

Despite these gains, this review indicates remaining challenges for Vermont. The rate of intended pregnancy remains relatively consistent at about 50%, well below the 65% Healthy Vermonters 2020 goal. Furthermore, fewer than half (49%) of mothers whose pregnancies were unintended reported using any method of birth control. Alcohol and tobacco use during pregnancy remain consistently high compared to other states. Several sub-populations of concern were noted as having disparate unmet family planning need due to financial, transportation, and cultural barriers.

In the context of the gains, strengths, and challenges for Vermont's family planning service delivery system, the following focus areas are called out for consideration and intended to guide future efforts of the Health Department and other family planning programs and stakeholders in Vermont.

I. Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding.

II. Promote awareness, implementation, and adherence to evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.

III. Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling.

IV. Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's heath centers); support innovations and solutions to promote access and awareness of LARC.

V. Facilitate linkages between primary care providers and Title X health centers in Vermont.

VI. Increase provider and consumer knowledge of covered family planning and related preventive health services.

VII. Explore potential opportunities to address family planning, reproductive and sexual health needs of adolescents within school-based health centers in Vermont.

VIII. Explore opportunities for clinical-community linkages between Vermont Title X health centers and community based organizations to establish family planning—human service referral networks.

The considerations are further described on page 25 of the full report.

Introduction

The Title X family planning program is the nation's only dedicated source of federal funding for comprehensive family planning and related preventive health services. The United States Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program and funds a network of family planning centers across the country that serve about five million low-income women and men each year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, and other private nonprofits. In addition, Title X is the only federal program that funds critical infrastructure needs not paid for under Medicaid and private insurance, such as staff salaries, patient education, and community education about family planning and sexual health issues. Title X is also used to subsidize health center rent, utilities, and health information technology.

For more than 45 years, the Title X program has supported clinics to provide family planning services and other preventive health care to low-income, under-insured and uninsured individuals who may otherwise lack access to health care. Title X family planning centers play a critical role in ensuring access to voluntary family planning information and services. They provide high quality, culturally-sensitive, and cost-effective family planning and related preventive health services for low-income women and men including a broad range of FDA-approved contraceptive methods and related counseling; as well as breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals.

Title X in a Changing Health Care Environment. Title X, like many large and historical grant programs, was significantly and positively impacted by the passage of the Patient Protection and Affordable Care Act (ACA). ACA put in place comprehensive health insurance reform expanding access to sexual and reproductive health services thus decreasing the likelihood that coverage is the predominant access issue. The law makes preventive care—including family planning and related care—more accessible and affordable for many Americans. With the implementation of the ACA and expansion of Medicaid, more Americans, including Vermonters, will have health insurance, including coverage of a full range of family planning and related preventive services without out-of-pocket costs. As the health care systems in the United States (U.S.) and Vermont reform, Title X-funded health centers will continue to be important safety-net providers, and will continue to serve: individuals who don't qualify for health insurance, underinsured individuals, insured and uninsured individuals where confidentiality cannot be ensured (e.g., adolescents), and individuals who want to continue receiving care at a family planning site.

Additionally, as our health system evolves to expand access to care, initiatives to improve and ensure quality of care are also being implemented. In 2014, the OPA and Centers for Disease Control and Prevention (CDC) released new recommendations called *Providing Quality Family Planning Services*

(QFP).[1] The QFP provides clear evidence-based clinical practice guidelines intended to improve the quality of family planning services and thereby improve reproductive health outcomes. The QFP recommendations: (1) define a core set of family planning services for women and men, including contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services; (2) describe how to provide contraceptive and other clinical services, serve adolescents, and conduct quality improvement; and (3) encourage the use of the family planning visit to provide selected preventive health services for women, in accordance with the national recommendations for guideline-based care for women. The QFP recommendations supplement the *Title X Program Requirements*[2] and are intended for all providers of family planning services, in addition to Title X-funded programs. Implementing the QFP clinical guidelines in addition to Title X Program Requirements will help Title X-funded programs improve family planning service delivery and provide the services and supports couples need to achieve their desired number and spacing of children.

Title X-funded health centers serve a fundamental role in providing health care to Vermonters. Compared to other health providers in the state, Title X centers in Vermont are ahead of the curve in providing comprehensive high-quality, guideline-based, culturally competent family planning and reproductive health care. However, there is still room for improvement. The 2015 Vermont Title X assessment process helps to ensure that the state's safety net for sexual and reproductive health services continues to meet the needs of women 15-44 years of age, particularly the most vulnerable. The findings and considerations from the Title X Needs Assessment will guide the Vermont Department of Health (Health Department), policy makers, healthcare providers, health and human service organizations, schools and communities in Vermont in their planning, programming, and provision of services to ensure a high quality family planning service delivery system that supports Vermont's most vulnerable populations. This report provides a demographic description of Vermont as it relates to family planning, a description of Vermont's Title X family planning system and services, and a description of Vermont's family planning and reproductive health services and population needs.

Needs Assessment Process

Vermont's approach to the 2015 Title X Needs Assessment was designed to examine both strengths and needs of the state's family planning service delivery system, and the family planning and reproductive health needs of Vermonters. Additionally, the QFP,[3] which provides recommendations for delivering quality family planning services, was used as a framework to inform the needs assessment and its findings and considerations.

[1] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).
[2] Office of Population Affairs. Program Requirements for Title X Funded Family Planning Projects. April 2014.
[3] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).

Overall direction for Vermont's 2015 Title X Needs Assessment was provided by the Health Department Director of Preventive Reproductive Health, including input on the assessment process, identification of stakeholders to participate in key informant interviews and group discussion, review of data as well as the development of the final report and considerations. The 2015 Title X Needs Assessment consisted of two primary information gathering processes: (1) review and analysis of public health surveillance data, including secondary quantitative data (e.g., Family Planning Annual Report) and (2) qualitative data collected through a series of key informant interviews and group discussions with Vermont's family planning and maternal and child health (MCH) stakeholders. Stakeholders represented Planned Parenthood of Northern New England (PPNNE), MCH Coordinators, Parent Child Centers, public health professionals, School Liaisons, medical providers, human service providers (e.g. early childhood) and state program administrators. Over 40 stakeholders were identified who then participated in either individual or group discussions with a total of 23 conducted. Interviews and group discussions explored family planning and related preventive health service needs, including needs of vulnerable populations; family planning systems and supports, including quality; strengths and challenges for family planning services; and, opportunities for improvements and/or assets to be leveraged. A complete list of interviewees and interview guides are available in Appendix I.

Vermont's Family Planning Safety-Net

Title X. Vermont has been funded by the Title X program since its inception, with the overarching goal to *provide high quality clinical family planning and related preventive health services, education, and counseling to Vermonters who would otherwise not have access, with a special focus on low-income and rural populations*. The Vermont Department of Health, the Title X grantee for the state of Vermont, contracts with Planned Parenthood of Northern New England (PPNNE) to provide Title X supported family planning services throughout the state. Ten of PPNNE's 12 Vermont health centers are supported with Title X funds; Title X sites are located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury

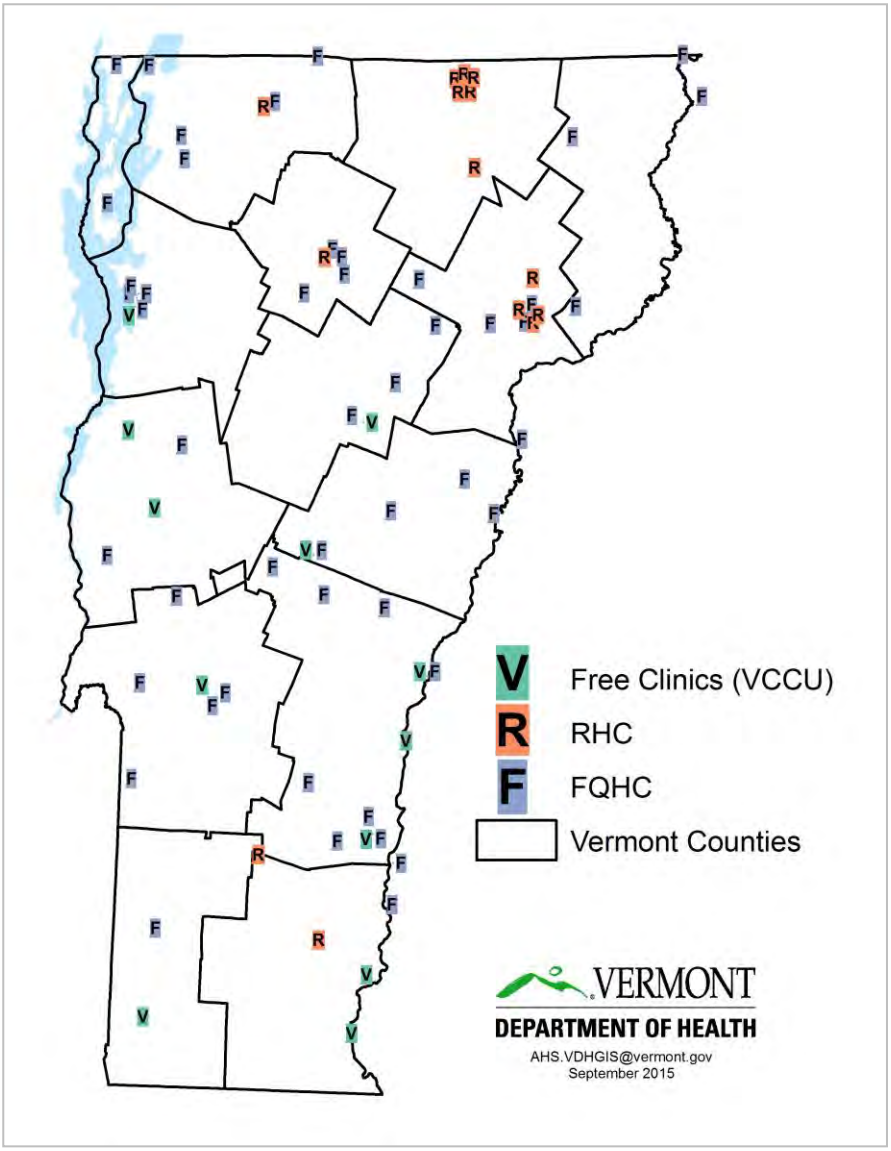
Figure 1. PPNNE Vermont Health Center Sites, 2015

and White River Junction[4] (Figure 1). At present, the PPNNE health centers in Burlington and Williston are not Title X sites. This network of health centers serves as a foundation for providing sexual and reproductive health, and related preventive health services to Vermont's low-income and vulnerable populations.

The state's Title X-funded health centers provide comprehensive family planning and related preventive health services, including contraceptive services; pregnancy testing and counseling; screening, testing, and treatment for sexually transmitted infections; rapid HIV testing; screening for breast, cervical, colorectal, and testicular cancer; preconception education and prenatal referral; basic fertility services; well woman visits; screening for high blood pressure, diabetes and obesity; and referrals for other health and social services. All services provided are based on and adhere to national clinical guidelines and recommendations.

Other Safety-Net Providers. In addition to Vermont's network of Title X health centers, several other organizations and clinics make up Vermont's safety net, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), free clinics, and Vermont's hospital system. Across the country FQHCs and RHCs play a critical role in many communities in ensuring access to care for the uninsured and underinsured. FQHCs and RHCs provide primary care in areas designated by the federal government as underserved; and benefit from an enhanced reimbursement for Medicaid and Medicare services.

There are 12 FQHCs and 12 RHCs located throughout Vermont (Figure 2). FQHCs provide comprehensive



[4]The White River Junction health center site is currently funded by New Hampshire's Title X funding.

Figure 2. Vermont healthcare safety-net sites: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Vermont free clinics. 2015

primary care services across the life span. They are organized as a network of clinics or satellites with a central administration. In Vermont, FQHCs have about 50 primary care sites located in 13 of the state's 14 counties.[5] RHCs are only developed in rural areas and specialize in primary care (pediatrics, internal medicine, family practice, obstetrics).

Vermont's network of free clinics adds further strength to the state's safety net system. The Vermont Coalition of Clinics for the Uninsured (VCCU) is the association of 10 organizations serving the needs of Vermonters without adequate medical and dental insurance and without the means to pay for their health care. Six of these clinics provide onsite medical care by volunteer clinician teams, three offer dental care, and four refer patients to available local clinicians. At each clinic, adult patients are screened for eligibility for various public assistance programs including hospital affordable care programs and Medicaid extension programs.[6]

Vermont's hospitals are also an important safety-net provider of the family planning service delivery system. In particular are Vermont's eight critical access hospitals located in rural communities throughout the state and serve as the first line of defense in emergency situations. The critical access hospitals are all non-profit and required by Vermont to provide care to anyone who walks in the door without regard to insurance status or ability to pay.

Other Vermont Resources to Support Family Planning Needs

Other assets in the state intended to support the reproductive and sexual health needs of Vermonters include: "The Access Plan", the Vermont Sexual Health & Education Program (V-SHEP), the Personal Responsibility Education Program or PREP, school-based health centers, and the Department for Vermont Health Access Medicaid Obstetrical and Maternal Support (MOMS) Program.

Nationally and in Vermont, innovative Medicaid-related initiatives are being implemented to increase access to family planning services. In 2012, the Health Department initiated a program with PPNNE branded "The Access Plan". Vermont has not yet implemented the State eligibility option for family planning services and The Access Plan offers the same statewide scope of services for the same population, using funding through Vermont's 1115 Medicaid waiver. This program provides access to free, confidential and convenient family planning services and supplies to men and women in Vermont who have incomes below 200% FPL and are underinsured or uninsured. Eligible individuals can enroll in The Access Plan at any PPNNE health center in Vermont. Covered services include birth control, annual exams, STI testing and treatment, patient education and counseling, and others.

In 2013 Vermont received a CDC grant award called "Promoting Adolescent Health Through School-Based HIV/STD Prevention" to create the Vermont Sexual Health & Education Program (V-SHEP). From 2013-2018 the Agency of Education is working with 15 supervisory unions and school districts throughout Vermont to assist in improving sexual health and education for middle and high school students. There are three main components to this work: providing comprehensive sexual health

[5] Vermont State Office of Rural Health and Primary Care, 2015
[6] Vermont State Office of Rural Health and Primary Care, 2015

education, working with school nurses to ensure all students have a medical home and receive guideline-based preventive pediatric health care, and providing a learning environment in which all students can expect to feel safe and supported. The Agency of Education is partnering with several local and national partners to implement this work including Outright Vermont in Burlington, The Center for Health and Learning in Brattleboro, and Answer, which is a national sexual education organization.

In 2011, the Health Department was awarded a Personal Responsibility Education Program (PREP) grant to support comprehensive education on sexual health, abstinence, and contraception for the prevention of pregnancy and sexually transmitted infections (STIs). The program targets youth between ages 10-19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen birth rates, or come from racial or ethnic minority groups. The program also supports pregnant and parenting youth under 21 years of age. The Health Department is currently funding six community-based organizations throughout the state to implement PREP; PREP is offered at 13 sites across the state and will serve approximately 440 youth in the 2015 grant year.

School-based health centers (SBHC) have become an important method of health care delivery for youth throughout the country. They provide a variety of health care services to youth in a convenient and accessible environment. Although SBHC models vary, they are typically operated as a partnership between the school and a community health organization, such as a community health center. The services provided by SBHCs vary based on community needs and resources as determined through collaborations between the community, the school district and the health care providers. Currently, there are about five SBHCs in Vermont, including in Burlington High School and in St. Albans. The structure of SBHCs in Vermont varies depending on need and they are intended to supplement rather than replace the medical home. They assure the provision of key physical and mental health services as well as preventive health services.

The MOMS Program is administered through the Vermont Chronic Care Initiative (VCCI) at the Department of Vermont Health Access. The goal of this program is to improve pregnancy outcomes for Medicaid covered pregnant women considered high risk due to a mental health condition, substance use, and/or having had a previous pre-term delivery prior to 32 weeks gestation. Them MOMS Program provides enhanced prenatal care that includes a comprehensive psychosocial assessment, care coordination, an individualized maternity care plan, and referral to other social support services and resources that may result in improved pregnancy outcomes.

Vermont Geographic, Demographic & Socioeconomic Overview

Geography. Vermont is one of the most rural states in the U.S., and one of the smallest, with a population estimate of 626,630 in 2013.[7] Vermont has only one true urban area (i.e. metropolitan statistical area) comprised of Chittenden, Franklin, and Grand Isle counties. Over 60% of Vermont's population resides in rural areas.[8]

Demographics. In 2013, Vermont's population distribution by age was estimated as follows:[9]

- 19.6% children 0-17 years of age
- 33.8% adults 18-44 years of age
- 30.2% adults 45-64 years of age
- 16.4% 65 years of age and older

About 51% of Vermont's population is female.[10]

Although Vermont's racial and ethnic minority populations are growing, the large majority of Vermonters are white. In 2013, the population distribution by race and ethnicity was estimated as follows:[11]

- 95.2% White
- 1.2% Black or African American
- 0.4% American Indian and Alaska Native
- 1.4% Asian
- 1.8% Multiracial
- 1.7% Hispanic or Latino

Vermont's largest urban area, Chittenden County, is composed of greater racial and ethnic diversity compared to the state:[12]

- 92.2% White
- 2.3% Black or African American
- 0.3% American Indian and Alaska Native
- 3.2% Asian
- 2.0% Multiracial
- 2.0% Hispanic or Latino

Employment. Since July 2013, the Vermont economy has been steadily improving. As of May 2015, Vermont's unemployment rate was 3.6%, compared to a national rate of 5.5%. However, the

[7] Vermont Department of Health. Vermont Population Estimates 2013.
[8] Census Bureau. Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports. March 26, 2012. https://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html Accessed June 26, 2015.
[9] Vermont Department of Health. Vermont Population Estimates 2013.
[10] Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.
[11] Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.
[12] Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.

unemployment rate varies across counties, ranging from 2.5% in Chittenden County and 5.7% in Essex county, and across towns, ranging from 1.9% in Middlesex up to 17.3% in Killington.[13]

Income. In 2014, Vermont's average annual wage was $43,011, with higher wages in Chittenden County at $49,656 and the lowest wages in Grand Isle County at $31,111.[14] According to the 2014 federal poverty guidelines, an income of $23,850 for a family of four is equal to the federal poverty level (FPL).[15]

Poverty. In 2013, 9% of the Vermont population was under 100% FPL compared to 15% of the U.S. population;[16] and 19% of the Vermont population fell between 100%-199% FPL, equivalent to the U.S. population.[17]

Education. About 91% of Vermonters age 25 and older are high school graduates, compared to 86% of the U.S. population.[18] Just over three in ten (32%) Vermont adults have a college education or higher; four in ten or 39% have a high school education or less.[19]

Insurance Status. Children 0-18 years of age with a family income of 312% FPL are eligible for Medicaid in Vermont. Women who are pregnant with an income up to 208% FPL are eligible for Medicaid in Vermont. Vermont has expanded Medicaid coverage to low-income adults as well, up to 133% FPL.[20] In 2014, 21% or 132,829 Vermonters were insured by Medicaid.[21]

In 2014, it was estimated that 3.7% or 23,000 Vermonters were uninsured. Compared to 2012, the number of Vermont residents reporting no health insurance decreased by about 20,000 individuals (6.8% to 3.7%). About 1,300 of Vermont's uninsured population are under age 18, representing 1% of Vermont's children 0-17 years of age. About 2,900 or 4.6% of young adults 18-24 are uninsured and about 7,900 or 11% of adults 25-34 years of age are uninsured.[22]

[13] Vermont Department of Labor. Local Area Unemployment Statistics. May 2015.
[14] Vermont Department of Labor. Vermont Quarterly Census of Employment Wages. 2014.
[15] U.S. Department of Health and Human Services. 2014 Federal Poverty Guidelines.
[16] The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $18,751 in 2013.
[17] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[18] Census Bureau. Quick Facts Vermont. Accessed June 26, 2015.
[19] Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.
[20] Medicaid.gov. Vermont Profile. Accessed September 9, 2015.
[21] Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.
[22] Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.

Vermont Family Planning & Reproductive Health Overview

Women of Reproductive Age. In 2013 in Vermont, there were 116,335 women of reproductive age (aged 15–44).[23] According to Vermont's Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey conducted annually among adults 18 and older, in 2013:[24]

- 36% of women age 18-44 said a health care professional had ever spoken with them about ways to prepare for a healthy pregnancy and baby.
- 72% of women 18-44 said they used birth control at the last time they had sex. More than a third (36%) said it was a shot, pill, contraceptive patch or a diaphragm; 22% used a permanent method (i.e., sterilization); and 17% used a LARC.
- Women who did not use birth control during their most recent sex indicated most often it was because they were unable to get pregnant (43%) or they were seeking pregnancy (26%).

Births. In 2013, 5,951 babies were born to Vermont residents, representing a birth rate of 51.2 births per 1000 women 15-44 years of age (i.e., fertility rate), a slight decrease from 51.5 in 2012 and 51.6 in 2011. The teen birth rate in Vermont in 2013 was 14.5 births per 1000 women 15-19 years of age, compared to the U.S. rate of 26.5; 317 infants were born to Vermont mothers ages 15-19 in 2013.[25]

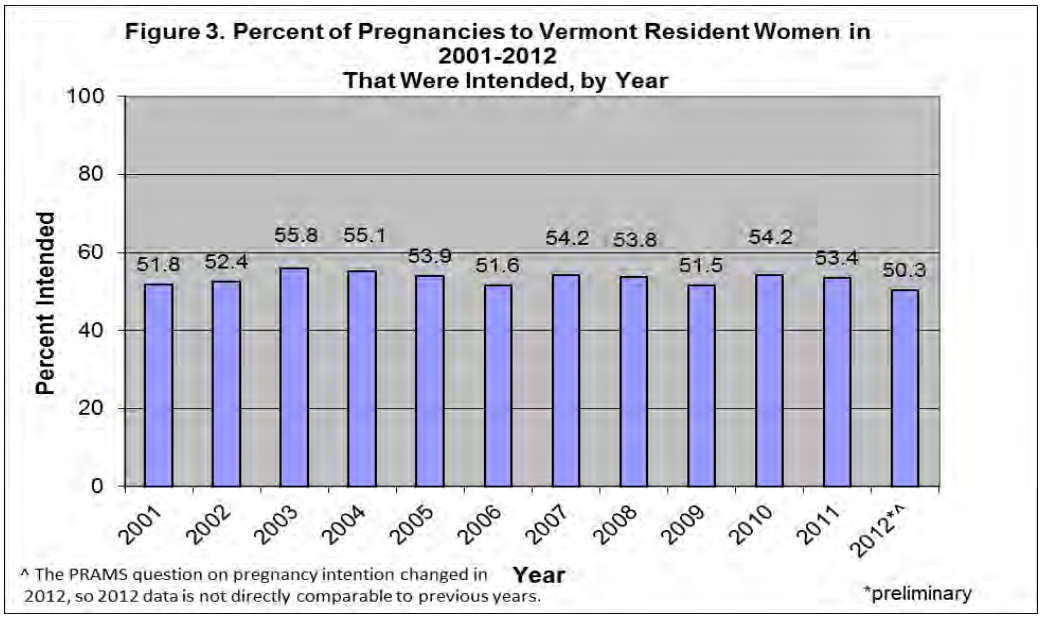
Vermont's preterm birth rate in 2013 was 8.1% compared to 11.4% among the U.S. population. Vermont's low birthweight rate in 2013 was 7% compared to 8% among the U.S. population. Vermont's infant mortality rate was 5.0% compared to 6.4% among the U.S. population.[26]

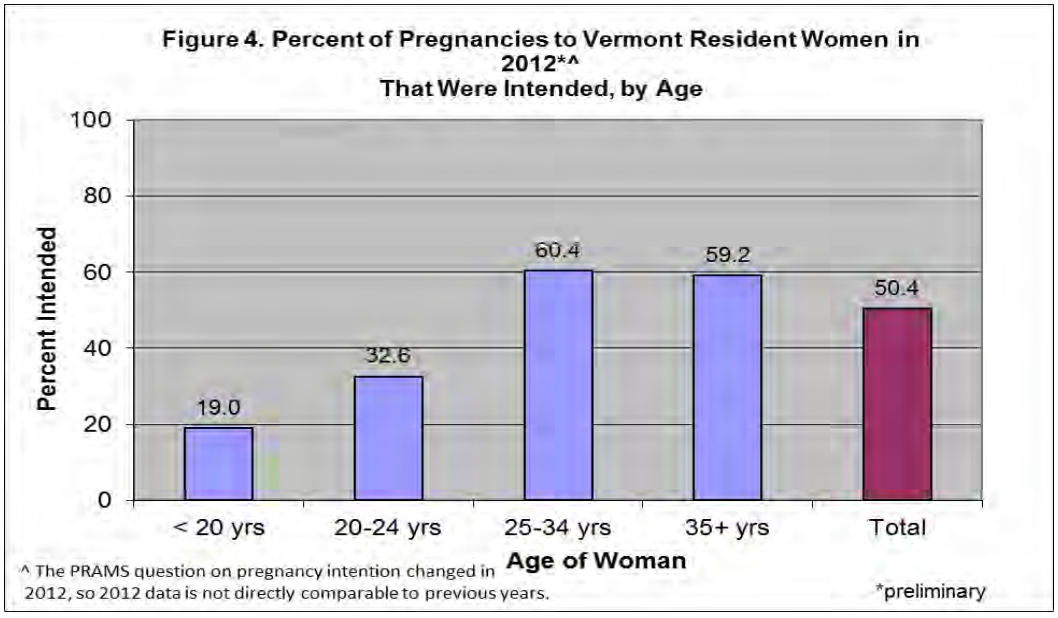
Pregnancy & Unintended Pregnancy. In 2013, the pregnancy rate in Vermont was 61.2 pregnancies per 1,000 women age 15 to 44, a decrease from 61.7 in 2012 and 62.4 in 2011. The 2013 teen pregnancy rate was 21.9 pregnancies per 1,000 women age 15 to 19 years, a decrease from 23.1 in 2012 and 25.2 in 2011. In general the teen pregnancy rate has been decreasing since 1991.[27]

Unintended Pregnancy. The Pregnancy Risk Assessment Monitoring System (PRAMS) helps public health professionals survey the population and track trends over time. The survey is of women who recently gave birth and asks about their experiences and behaviors before, during and shortly after their pregnancy. In 2012, PRAMS indicated that 39.8% of pregnancies among Vermont women who had a live birth were unintended. This is an increase from 2010 and 2011, in which 35.1% and 35.4% of Vermont pregnancies were reported as unintended, respectively. However, of note is a change in the 2012 PRAMS survey question on the intendedness of a pregnancy. The 2012 respondents were given the option of responding to the question with "I wasn't sure what I wanted". This answer option is included as unintended and therefore 2012 data are not directly comparable to previous years.[28]

[23] Vermont Department of Health. Vermont Population Estimates 2013.
[24] Vermont Behavioral Risk Factor Surveillance Survey. 2013 Data Summary.
[25] Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.
[26] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[27] Vermont Department of Health. Vital Statistics. Internal Communication.
[28] Vermont Department of Health. Pregnancy Risk Assessment Monitoring System. Internal Communication.

Using PRAMS data to estimate the percentage of women with live births who report their pregnancy was intended and applying this to Vermont's vital statistics data on the number of pregnancies, live births, and abortions (considered unwanted pregnancies), intended pregnancies among Vermont women can be further analyzed. Figure 3 displays the percent of pregnancies to Vermont women that were intended, by year, and Figure 4 displays the percent of pregnancies to Vermont women in 2012 that were intended, by age. According to 2012 data, 50.4% of pregnancies to Vermont women were intended relative to the Healthy Vermonters 2020 goal of 65%.[29]





[29] Vermont Department of Health. Pregnancy Risk Assessment Monitoring System and Vital Statistics.

Teen Sexual Behavior, Pregnancy & Birth Rate. In 2013, 43% of high school students in Vermont reported ever having sex and 44% reported ever having oral sex. Among those sexually active, 85% reported using prescription birth control or condoms at last sex. Twenty two percent of students reported using drugs or alcohol at last sex.[30]

Vermont has a relatively low teen pregnancy rate of 22 pregnancies per 1000 women 15-19 years of age, a decrease from 23.1 in 2012 and 25.2 in 2011. In 2013, there were 478 pregnancies to Vermont teens aged 15–19; 317 or 66% resulted in a live birth. Based on this data, the 2013 teen birth rate is 14.5 per 1,000 women 15-19 years of age, a decrease from a rate of 16.3 in 2012 and 16.8 in 2011.[31]

STIs & HIV.

Syphilis [32]

- In Vermont, the rate of primary and secondary syphilis was 1.8 per 100,000 in 2008 and 1.0 per 100,000 in 2012. Vermont ranks 44th in rates of syphilis among the 50 states.
- There were 0 cases of congenital syphilis from 2008 through 2012.

Chlamydia & Gonorrhea[33]

In 2012, Vermont:

- Ranked 46th among 50 states in chlamydial infections (275.2 per 100,000 persons) and ranked 46th among 50 states in gonorrheal infections (15.8 per 100,000 persons).
- Reported rates of chlamydia among women (408.1 cases per 100,000) were 2.9 times greater than those among men (138.6 cases per 100,000).

HIV

- In 2011, an estimated 12 adults and adolescents were diagnosed with HIV in Vermont. Vermont ranked 50th among the 50 states in the number of HIV diagnoses in 2011. [34]
- In 2014, 3 in 10 (31%) of Vermont adults reported every being tested for HIV, with more than half indicating their last HIV test was at a private doctor's office. Adults 25-44 were significantly more likely to have ever been tested for HIV (52%) than other age groups. Six percent of Vermont adults reported HIV testing in the past year.[35]

Family Planning Behaviors & Risk Factors. Understanding family planning behaviors and risk factors that affect reproductive and sexual health help to identify opportunities for prevention, early intervention, and education, particularly for those who experience an unintended pregnancy. The following information is from the 2011 Vermont PRAMS:[36]

[30] Vermont Youth Risk Behavior Survey. 2013.
[31] Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.
[32] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[33] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[34] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[35] Vermont Behavioral Risk Factor Surveillance System. 201.
[36] Vermont Pregnancy Risk Assessment Monitoring System. 2011.

- Half (49%) of mothers whose pregnancies were unintended reported using any method of birth control.
- Vermont has a relatively high rate of postpartum contraception use compared to other PRAM states; 88% of mothers used contraception after their most recent birth, including 95% of teen mothers.
- Although the Vermont PRAMS survey found a discussion with a health care worker about birth spacing was not associated with the likelihood of using contraception, postpartum contraception use occurred more frequently with women who had talked to a health care worker about a specific method of birth control after delivery. The most common reasons women gave for not using postpartum contraception were abstinence and "don't want to use".

Vermont 2011 PRAMS data indicate the following regarding preconception health:

Multivitamin Use and Weight Gain: 38% of women reported taking a multivitamin every day in the month prior to pregnancy; 19% of mothers age 20 - 24 took a daily multivitamin during the month prior to pregnancy. 23% of mothers were overweight prior to pregnancy, and 20% were obese. 29% of mothers were dieting to lose weight in the year prior to pregnancy, and over half (52%) reported exercising 3 or more times per week.[37]

Alcohol and Tobacco Use: 31% of women smoked in the three months prior to pregnancy; 19% smoked during the last trimester. 67% of women reported drinking at least some alcohol in the 3 months prior to pregnancy; and, 13% of women reported drinking during the last 3 months of their pregnancy, the highest rate reported among states with PRAMS data.[38]

Stress and Abuse: 70% of women reported at least one stressor during the year before giving birth, with 27% reporting at least 3 stressors, and 6% reporting 6 or more.[39]

- 53% reported financial stress
- 29% reported experiencing emotional stress
- 28% reported partner stress
- 20% reported traumatic stress

Intimate Partner Violence. The 2014 Vermont BRFSS survey included questions on intimate partner violence. Responses indicate that 13% of adults said an intimate partner had ever hit, slapped, pushed, kicked or hurt them in any way. Having ever experienced physical abuse by an intimate partner was statistically more common among women at 16% compared to 9% of men. Additionally, 12% of adults said an intimate partner had ever threatened or made them feel unsafe in some way, and 13% said that an intimate partner had ever tried to control their daily activities. These experiences

[37] Vermont Pregnancy Risk Assessment Monitoring System. 2011.
[38] Vermont Pregnancy Risk Assessment Monitoring System. 2011.
[39] Vermont Pregnancy Risk Assessment Monitoring System. 2011.

were also statistically more common among women compared to men, 19% versus 5% and 16 versus 9%, respectively.[40]

Impact of Services Provided by Title X

- In 2013, there were 68,060 women in Vermont in need of *publicly supported* contraceptive services and supplies. Of these, 9,830 were in need of publicly supported services because they were sexually active teenagers and 26,030 because they had incomes below 250% FPL.[41]
- In 2013, Title X family planning services helped women in Vermont avoid 2,000 unintended pregnancies, 1000 unplanned births, and 700 abortions, including 400 pregnancies to teens, 200 births to teens, and 100 abortions to teens.[42]

Vermont's Title X Population

In 2014, PPNNE's Title X network of health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont,[43] compared to a total of 8,872 served in 2013.[44] Of the 8,719 clients served in 2014:

- 47% had incomes at or below 100% FPL, 77% had incomes at or below 250% FPL
- 24% were uninsured
- 21% were teens under the age of 20, and
- 11% were men

The following tables further describe the 8,719 Vermont residents served by Title X in 2014.[45]

Table 1. Unduplicated Number of Family Planning Users by Age Group and Sex

Age Group	Female Users	Male Users	Total Users (%)
Under 15	96	4	100 (1%)
15 – 17	799	24	823 (9%)
18 – 19	871	49	920 (11%)
20 – 24	2193	286	2479 (28%)
25 – 29	1556	207	1763 (20%)
30 – 34	899	171	1070 (12%)
35 – 39	521	65	586 (7%)
40 – 44	376	50	426 (5%)
Over 44	485	67	552 (6%)
Total Users	7796	923	8719

[40] Vermont Behavioral Risk Factor Surveillance System. 2014.
[41] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.
[42] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.
[43] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.
[44] Vermont Title X Family Planning Annual Report. 2013.
[45] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

Table 2. Unduplicated Number of Family Planning Users by Race and Ethnicity

Race	Hispanic or Latino	Not Hispanic or Latino	Unknown/ Not Reported	Total Users (%)
American Indian or Alaska Native	0	11	1	12 (<1%)
Asian	0	44	5	49 (<1%)
Black or African American	5	91	12	108 (1%)
Native Hawaiian or Other Pacific Islander	0	3	0	3 (<1%)
White	63	5109	465	5637 (65%)
More than one race	7	29	4	40 (<1%)
Unknown/not reported	70	2533	267	2870 (33%)
Total Users	145	7820	754	8719

Table 3. Unduplicated Number of Family Planning Users by Income Level

Income Level as a Percentage of the HHS Poverty Guidelines	Number of Users (%)
100% and below	4110 (47%)
101% - 150%	1275 (15%)
151% - 200%	885 (10%)
201% - 250%	433 (5%)
Over 250%	929 (11%)
Unknown / Not Reported	1087 (12%)
Total Users	8719

Table 4. Unduplicated Number of Family Planning Users by Principal Health Insurance Coverage Status

Principal Health Insurance Covering Primary Medical Care	Number of Users (%)
Public Health Insurance	3342 (38%)
Private Health Insurance	3278 (38%)
Uninsured	2099 (24%)
Unknown / Not Reported	0
Total Users	8719

Contraceptive Methods Used. PPNNE health centers provide contraceptive counseling to all clients as part of a family planning visit and/or for all clients at risk for pregnancy. In 2014, 7714 female clients not pregnant or seeking pregnancy were using the following contraceptive methods:[46]

- 53% Moderately effective hormonal method – pill, patch, ring, Depo
- 16% Long-acting reversible contraception (LARC) – IUD or implant
- 3% Permanent sterilization
- 3% Abstinence

Table 5. Unduplicated Number of Female Family Planning Users by Primary Method of Contraception

Primary Contraceptive Method	Total Female Users
Female Sterilization	235
Intrauterine Devise or System	797
Hormonal Implant	445
Hormonal Injection	726
Oral Contraceptive	2918
Contraceptive Patch	139
Vaginal Ring	311
Cervical Cap or Diaphragm	8
Contraceptive Sponge	0
Female Condom	7
Spermicide (used along)	5
Fertility Awareness or Lactational Amenorrhea Method	0
Abstinence	206
Withdrawal or other method	74
Rely on Male Method	
Vasectomy	37
Male Condom	543
No Method	854
Unknown/Not Reported	409
Total Female Users	7714

Similar to national trends, LARC use among Vermonters is growing, particularly among women served by Title X clinics in Vermont. In 2010, 7.2% of the females served by Title X clinics and using contraception reported a LARC as their primary method of contraception. In 2014, LARC use grew to 17.5% among females served by Title X clinics and using contraception (Figure 5.)[47]

[46] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

[47] Vermont Title X Family Planning Annual Report. 2010 -2013; Preliminary Data 2014. Denominator excluded female clients reporting pregnant or seeking pregnancy, refraining from sexual intercourse, and whose primary method was unknown.

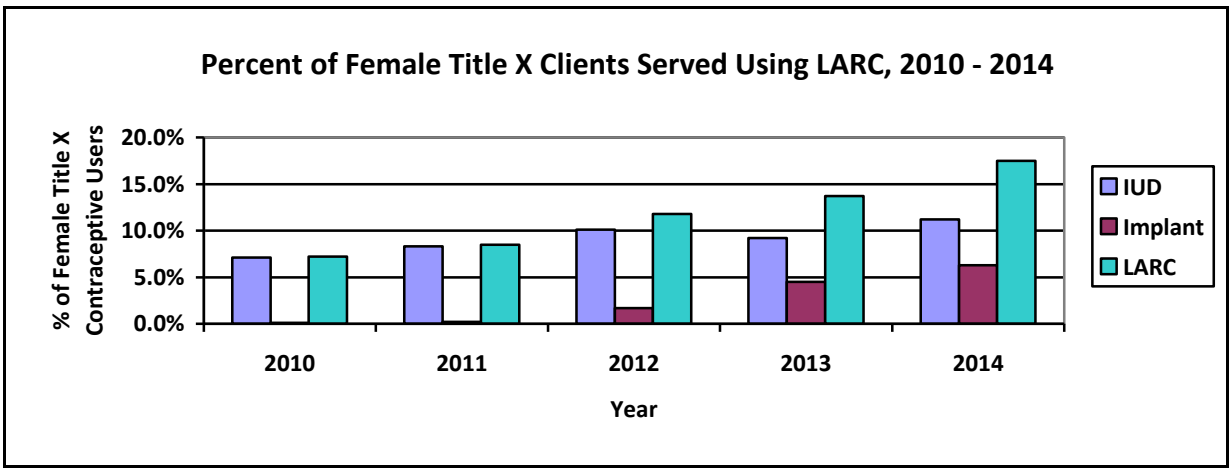


Figure 5. Percent of Title X Female Family Planning Users Reporting use of LARC, 2010 –2014.

In 2014, the 776 male clients not seeking pregnancy were using the following contraceptive methods:[48]

- 65% Male condom
- 1% Vasectomy
- 1% Withdrawal
- 2% Rely on female method

Table 6. Unduplicated Number of Male Family Planning Users by Primary Method of Contraception

Primary Contraceptive Method	Total Male Users
Vasectomy	7
Male Condom	508
Fertility Awareness Method	0
Abstinence	41
Withdrawal or other method	10
Rely on Female Method	14
No Method	136
Unknown/Not Reported	60
Total Male Users	776

STI & HIV Testing. PPNNE provides evidence-based STI screening, testing, and counseling. In 2014, PPNNE Vermont Title X health centers performed the following tests:

- 5,281 Chlamydia tests
- 5,283 Gonorrhea tests
- 1,544 HIV tests
- 403 Syphilis tests

[48] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

- 1030 HSV tests
- 1544 rapid HIV tests

Furthermore, 60% of all female patients under 25 years of age received a chlamydia test in 2014.

Preventive Health Services. In 2014, 15% of all female clients received a Pap test for cervical cancer screening and 24% received a clinical breast exam.[49]

Findings from the Field

To assess the strengths, challenges, and needs of Vermont's family planning service delivery system, with a particular focus on Title X-funded health centers and services, key informant interviews and discussion groups were conducted with organizations and stakeholders such as PPNNE (e.g., Medical Director, Senior Operations Manager, Director of Government Grants); Vermont's Primary Care Public Health Integration group, Department for Vermont Health Access, and School Liaisons from Vermont's Office of Local Health. A summary of findings and themes related to quality, access, needs, and high priority populations is provided.

Strengths of Vermont's Family Planning System. As the sole Title X provider in Vermont, PPNNE is a valued asset in the state, according to interviewees. PPNNE interviews indicated they provide comprehensive, standardized, high-quality family planning and reproductive health care across all of their health centers throughout the state. To ensure accessible and timely services, health center sites are maintained regionally throughout the state. As a result, access to PPNNE's services is considered strong, even in the very rural parts of the state. Vermont's Medicaid program and the Access Plan further bolster access to family planning services, according to interviewees. The Medicaid income eligibility limit for Vermont adults is 138% FPL and 213% FPL for women who are pregnant.[50] For children 0-18, the Medicaid income eligibility limit is set at 242% FPL and 317% FPL for the Children's Health Insurance Program (CHIP).[51] The Access Plan, sponsored by the Health Department, supports PPNNE's delivery of family planning services to low-income Vermonters living at less than 200% FPL. Interviewees were optimistic that as health care reform is implemented in Vermont, there will increasingly be more people with access to private health insurance and have no cost-sharing for most of the services PPNNE provides (i.e. preventive services).

Vermont has a relatively low number and proportion of uninsured individuals compared to other states and as more become insured, PPNNE expects it will benefit from a business perspective because there will be fewer men and women to cover via a sliding fee. As the health care system in Vermont evolves in response to health care reform, interviewees indicated a need to establish the role of family planning within the strategies for improved population health, which currently focuses on chronic conditions. Interviewees have found it challenging to weave family planning strategies (e.g., LARC) into health reform conversations that focus on exploring high impact opportunities to promote

[49] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.
[50] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[51] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org

preventive care and wellness as a mechanism to improve overall population health. One challenge noted is conveying the long-term shared savings from family planning interventions relative to providers being limited to capturing savings from attributable patients. As one interviewee noted, "…the savings needs to be shared more broadly". It was suggested that accountable communities of health may be an opportunity to better address the health impact and savings of family planning strategies within the context of improving population health while reducing costs to the health care system.

To ensure accessible high-quality systems and services, PPNNE shared that they have established practices to monitor, assess and improve their clinical and administrative workflows, workforce capacity, and better address patient needs. Specific initiatives include:

- Transitioning all health centers to an electronic health record system (EHR), with a final rollout to be complete by September 2015.
- Enhanced staffing models (e.g., Health Care Associates), flexible staffing (e.g., telecommute), and telemedicine initiatives (e.g., contraceptive counseling and options, urinary tract infection visit, and STI/HIV screening) to maximize capacity, and to support a feasible and financially sustainable business model, high-quality staffing and retention, and a work environment supportive of work-life balance.
- Rebranding of all health centers to have an aligned look and feel that speaks to the quality of care PPNNE provides. This initiative is intended to support a change in PPNNE's tagline to a provider of choice rather than a provider of last resort. The rebranding initiative is expensive and has been supported by private donations to date.
- Efforts to ensure culturally competent care, such as recruiting a diverse workforce representative of the patient population PPNNE serves, and providing ongoing training of staff to increase culturally competent care (e.g., PPNNE human resources Inclusivity Project).
- Strategic collaboration with community partners to best serve the needs of vulnerable populations (e.g., maintain same day access to services at the St. Albans health center to support needs of population with substance abuse issues).
- Addition of a centralized nurse care coordinator to provide care coordination for clients across PPNNE Vermont health centers and other primary care or specialty providers.

Other strengths reported beyond the Title X funded health centers focused on schools and potential for SBHCs to address sexual and reproductive health. Interviewees reported that Vermont has done good work in HIV and sexuality education within schools using research and evidence-based curricula. PREP and V-SHEP are examples. School Liaisons and school nurses throughout the state make efforts to coordinate with local parent child centers and providers to support students' reproductive and sexual health needs. For example, in Brattleboro the School Liaison makes efforts to coordinate with the local PPNNE health center to facilitate student contraceptive needs; in Morrisville the Coordinated School Health Team is currently focusing on sexuality education across grades K-12. Building on this work, interviewees feel there is further need and opportunity to do more systems-level work to address barriers (e.g., transportation, financial, and attitudes and beliefs on providing sexual and reproductive health education and services within the school setting), and to create linkages between schools, communities, and health care providers in support of student health, including reproductive and sexual health. Interviewees suggested the *Whole School, Whole Community, Whole Child* model

is an opportunity to address student reproductive and sexual health more broadly within schools and communities, as this model emphasizes collaboration among the school, health, and community sectors to improve each child's learning and health.[52]

SBHCs were also noted as strength where they exist in the state. Some health care providers have looked at how SBHCs could provide services for specific areas of need in concert with primary care providers. Burlington High School has a SBHC in which primary care providers see students at the SBHC for acute visits. The providers are currently working more on connecting students with primary care for regular routine visits, such as adolescent health visits. However, providers noted that not all students are receptive to following up with a primary care provider or medical home, and therefor there is need to provide primary care services to students at the SBHC (e.g., vaccines).

The SBHC in St. Albans was indicated as a long-standing example of a SBHC in which a local community provider goes to the high school once a week to see patients to provide health services such as followup on asthma and depression. In Burlington's SBHC, providers find that mental health and behavioral health issues are the most prevalent issues they address with students. Providers work closely with the guidance counselors and the Community Health Team to support student counseling needs. Reproductive health and sexual health services are not currently provided by SBHCs, according to those interviewed.

Challenges for Vermont's Family Planning System. Although PPNNE has implemented several innovative strategies to enhance access to services throughout the state and to target populations, interviewees feel there is room for improving access. They reported that maintaining access in the very rural areas of the state has been difficult due to challenges related to financial sustainability and staff recruitment and retention. Thus, some of PPNNE Vermont health centers are very small and open on a limited basis (e.g., fewer hours and/or days per week).

Interviewees are interested in improving access to services for teens, particularly for teens insured under their parents' health care plans but who may be reluctant to use their insurance due to concerns about confidentiality.

Gaps in access to family planning services were reported for other vulnerable populations in Vermont as well, such as the immigrant and migrant populations, both due to barriers in access related to lack of insurance and barriers related to outreach, engagement, transportation, and health literacy.

Interviewees reported there are gaps in the system on engagement and access for individuals with substance abuse issues. Although PPNNE health centers and community based organizations are making efforts to better reach these individuals to meet their family planning needs, they find it is a difficult population to reach as family planning is often a secondary priority relative to substance use and treatment.

[52] Centers for Disease Control and Prevention. Whole School, Whole Community, Whole Child. http://www.cdc.gov/healthyyouth/wscc/ Accessed October 2, 2015.

Long-Acting Reversible Contraception (LARC). Interviewees felt strongly that increasing awareness, access, and availability to long-acting reversible contraception (LARC) is a key strategy to reducing unintended pregnancy. LARC includes intrauterine devices (IUD) and implants, which are highly effective contraceptive methods for preventing pregnancy. Energy and efforts to improve access to LARC in Vermont, specifically within PPNNE's network of health centers, are felt to have been successful in promoting use of LARC. Interviewees reported the following initiatives have been important factors in improving access and uptake of LARC over recent years:

- All PPNNE clinicians are trained to provide LARC
- A centralized supply chain for LARC ensures adequate supplies at each site to provide same-day services as needed
- Bulk purchase of LARC supports affordability
- Establishing referral relationships and processes with other providers to support access to LARC
- Tiered counseling for all patients promotes awareness and uptake of LARC
- Establishment of a LARC Workgroup (e.g., Health Department, PPNNE, Primary Care Public Health Integration group members, UVM Medical Center Departments of Obstetrics and Gynecology and Family Medicine, and VCHIP)
- Conducting a needs assessment, provider survey and mapping of LARC services in Vermont to inform LARC training to providers. Training will be provided by the Vermont Child Health Improvement Program, a maternal and child health services research and quality improvement program of the University of Vermont.

Remaining barriers and challenges to promoting access and use of LARC were identified and include addressing (1) misperceptions, attitudes, and beliefs on LARC, and (2) the low margins of reimbursement most providers realize for providing LARC, which lends to low financial incentive for promoting provision of LARC. One emerging solution noted to reduce the financial burden of providing LARC is a new alternative IUD, Liletta. PPNNE reported that Liletta is recently available at an improved pricing structure for Title X grantees and FQHCs. PPNNE has replaced the Mirena IUD with Liletta to ease the financial burden of stocking and providing these devices.

Another reported barrier to expanding access to LARC post-partum is the bundled reimbursement mechanism for providing an IUD. In general, both public and private insurers have a global reimbursement rate for hospital care and services during the time of delivery. Provision of LARC post-partum after delivery is included in this bundled rate, resulting in a financial loss to hospitals that provide an IUD post-partum.

As Vermont works to expand access to LARC, particularly for adolescents, interviewees feel that strengthening relationships and referrals from the pediatric community will be important. Interviewees feel the pediatric community is currently not comfortable with providing LARC. PPNNE feels their well-established systems and skilled workforce could serve as an important resource to meet the LARC need among interested Vermont adolescents. In addition to relationship building, it is felt that culture change regarding the perception and role of PPNNE health centers among the medical community will be necessary to facilitate collaborative agreements and referral networks.

The Community Health Centers of Burlington, an FQHC, noted they too have strong systems in place to provide LARC. Staff are trained to provide LARC, including mid-level providers, they stock LARC supplies, and have found they have good uptake of LARC among their patient population.

High Priority Populations. Interviewees noted several populations in Vermont they prioritized as vulnerable and in need of family planning services. These included individuals of low income; teens; men; individuals with mental health and/or substance abuse issues; the lesbian, gay, bisexual, transgender and queer population (LGBTQ); racial and ethnic minorities; and women who are incarcerated.

Low Income. Interviewees indicated that PPNNE health centers serve clients across all incomes, but the majority of their clients are of low income, at or below 100% FPL. Interviewees expressed concern around fully meeting the many social needs of low income clients, which can also influence family planning outcomes. A common example shared was that when impoverished individuals are struggling with food insecurity and housing insecurity, family planning and contraceptive use is not always a priority. To better support client needs beyond family planning and other health care needs, PPNNE is currently working with Vermont's 3 Square Program to establish referrals to and from the Program in an effort to ensure food security among their clients.

Teens. Interviewees indicate need to improve access for teens, particularly teens with health insurance that choose not to use their health insurance for services due to confidentiality concerns. Although this group is a small subset of the population served, PPNNE would like to determine how to best serve this population.

The majority of PPNNE's population served is 16-26 years of age. In their outreach and engagement efforts, PPNNE works to meet teens where they are at, for example, using multiple social media platforms and exploring potential opportunity to use telemedicine to serve teens and mitigate transportation barriers. PPNNE is also starting to work with the school system again and currently has a condom program at their White River Junction site.

Another resource called out to support teens' family planning, reproductive and sexual health needs are SBHCs in Vermont. Interviewees feel they offer an effective mechanism to reach adolescents and provide contraceptive services and/or refer students to other providers to address family planning and other health care needs.

Many interviewees noted concern on maintaining engagement in the health care system as adolescents transition to young adulthood. Continued engagement and use of the health system was indicated as an important facilitator in ensuring continuity of care and preventive care. This is considered important because family planning services are often a primary entry point and use of the health care system for adolescents and young adults, and interviewees indicated that young adults in Vermont experience challenges in obtaining timely access to primary care. Some interviewees felt that integrating well-woman care into family planning and preconception care may be promising strategy to maintain access and engagement in the health system as adolescents transition to adulthood.

Men. PPNNE indicated they are growing the number of male clients served each year, and have made intentional efforts to better reach and serve men. PPNNE's recent rebranding included marketing campaigns inclusive of men (i.e., messaging that in addition to serving women, PPNNE is a place for men to receive high-quality family planning and reproductive health services, too), and the redesign of health centers that are intended to be a comfortable environment for men and women. PPNNE has also tailored services to better reach men and ensure services are inclusive of men's family planning and reproductive health needs (i.e., integrating STI services into patient visits and providing expedited partner treatment).

Interviewees report that men primarily access and use the family planning service delivery system for STI screening. Providers try to segue conversations during visits to talk about contraception, reproductive life planning, and provide some basic primary care (e.g., smoking cessation counseling); transitioning the conversation from STI screening and treatment to reproductive life planning and other health needs can be difficult. Providers feel that until there are more contraceptive options for men, they will continue to serve a much smaller proportion of men than women. Furthermore, PPNNE does not provide vasectomy services, but does offer vasectomy education, counseling, and referral.

In addition to addressing the family planning and reproductive health needs of men, providers would like to expand on the level of education PPNNE provides on intimate partner violence to better reach men. It was suggested that identifying the right community partners may help facilitate this work.

Mental Health/Substance Abuse. Substance abuse was recognized as a growing problem in Vermont and often associated with a transient lifestyle. Interviewees experience that this population can be difficult to reach to address family planning needs because often times substance use or sobriety are deemed a higher priority than family planning and contraception. They would like to determine how to better reach and serve this population. One approach suggested that has been implemented at the St. Albans PPNNE health center is to provide same day access to services and consider how to best offer comprehensive and efficient services within a single visit knowing providers may not see the client again for some time. Furthermore, by coordinating with community-based organizations in select regions, PPNNE has been able to identify how to better serve and meet the needs of this vulnerable population. Regional meetings were coordinated by the Health Department in St. Albans and White River Junction. PPNNE and community-based organization participants found the meetings to be a great help in increasing awareness and building understanding of the services available within communities and the needs of the populations they serve. The Health Department plans to continue coordinating similar meetings in other regions of the state in the future.

LGBTQ. PPNNE interviewees indicated that all providers receive general cultural competency training and training on culturally competent transgender care, lending to an established comfort level with preventive care for transgender among providers. PPNNE's Burlington health center is receiving training to provide trans-care.

Although providers are well-trained to serve the family planning and reproductive health care needs of the LGBTQ population in Vermont, interviewees indicated there is need for more outreach to this population and engagement in the health care system. Additionally, interviewees remarked that while

there are several resources and supports targeting the LGBTQ community within Chittenden County, there are very few in most other parts of the state. This makes it difficult to reach this population as well as provide appropriate supports to this population.

Racial & Ethnic Minorities. As the racial and ethnic minority population in Vermont grows, particularly immigrants and refugees residing in Chittenden County, interviewees are identifying more need to outreach to these populations and to provide culturally sensitive services. For example, providers indicated challenges with addressing family planning needs of some immigrant and refugee patients due to cultural and religious beliefs and attitudes on contraception. The Hispanic/ migrant worker population in Addison County was also called out has a population with unmet health and family planning needs, partly due to cultural barriers and partly due to financial and transportation barriers.

PPNNE interviewees noted efforts to better service racial and ethnic minority populations by way of coordinating with other organizations, including Community Health Centers of Burlington who sees a significant proportion of the immigrant and refugee population in Chittenden County, to establish referrals to PPNNE to serve the family planning and reproductive health needs of this population. PPNNE's Cultural Inclusivity Project has benefited staff in becoming more aware of cultural attitudes, behaviors and beliefs related to family planning. Providers have found their tiered counseling approach works well when broaching contraceptive counseling with the recent immigrant and refugee population. Use of phone interpreters has also facilitated serving the needs of this population.

Incarcerated. Women who are incarcerated in Vermont were noted by PPNNE interviewees as a population of interest with unmet family planning need. The Vermont Department of Corrections reported that approximately 85% (about 850 of 1000 women annually) of their female incarcerated population are 18-44 years of age. PPNNE has initiated conversations with the Department of Corrections to determine if there is a role for PPNNE to support the family planning and reproductive health needs of this population or if there is a better solution to the system.

Considerations

This review of Vermont's family planning system and population needs presents a positive picture overall. Interviewees described a family planning system with high access, high quality, comprehensive services, and a supportive landscape. In addition to the 10 Title X funded health centers, Vermont has a broad network of safety-net providers supporting the health care needs of residents throughout the state. Key health and reproductive health indicators also present a favorable status for Vermonters. Most all Vermonters now have health insurance and Vermont's infant mortality, preterm birth, and low weight birth rates rank lower than national rates. Furthermore, the teen pregnancy rate and fertility rate for Vermont continue to decline and post-partum contraceptive use is high among Vermonters.

Despite these gains, this review indicates remaining challenges for Vermont. The rate of intended pregnancy remains relatively consistent at about 50%, well below the 65% Healthy Vermonters 2020 goal. Furthermore, about half (49%) of mothers whose pregnancies are unintended report using any method of birth control. Alcohol and tobacco use during pregnancy remain consistently high

compared to other states. Several sub-populations of concern were noted as having disparate unmet family planning need due to financial, transportation, and cultural barriers. These sub-populations include adolescents, individuals with mental health and/or substance abuse issues, LGBTQ individuals, and racial and ethnic minorities.

In the context of the gains, strengths, and challenges for Vermont's family planning service delivery system, the following focus areas are called out for consideration and intended to guide future efforts of the Health Department and other family planning programs and stakeholders in Vermont.

I. Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding. Interviewees indicated limited understanding as to why the Burlington and Williston sites, which serve the largest number of clients in the state relative to other sites, are not included as Title X sites. There is also uncertainty on whether this exclusion impacts access to services among low-income and other vulnerable populations being served by these sites.

II. Promote awareness, implementation, and adherence to the QFP's evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.
   - Disseminate QFP guidelines and related resources (e.g., job aids, webinars, e-learning courses) to providers, programs and organizations. Refer to OPA's National Family Planning Training Centers for existing resources. Explore dissemination mechanisms such as developing a resource hub for providers to access information, announcements, and tools.
   - Identify, coordinate, and support opportunities for provider education and training on QFP guidelines, with a focus on contraceptive effectiveness counseling and informed choice.

III. Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling. Providers should offer contraceptive services for women and men who want to prevent pregnancy and space births, including contraceptive counseling services. For individuals who might want to get pregnant in the future and prefer a reversible method of contraception, providers should use a tiered approach to presenting a broad range of contraceptive methods, presenting the most effective methods before less effective methods.[53]
   - Explore the use of family planning quality measures among health care organizations to monitor on an ongoing basis (e.g., percentage of patients using moderately or highly effective contraceptive methods; or percentage of patients using LARC methods). Refer to

[53] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).

the QFP and OPA National Family Planning Training Centers for guidance on performance measures.

IV. Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's heath centers); support innovations and solutions to promote access and awareness of LARC.
- Work with Medicaid to establish reimbursement for post-partum provision of IUD
- Coordinate with ACOs to include LARC use as a payment measure
- Assess access and provision of LARC via other safety net providers such as FQHCs and RHCs
- Explore use of quality improvement initiatives with safety net providers (e.g., FQHCs, RHCs) and primary care providers to promote a broad range of contraceptive method availability, and guideline-based contraceptive counseling and education
- Establish collaborative agreements and referrals systems with PPNNE and other safety net providers well-equipped to provide LARC (e.g., Community Health Centers of Burlington)

V. Facilitate linkages between primary care providers and Title X health centers in Vermont. Vermont's network of Title X health centers provides access to comprehensive guideline-based family planning services throughout the state. Coordinate with primary care providers and practices, such as community health centers, to better understand: (1) their capacity for providing guideline-based contraceptive services and other family planning services; (2) existing referral systems; and (3) opportunities to support or strengthen referral systems with Title X health centers to ensure access to comprehensive high-quality family planning services and continuity of care.

VI. Increase provider and consumer knowledge of covered family planning and related preventive health services. The Affordable Care Act has expanded health payer coverage of contraception and a wide range of preventive services, including well-woman visits (Pap tests, cancer screenings, etc.). To promote high utilization of expanded health care benefits, disseminate information on covered family planning and related preventive health services to providers and consumers throughout Vermont. Explore dissemination and repackaging of existing information and education resources as well as developing resources specific to Vermont's health payer member benefits.

VII. Explore potential opportunities to address family planning, reproductive, and sexual health needs of adolescents within SBHCs in Vermont.
- Establish understanding of existing SBHCs in Vermont, including location, model of care, scope of services, and community linkages
- Coordinate with SBHCs to identify prominent family planning, reproductive health, and sexual health needs within communities and related services that could be feasibly integrated into SBHCs scope of services
- Assess other state models of SBHCs and scope of family planning services offered

VIII. Explore opportunities for clinical-community linkages between Vermont Title X health centers and community based organizations to establish family planning—human service referral networks.

- Continue Health Department coordination of regional meetings convening PPNNE Title X sites and community programs and organizations to build awareness and understanding of community specific needs and available resources.
- Establish referral networks of social support services within Title X sites; PPNNE recently added centralized care coordinator may be an opportunity to facilitate this effort
- Identify and reach out to programs or organizations currently working with high priority populations to increase awareness of Title X site family planning services and opportunities for outreach and engagement of priority populations (e.g., DVHA MOMS Program, Howard Center, Pride Center, Vermont Refugee Resettlement Program)

Appendix I: Key Informant Interview Participants & Guides

The following table includes the list of organizations, programs, and groups represented in the series of interviews and discussion groups conducted for the 2015 Title X needs assessment interviews. Examples of the guides used to facilitate discussion during interviews follow.

Title X Needs Assessment Key Informant Groups and Organizations	
1	Community Health Centers of Burlington
2	Department of Vermont Health Access, Integrated Family Services
3	Department of Vermont Health Access, Medicaid Obstetrical and Maternal Support Program
4	Department of Vermont Health Access, Policy
5	Parent Child Centers
6	Planned Parenthood of Northern New England
7	University of Vermont
8	UVM Pediatric Primary Care
9	Vermont Center for Health and Learning
10	Vermont Department of Health School Liaisons
11	Vermont Department of Health, Health Promotion Disease Prevention
12	Vermont Department of Health, Maternal and Child Health
13	Vermont Family Network
14	Vermont Federation of Families for Children's Mental Health
15	Vermont PREP Grantees
16	Vermont Primary Care and Public Health Integration Group

Title V Strengths and Needs Assessment
Key Informant Interview Guide

For the 2015 Title V strengths and needs assessment states must identify 7 among the 15 National Performance Measures they will prioritize to improve the health and wellbeing of Vermont's women, mothers, children and families.

Title V of the Social Security Act reflects our nation's commitment to improving the health and well-being of mothers, children, and their families, and is operationalized through a block grant. Every five years, as a part of the federal Title V Block Grant, states are required to complete a comprehensive assessment of the needs, desired outcomes, and system capacity for the maternal and child health population, including children and youth with special health care needs. The results of this assessment will be used to establish the priorities that will guide our Title V program for the next five years (2015-2020).

Background: This is an exciting time in the field of Maternal and Child Health, as the Title V MCH Block Grant is currently undergoing a transformation. One of the primary goals of this transformation is to demonstrate the vital leadership role that state Title V programs play in assuring and advancing public health systems that address MCH population health needs. To achieve this goal, the federal Maternal and Child Health Bureau has defined a core set of national health priority areas that Title V programs across the country will work on to collectively "move the needle." Fifteen national health priority areas have been identified (see Table 1), from which states must select seven to ten to address through their Title V program along with any state specific priority areas. Collectively, these priority areas represent six MCH population domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; 5) CYSHCN; and 6) Cross-cutting or Life course. You have been identified as someone with expertise in the _____population domain(s). Throughout the interview, I will be referring to this domain and the corresponding national priority areas (see Tale 1). VDH is also currently conducting their 2015 Title X Needs Assessment. Vermont's Title X program provides high quality clinical family planning (e.g., a broad range of FDA-approved contraceptive methods and related counseling) and related preventive health services, including breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals to women and men in Vermont who would otherwise not have access, with a special focus on low-income and rural populations. You have been identified by VDH as well suited to speak to 1) the _____ domain to inform the VDH'S 2015 Title V Needs Assessment, and 2) the family planning needs ands and services in Vermont for VDH's 2015 Title X Needs Assessment.

---

1. Let's begin by setting the context for the interview. Can you briefly describe your organization and its role in addressing the needs of Vermont's women, mothers, children and families?
    a. Describe specific programs
    b. Reach/ Population focus
    c. Partnerships across the state

2. Now let's turn to thinking about the quality of the system of care for Vermont's women, mothers, children and families. Components of a quality system include *accessible*, *equitable*, *timely*, *coordinated*, *client-centered*, and *culturally competent* care.
    a. What components of quality are well-addressed within Vermont's current system of services and supports for women, mothers, children and families?
    b. What components of quality could be better addressed within Vermont's current system of services and supports for women, mothers, children and families?

3. Thinking about [population domain] and the corresponding national priority areas identified by the federal Bureau of Maternal of Child Health….

    a. What have been some gains in this area for Vermont?
    b. What have been the challenges?
    c. What do you see as key strategies for addressing this issue?
    d. What would be some challenges encountered?
    e. What are the leverage points/opportunities that exist to address this issue (e.g., existing initiatives, coalitions, etc.)?

4. The sixth population domain is Cross-cutting or Life Course and refers to public health issues that impact multiple MCH population groups such as smoking or oral health. What do you see as significant cross-cutting issues for Vermont's MCH populations? Why?

    a. Cross-cutting or Life Course can also include social determinants of health—how where we live, learn, work and play impacts our overall health and well-being. How do you see social determinants of health playing into the health and well-being of Vermont's women, mothers, children and families?
        i. Which of those that you listed has the greatest impact for [population domain]?

<u>Title X</u>

The U.S. Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program. OPA funds a network of family planning centers which serve about five million clients a year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits. Title X family planning centers provide high quality and cost-effective family planning and related preventive health services for low-income women and men including a broad range of FDA-approved contraceptive methods and related counseling; as well as breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals. Family planning centers play a critical role in ensuring access to voluntary family planning information and services for their clients based on their ability to pay. Every three years states receiving Title X funds are required to conduct a family planning needs assessment. Title X and Title V needs assessment processes overlap for the 2015 cycle. We understand that your work interfaces with the family planning system. We would like to ask you a few questions specific to family planning.

5. Describe your involvement in the family planning system in Vermont?

6. Describe the populations most in need of family planning services in Vermont?

    a. What is Vermont currently doing on outreach and access to best meet the needs of these populations?
    b. Is the system effectively reaching and engaging vulnerable populations?
        i. What are the barriers or challenges to doing so?
        ii. What more could be done to engage vulnerable populations?
    c. What are their most pressing family planning needs?
    d. What more could providers and/or the system be doing?

Recommendations/Closing Observations

7. As we come to the close of our interview, what are the top recommendations you have for ensuring an accessible high-quality system of support and services for Vermont's women, mothers, children and families?

8. Are there any closing observations or thoughts you would like to share regarding _____ [population domain] and how Vermont can strive to ensure the overall health and well-being of_____[population domain]?

Table 1: National Priority Areas by Population Domain

MCH Population Domain	National Priority Area
Women/Maternal Health	Well Woman Care Low Risk Cesarean Deliveries
Perinatal/Infant Health	Perinatal Regionalization Breastfeeding Safe Sleep
Child Health	Developmental Screening Injury Prevention Physical Activity
Adolescent Health	Injury Prevention Physical Activity Bullying Adolescent Well Visit
Children and Youth with Special Health Care Needs	Medical Home Transition
Cross-cutting/Life course	Oral Health Smoking Adequate Insurance Coverage

Vermont Title X Needs Assessment
Key Informant Interview Guide

Background: Title X of the Public Health Service Act is designed to ensure access to comprehensive reproductive health care, with an emphasis on services to lower income women and men. The U.S. Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program. OPA funds a network of family planning centers which serve about five million clients a year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits. In Vermont, Title X services are provided by Planned Parenthood of Northern New England.

The overarching goal of Vermont's Title X program is to provide high quality clinical family planning (e.g., a broad range of FDA-approved contraceptive methods and related counseling) and related preventive health services, including breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals to women and men in Vermont who would otherwise not have access, with a special focus on low-income and rural populations. Specifically, Vermont's Title X program seeks to:

- Reduce unintended pregnancies in Vermont
- Improve access to a broad range of effective contraceptive methods
- Provide access to emergency contraceptive services
- Reduce sexually transmitted diseases
- Promote healthy relationships, healthy sexual behaviors and strengthen community capacity to promote positive reproductive health

Thank you for taking the time to participate in Vermont's 2015 Title X needs assessment process by way of this interview. The information collected from key informants will be used by the Vermont Department of Health's Division of Maternal and Child Health to inform 1) their upcoming application to OPA for continued Title X funding in Vermont, and 2) planning and priorities of their future Title X, family planning, and reproductive-health related work.

1. Let's begin by setting the context for the interview. Can you briefly describe your organization and its involvement in the family planning system in Vermont?
    a. Describe specific programs
    b. Reach/ population focus

2. Thinking about Title X and the family planning service delivery system in Vermont, what are the strengths of Vermont's Title X service delivery system and/or existing family planning services?
    a. What have been some of the gains for Vermont in recent years?
    b. To what do you attribute these gains?
    c. What partners are important to expanding or enhancing the Title X service delivery system?

d. Which of these partners do you collaborate/partner with, and how, to meet family planning needs in the state?

3. Similarly, what are some of the barriers or challenges of Vermont's Title X service delivery system and/or existing family planning services?
    a. What are potential strategies to address barriers or challenges of the system?

Access & Quality

4. Describe the populations most in need of family planning services in Vermont?
    a. What are we currently doing on outreach and access to best meet the need(s) of these populations?
    b. What more could providers and/or the system be doing?

5. Is the system adequately reaching the needs of vulnerable populations (e.g., teens, LGBT, racial and ethnic minorities, recent immigrants and refugees)?
    a. Is the system effectively reaching and engaging vulnerable populations?
        i. What are the barriers or challenges to doing so?
        ii. What more could Title X/PPNNE centers and other providers do to engage vulnerable populations?
    b. What are their most pressing family planning needs?

6. Is the system effectively reaching and engaging men?
    a. What are the barriers or challenges to doing so?
    b. What types of services are most commonly delivered to the men served in your program/organization?
    c. What more could Title X/PPNNE centers do to engage men?

7. Now let's turn to thinking about the quality of the family planning service delivery system in Vermont. Components of a quality system include *accessible*, *equitable*, *timely*, *coordinated*, *client-centered*, and *culturally competent* care.
    a. What components of quality are well-addressed within Vermont's current system of family planning and reproductive health care?
    b. What components of quality could be better addressed within Vermont's current system of family planning and reproductive health care?

Long-Acting Reversible Contraceptives (LARCs)

8. To what extent do you feel family planning patients have access to a broad range of contraceptive options, including long acting reversible contraceptives (LARCs)?
    a. What are the primary barriers to promoting use of LARCs to prevent unintended pregnancy?
        i. Provider training and skills to counsel and provide LARCS

ii. Adolescents' knowledge, attitudes, beliefs, and use of LARCs

Preconception Health & Related Preventive Health Services

9. Promoting preconception health and reproductive health planning are important components of family planning, as they influence birth outcomes and men and women's health in general. How does Vermont's family planning service delivery system fair in regard to providing recommended preconception health services (i.e., per USPSTF recommendations)?
    a. What are some of the challenges or barriers to doing so?

10. The family planning service delivery system is often a point of access into the health care system for many women and men, and therefore presents an important opportunity to provide or refer for other related preventive health care services (e.g., cervical cancer screening, breast cancer screening). Similar to the previous question, how does Vermont's family planning service delivery system fair in regard to providing or referring clients for other preventive health services?
    a. What are some of the challenges or barriers to doing so?

11. To wrap up our discussion, what are the top recommendations you have for ensuring an accessible high-quality system of family planning and reproductive health in Vermont?

From:	Spottswood, Eleanor
To:	Swartz, Kimberly
Subject:	RE: Family Planning Program documents
Date:	Thursday, July 19, 2018 12:00:00 PM

Wonderful, thank you Kim!
Ella

From: Swartz, Kimberly
Sent: Thursday, July 19, 2018 11:58 AM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: Family Planning Program documents

Hi Eleanor,

The Director of the AHS Internal Audit Group is Peter Moino. Peter's number is 241-046. PPNNE conducts annual audits and submits them to AHS.

I have attached some documents for your review:

- FY18 grant agreement (a new AHS scope of work template was piloted for this grant)
- FY 17 grant agreement (same scope of work, previous format)
- Our most recent OPA program review reports and VT's response to the findings

I will look for older program review reports now and send them along to you shortly.

Feel free to reach out if you have additional questions.

Best wishes,
Kim

Kim Swartz, MHSc
Director, Preventive Reproductive Health
Division of Maternal and Child Health
Vermont Department of Health
(802)-652-4184
kimberly.swartz@vermont.gov
http://healthvermont.gov/

From:	Swartz, Kimberly
To:	Spottswood, Eleanor
Subject:	Family Planning Program documents
Date:	Thursday, July 19, 2018 11:58:15 AM
Attachments:	VDH Title X Program Report (final).pdf VDH PR 2017 executive summary (final 29-Aug-2017).pdf VDH Title X Program Review Summary Response Sept 2017 .pdf Grant 6959S_PPNNE_final.pdf Grant 6790S_PPNNE_final.pdf

---

Hi Eleanor,

The Director of the AHS Internal Audit Group is Peter Moino. Peter's number is 241-046. PPNNE conducts annual audits and submits them to AHS.

I have attached some documents for your review:

- FY18 grant agreement (a new AHS scope of work template was piloted for this grant)
- FY 17 grant agreement (same scope of work, previous format)
- Our most recent OPA program review reports and VT's response to the findings

I will look for older program review reports now and send them along to you shortly.

Feel free to reach out if you have additional questions.

Best wishes,

Kim

Kim Swartz, MHSc
Director, Preventive Reproductive Health
Division of Maternal and Child Health
Vermont Department of Health
(802)-652-4184
kimberly.swartz@vermont.gov
http://healthvermont.gov/

PROGRAM REVIEW
TITLE X FAMILY PLANNING PROJECT
Vermont Department of Health

May 15 – 19, 2017

TABLE OF CONTENTS

BACKGROUND INFORMATION

Grantee Name: Vermont Department of Health (VDH)

Grantee Number: FPHPA016246

Project Name: Title X Family Planning Services, Vermont

Project Address: 108 Cherry Street
PO Box 70, Suite 302
Burlington, VT 05402-0070

Site Visit Dates: May 15, 2017 – May 19, 2017

Program Review Team Members:
Leader: Natalia Guevara
Financial Services: Gerry Christie (Joyce McIntyre, Trainee)
Clinical Services: Karen Ward
Administrative: Shelley Miller

VDH - May 15, 2017

- Vermont Department of Health
  - Breena Holmes, MD, Director, Maternal & Child Health
  - Ilisa Stalberg, Deputy Director, Maternal and Child Health
  - Kim Swartz, Director, Preventive Reproductive Health (Title X Program Administrator)
  - Patrick Burke, VDH Financial Manager, Business Office
  - Karen Kelly, VDH Financial Administrator/ Grants and Contracts, Business Office
  - Kim Bean, Maternal and Child Health Business Administrator
  - Sara Chesbrough, PREP Program Coordinator

- Planned Parenthood of Northern New England
  - Holly Schiavoni, Director, Government Grants
  - Kai Williams, VP of Health Center Operations
  - Donna Burkett, MD, Medical Director
  - Heather Bushey, Chief Financial Officer
  - Meagan Gallagher, President and CEO
  - Yvonne Lockerby, VP of Centralized Operations
  - Matthew Houde, PPNNE Board Chair

PPNNE Administrative Site - May 16, 2017

- Vermont Department of Health
  - Kim Swartz, Director, Preventive Reproductive Health (Title X Program Administrator)
- Planned Parenthood of Northern New England

- Meagan Gallagher, CEO
- Matthew Horde, Board Chair
- Kathy Landry, VP of HR
- Kai Williams, VP of Health Center Operations
- Megan Quain, Call Center Operator
- Taylor Clark, Call Center Operator
- Brittany Parrish-Totin, Training Manager
- Maura Graff, EPIC Education Manager
- Holly Schiavoni, Director of Government Grants
- Christie Allen, RN, Clinical Quality Coordinator
- Yvonne Lockerby, VP of Centralized Operations
- Donna Burkett, MD, Medical Director
- Tanya Waters, CNM, Director of Clinical Care
- Heather Bushey, CFO
- Jessica Morris, Controller

PPNNE's St. Albans Health Center - May 17, 2017

- Vermont Department of Health
  - Kim Swartz, Director, Preventive Reproductive Health (Title X Program Administrator)
- Planned Parenthood of Northern New England
  - Pamela Polhemus, St. Albans Site Manager
  - Jenny Cox, Health Care Associate
  - Adrienne Bonvini, PA
  - Holly Schiavoni, Director of Government Grants
  - Paula Hemingway, VT Senior Operations Manager
  - Tanya Water, CNM, Director of Clinical Care

PPNNE's Rutland Health Center - May 18, 2017

- Vermont Department of Health
  - Kim Swartz, Director, Preventive Reproductive Health (Title X Program Administrator)
- Planned Parenthood of Northern New England
  - Carla Stewart, Rutland Site Manager
  - Rachel Guy, Regional Clinical Director
  - Samantha Price, Health Care Associate
  - Joanne Lemay-Green, Assistant Site Manager
  - Paula Hemingway, VT Senior Operations Manager
  - Holly Schiavoni, Director of Government Grants

VDH – May 19, 2017

- Vermont Department of Health
  - Dr. Mark Levine, MD, Commissioner
  - Tracy Dolan, MPH, Deputy Commissioner

    - Kim Swartz, Director, Preventive Reproductive Health (Title X Program Administrator)
    - Patrick Burke, Financial Manager, VDH Business Office
    - Karen Kelley, Financial Administrator/ Grants and Contracts, VDH Business Office
    - Kim Bean, MCH Business Administrator
- Planned Parenthood of Northern New England
    - Meagan Gallagher, PPNNE President/CEO
    - Matthew Houde, PPNNE Board Chair
    - Donna Burkett, MD, Medical Director
    - Heather Bushey, CFO
    - Yvonne Lockerby, VP of Centralized Operations
    - Kai Williams, VP of Health Center Operations
    - Paula Hemingway, VT Senior Operations Manager
    - Holly Schiavoni, Director of Government Grants

Materials Reviewed-Central Level

Documents reviewed at the Administrative Level
VT Department of Health (VDH):

- VT FPAR data
- VDH Policies and Procedures
    - HIPPA Policy
    - Information for Research
    - General Operating Procedures
    - Non-discrimination Policy
    - LEP Policy
    - MCH/CSHN Operating Procedures
- VT Title X Progress Reports
- VT Family Planning Needs Assessment
- Community Advisory Board Overview
- Family Planning Workgroup meeting minutes
- VDH & PPNNE Family Planning Medical Director's Meeting Minutes
- Family Planning Site Review – Middlebury, VT
- VT Title X Application
- Title X Sub-Recipient Contract with PPNNE

PPNNE:

- Medical Standards and Guidelines (MS&G)
- Administrative Policy and Procedures
    - Conflict of Interest (revised 11/5/14)
    - Prohibition Against Coercion (revised 4/1/17)
    - Research (revised 12/22/15)
    - EEO
    - Diversity
    - Confidentiality (7/15/16)

    - HIPPA (5/10/16)
    - Conflict of Interest Policy
    - Prohibition against Coercion
    - Components of Patient-Centered Communications
    - LEP
    - Language Certification and Compensation (7/1/16)
    - Consent, Informed Consent and Patient Education
    - Minors Policy: Encouraging Family Involvement
    - Mandated Reporting or Vulnerable Adult Abuse (4/14/17)
    - Minors and Vulnerable Adult Abuse Report (4/22/11)
    - Facilities Inspection Worksheet
    - Human Trafficking Policy (4/1/11)
    - Policy and Procedure Updating Policy (revised 5/15
- General Consent
- Separation of Abortion and Title X Services (4/11/17)
- HIPPA
- MOU's
- I & E
    - Survey Monkey questionnaire
    - Spreadsheet of findings
    - Committee list
- Patient Satisfaction Survey results
- New Staff Orientation (on-boarding)
    - Introduction to PPNNE
    - Introduction to Title X
- Professional Standards Policy
- Referral data base
- pePPer Intranet (Community outreach and education data base)
- Center for Affiliate Services (CALS) database
- VT Blueprint for Health: Rutland Area Community Resource Guide binder

OVERVIEW OF THE PROJECT

History and Development

The Vermont Department of Health (VDH) has been funded as a Title X grantee for more than 35 years and is the sole grantee for the state of Vermont. The Title X program supports local family planning services that ensure access to a broad range of family planning and related preventive health services for Vermont women, men, and their partners. Related preventive health services are also provided and include: patient education and counseling; breast and pelvic examinations; breast and cervical cancer screening according to nationally recognized standards of care; sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) prevention education, counseling, testing and referral; and pregnancy diagnosis and counseling.

The program is administratively located in the Maternal and Child Health Division of the health department, where one staff person dedicates part of her time to the program. Since the last review, there is a new Director of Preventive Reproductive Health Services, Kim Swartz, who, in addition to the Family Planning Program, oversees a variety of programs including Teen Pregnancy Prevention, Violence Prevention, and other related programs. Additional administrative and fiscal support is available from financial and contract management staff members at the department of health. The Maternal and Child Health Director is also actively involved with the family planning program and is a strong advocate for reproductive health services.

VDH contracts for all Title X services with Planned Parenthood of Northern New England (PPNNE), an affiliate of the Planned Parenthood Federation of America. VDH passes the vast majority of Title X funds to the sub-recipient, retaining only a very small proportion to cover its own costs.

VDH has a unique and strong relationship with PPNNE. In addition to Title X funds the state supports the agency through STD grants and two distinct contracts supported by a Section 1114 Medicaid waiver. One contract supports outreach, education, and infrastructure and the other funds the Vermont Access Program. This program operates like a Medicaid family planning waiver or state plan amendment, supporting the cost of a wide range of reproductive health services for clients with incomes under 200% at Planned Parenthood Health Centers.

In addition to supporting PPNNE's services VDH has a broad range of other programs related to reproductive health including an MCH performance measure on pregnancy intention, a home visiting program, and an evidence-based teen pregnancy prevention initiative. These programs are focused on groups in greatest need.

Description of the Program

At the time of review, the VDH's Title X project was in the second year of a three year grant for which it received $775,000. The project is comprised of 10 service sites, which, in 2016, served 10,053 unduplicated clients. Of the 10,053 users, 4,360 or 43% reported income of less than 100% FPL, 3,274 or 33% with income between 101%-250% FPL, 1,175 or 12% male users, and 1,884 or 19% users under age 20.

The Title X Program Review Process
This review was guided by the Title X Program Review Tool (02-2017) and the report follows the outline of the tool. Members of the review team consulted a variety of documents, interviewed staff, and observed care at the clinical sites.

The Program Review Tool
The tool describes strategies that grantees may use to operationalize applicable Title X statutory and regulatory requirements and lays out the minimum expectations for compliance. The document also illustrates how a grantee can implement QFP in a way that ensures quality care is provided throughout the Title X project.

Title X Program Requirements Assessment
This assessment relates to the grantee's compliance with the statute and regulations. For these requirements, the grantee will receive an assessment of compliance and will receive a rating of "met"," not met", or "N/A" (not applicable). The evidence that minimum criteria have been met will be determined based on both grantee and sub-recipient records and observation at grantee administrative offices and selected service sites as part of the monitoring process. Evidence may include but is not limited to, policies, procedures, protocols, documentation of training, direct visual confirmation per consultants and/or regional office staff to ensure that what is contained in written policy or instructions is actually being carried out, or any other form of documentation that substantiates that the project is operating in accordance with the Title X Program Requirements

QFP Quality Assessment
This assessment reflects the extent to which the grantee has implemented key aspects of QFP. Grantees will be assessed using the list of items providing evidence of various aspects of quality services. Based on the number of items identified as in use by the grantee will serve as a means of recognizing grantee achievements as well as identify areas in need of improvement and/or technical assistance.

Assessment Timeline
Before the review, VDH and the sites selected for visits were requested to compile a series of documents including policies and protocols, board meeting minutes, and medical charts (at the clinic sites); arrange for interviews with central office staff; and schedule an initial and debriefing meeting with relevant agency representatives.

At the initial meeting, the team discussed the review process, and VDH provided an overview of the project. Following meetings at the central office the first review day, the team visited two different clinic sites.

At the conclusion of each clinic visit, the team gave an oral report to clinic and accompanying central office staff. At a formal exit conference, the reviewers reported on the findings related to compliance in each area and gave program suggestions for correcting the findings. This written report follows the same format and contains findings and recommendations as reported by the review team to VDH at the exit conference on May 19, 2017.

The review found VDH to be in general compliance with key Title X requirements, regulations, and guidelines. This report contains three (3) findings, which indicate areas where VDH must take action to come into full and ongoing compliance with Title X. One key component of this compliance is improved oversight of the sub-recipient. The VDH and PPNNE staffs have a well-established working relationship; the VDH Project Manager and the PPNNE Grants Manager meet monthly to review the status of the grant and the Medical Directors and staff from both agencies meet twice annually. These processes could be improved in two ways: First, by including the grantee's Title X manager, along with the relevant VDH staff, in routine and periodic reviews of the financial information submitted by the sub-recipient. Second, VDH must be more directly involved in clinical observation and clinical health record audits. The clinical site reviews completed by the sub-recipient show that the clinic sites are in compliance with all Title X and State requirements, but the VDH grant manager must participate in these reviews in the future.

In this report, the grantee will find that for each finding, a corrective action plan is recommended. These recommended remedial actions reflect the opinions of the reviewers on how the grantee can come into closer compliance with Title X. The grantee may have other mechanisms to come into compliance. In any case, the grantee is responsible to respond within 30 days of receipt of this report with a remedial action plan addressing each of the findings. If actions have already been taken when the plan is submitted, appropriate documentation should be included. Where actions have not been taken, the plan should clearly outline when the required actions will be completed, and how the completion of the actions will be documented. Where findings relate to the sub-recipient, it is the responsibility of the grantee to assure that the sub-recipient takes appropriate remedial action. In addition to the findings, the report contains a number of recommendations (12). These recommendations are provided by the review team in the hope that they will be helpful to the grantee in improving practice. Please note that the report references the items where action must be taken, as well as recommendations for improvement and, where applicable, the quality rating related to QFP.

Title X Program Requirements

Administrative Aspects

The assessment focuses on Sections 8-13 of the Program Requirements because these are the sections that outline the key operational elements of a Title X family planning services project.

8. Project Management and Administration

8.1 Voluntary Participation

8.1.1 Prohibition of Coercion

Title X projects must "provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. (Sections 1001 and 1007, PHS Act; 42 CFR 59.5 (a)(2))

Such requirements are met through institutionalizing administrative procedures (i.e., staff training, clinical protocols, and consent forms) to ensure clients receive services on a voluntary basis.

REVIEW OF EVIDENCE
NOTE: *The following comments regarding the review of evidence will be relevant for several requirements throughout this program review report.*

VDH has a detailed contract with the sole sub-recipient PPNNE, which includes a statement that PPNNE will act "in accordance with the Title X Guidelines as described in the most current Program Requirements for Title X Funded Family Planning Projects." The compliance with this agreement includes adherence to all federal requirements and legislative mandates. However, the VDH does not have a Title X Policy and Procedures Manual at the grantee level. Currently, VDH relies on the PPNNE Policies which are very comprehensive.

VDH, through PPNNE's Administrative Policies and Procedures Manual, has an explicit policy that Title X projects must "provide services without subjecting individuals to any coercion to accept services." This policy is reviewed at the new staff orientation and must be acknowledged by signing, annually, the *Professional Standards Form* which includes the Title X requirements and legislative mandates. Staff training documentation further confirmed the grantee's compliance with the requirement. Staff training at the sub-recipient site is monitored through the CAL (Center for Affiliate Learning), an on-line monitoring system, which includes an Orientation to Title X. The CAL is monitored by the PPNNE Training Manager and the Center Manager at each health center.

This requirement was **MET**.

Recommendation #1 (Administrative) (Response Required):

It is strongly recommended that the grantee develop its own Title X Policy and Procedure Manual that addresses all Title X requirements or formally adopt the sub-recipient's manual rather than solely relying on the contract. The Policy and Procedure Manual should define the criteria that need to be met to ensure compliance.

8.1.2 Prohibition of Prerequisite for Other Services
Title X projects must ensure that "acceptance of services must...not be made a prerequisite to eligibility for, or receipt of, any services, assistance from or participation in any other program of the applicant." (Section 1007, PHS Act; 42 CFR 59.5 (a)(2))

This requirement is met through institutionalizing administrative procedures (e.g., staff training, clinical protocols, and consent forms) to ensure clients' receipt of family planning services is not used as a prerequisite to receipt of other services from the service site.

REVIEW OF EVIDENCE:
See comments in 8.1.1 above and 8.6.1 (Staff Training and Orientations) below.
Documentation exists that ensure that acceptance of services must not be a prerequisite to eligibility for other services.

This requirement was **MET**.

8.1.3 Prosecution for Coercion
Personnel working within the family planning project must be informed that they may be subject to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure (Section 205, Public Law 94-63, as set out in 42 CFR 59.5(a)(2) footnote 1).

Evidence that this requirement has been met includes 1) written policies and procedures 2) documentation that staff has been informed at least once during the project period, and 3) documentation exists at the sub-recipient level that staff has been informed.

REVIEW OF EVIDENCE:
See comments in 8.1.1 above and 8.6.1 below.
Documentation exists specifying that personnel working within the family planning project must be informed that they may be subject to prosecution if they coerce or try to coerce any person to undergo and abortion or sterilization.

This requirement was **MET**.

8.2 Prohibition on Abortion
Title X grantees and sub-recipients must be in full compliance with Section 1008 of the Title X statute and 42 CFR 59.5(a)(5), which prohibit abortion as a method of family planning.

Systems must be in place to assure adequate separation of any non-Title X activities from the Title X project. These include policies and procedures regarding the prohibition as well as for the separation of Title X services.

In addition, grantees have documented processes to ensure that they and any sub-recipients follow Section 1008, including language in any sub-recipient contracts addressing this requirement.

REVIEW OF EVIDENCE
See comments in 8.1.1 above and 8.6.1 below.
Staff are informed at new staff orientation that under Title X regulations, abortion must not be used as a method of contraception and a separation between Title X services and non-Title X services must be maintained. This separation was observed during the site visits.

This requirement was **MET**.

8.3 Structure and Management

8.3.1 Written Agreements
The grantee must have a written agreement with each sub-recipient and establish written standards and guidelines for all delegated project activities consistent with the appropriate section(s) of the Title X Program Requirements, as well as other applicable requirements (45 CFR parts 74 and 92).

REVIEW OF EVIDENCE
The contract between VDH and PPNNE is current and is comprehensive. It specifies all requirements the Title X grant.

This requirement was **MET**.

8.3.2 Sub-recipient Contracting of Services
If a sub-recipient wishes to subcontract any of its responsibilities or services, a written agreement that is consistent with Title X Program Requirements and approved by the grantee must be maintained by the sub-recipient (45 CFR parts 74 and 92).

Evidence that this requirement has been met include a signed sub-contracting agreement stipulating compliance with Title X requirements, documentation of grantee approval of sub-contracts, and monitoring reports to ensure compliance.

REVIEW OF EVIDENCE

This requirement was **NOT APPLICABLE**.

8.3.5 Sub-recipient Participation in Development of Policies and Procedures.
Sub-recipient agencies must be given an opportunity to participate in the establishment of ongoing grantee policies and guidelines (42 CFR 59.5 (a)(10)).

Evidence that this requirement has been met include a mechanism for sub-recipient participation in the policies and procedures and documentation of the sub-recipients' inclusion.

REVIEW OF EVIDENCE
The VDH and PPNNE staffs have a well-established working relationship. The VDH Project Manager and the PPNNE Grants Manager meet monthly to discuss and review the status of the grant. In addition, the Medical Directors along with staff from both agencies meet twice annually. Minutes from all meetings are maintained.

This requirement was **MET**.

8.5 Project Personnel

8.5.1 Federal and State Personnel Requirements
Grantees and sub-recipients personnel policies must comply with applicable Federal and State requirements, including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title I of the Americans with Disabilities Act, and the annual appropriations language.

Evidence that this requirement has been met includes grantee and sub-recipient personnel policies and procedures create a process to avoid discrimination in personnel administration.

REVIEW OF EVIDENCE
Evidence of this requirement was found in both the VDH and PPNNE Personnel Policies. There is documentation that staff have reviewed and signed off on this policy.

This requirement was **MET**.

8.5.2 Cultural Competency
Project staff should be broadly representative of all significant elements of the population to be served by the project, and should be sensitive to, and able to deal effectively with, the cultural and other characteristics of the client population (42 CFR 59.5 (b)(10)).

Evidence that this requirement has been met includes grantee and sub-recipient personnel policies and procedures regarding cultural competency that has been implemented through training and client surveys.

REVIEW OF EVIDENCE
The state of VT is very homogeneous, with 95% of the population identifying as white. There is a small black, Latino, and refugee population in the state. Nevertheless, the VDH has organizationally made a commitment to enhance their cultural competence. The Title X staff

have participated in a 5-day leadership training to explore cultural diversity and sit on a sub-committee to explore affirmative recruitment, and are working to create "Tips and Tools" in this recruitment practice. The health department has a Refugee and Health Equity Coordinator on staff, to address the special needs of this population.

PPNNE distributes patient satisfaction surveys which address patients' comfort level in services received and has multiple documented trainings on issues of cultural competence.

This requirement was **MET**.

8.5.3 Project Director

Projects must be administered by a qualified project director, and changes in the project director or other key personnel must be approved by the Office of Grants Management. (HHS Grants Policy Statement, 2007 Section II-54.)

Evidence that this requirement has been met includes documentation of OGM approval of personnel changes during the project period.

REVIEW OF EVIDENCE
Regional Program Consultant confirmed compliance with this requirement has been fulfilled.

This requirement was **MET**.

8.6 Staff Training and Project Technical Assistance

8.6.1 Orientation and In-Service Training

Projects must provide for the orientation and in-service training of all project personnel, including the staff of sub-recipient agencies and service sites (42 CFR 59.5(b)(4)).

Evidence that this requirement has been met includes grantee and sub-recipient staff training needs assessment and plan and records of personnel trainings completed.

REVIEW OF EVIDENCE
See 8.1.1 above.
Documentation of orientation training was reviewed at both VDH and PPNNE. PPNNE conducts a week-long new staff orientation (on-boarding), including information of Title X regulation and legislative mandates. Additional topics such as: contraception, customer service, and diversity are also explored using didactic and interactive activities. Following the new staff orientation, additional trainings are required of staff as defined by their role within the agency. Trainings may be offered live or on-line. All trainings are monitored through the CAL on-line monitoring system and can be directly accessed for updates by the staff or the appropriate designated staff.

All new staff at the VDH is required to complete an orientation including state and federal laws pertaining to such topics as ADA and HIPPA privacy.

This requirement was **MET**.

8.6.2 Mandatory Reporting Training
The project's orientation/in-service training includes training on Federal/State requirements for reporting or notification of child abuse, child molestation, sexual abuse, rape, or incest, as well as on human trafficking.

Evidence that this requirement has been met includes grantee and sub-recipient policies and procedures for meeting these training requirements, and training attendance records.

REVIEW OF EVIDENCE
See 8.1.1 and 8.6.1 above.
Documentation indicates that all staff are trained on mandated reporting requirements for reporting or notification of child abuse, child molestation, sexual abuse, rape or incest, as well as human trafficking.

This requirement was **MET**.

8.6.3 Counseling on Sexual Coercion
The project's orientation/in-service training includes training on involving family members in the decision of minors to seek family planning services and on counseling minors on how to resist being coerced into engaging in sexual activities.

Evidence that this requirement has been met include grantee and sub-recipient policies and procedures for meeting these training requirements, and training attendance records.

REVIEW OF EVIDENCE
See 8.1.1 and 8.6.1 above.
Documentation indicates that all staff are trained on involving family members in the decision of minors to seek family planning services and on counseling minors on how to resist being coerced into engaging in sexual activities.

Finding:
This requirement was **MET**.

8.7 Planning and Evaluation
Grantees must ensure that the project is competently and efficiently administered (42 CFR 59.5 (b) (6) and (7)).

Evidence that this requirement has been met includes written monitoring plans, documented periodic review of work plan progress, and timely, complete, and accurate submission of FPAR data.

REVIEW OF EVIDENCE
The VDH has a work plan with clear and measurable Goals and Objectives. The sub-recipient and VDH have monthly calls, the Medical Director team meets bi-annually, and the Director of Government Grants submits quarterly reports, including progress on goals. Data is submitted in a timely manner and FPAR reports are well maintained.

This requirement was **MET**.

9.1 Low-Income Families
Priority for project services is to persons from low- income families (Section 1006(c)(1), PHS Act; 42 CFR 59.5(a)(6)).

Evidence that this requirement has been met includes more than 50% of clients are at or below 100% FPL as reported on the FPAR and service site locations are accessible to low-income individuals.

REVIEW OF EVIDENCE
FPAR data showed that 44% of the patients seen fall at or below 100% of poverty.

This requirement was **NOT MET**.

Finding #1 (Administrative):
The data indicates that 44% of the patients seen fall at or below 100% of poverty. In order to show that priority for project services is to persons from low-income families, the clients a grantee serves must be comprised of 50% or more clients who are at or below 100% FPL.
Corrective Action #1 (Administrative):
VDH and PPNNE must explore ways to increase the number and percentage of low-income families being served. One way to achieve this goal would be to expand Title X to a Burlington site, where there is a large refugee population.

9.2 Dignity of the Individual
Services must be provided in a manner which protects the dignity of the individual (42 CFR 59.5 (a)(3)).

Evidence that this requirement has been met includes policies and observation of clinic operations indicate protection of client privacy and documentation which outlines clients' rights and responsibilities.

REVIEW OF EVIDENCE
See 8.1.1 and 8.6.1 above.

This requirement is included in the sub-recipient's new staff orientation and each site visited has posted a Patient Bill of Rights. In addition, each staff member that was observed consistently demonstrated respect and positive regard for all patients being seen.

This requirement was **MET**.

9.3 Non-Discrimination
Services must be provided without regard to religion, race, color, national origin, disability, age, sex, number of pregnancies, or marital status (42 CFR 59.5 (a)(4)).

Evidence that this requirement has been met includes written policies and procedures stating non-discrimination, documentation that staff have been informed of non-discrimination policies, and documentation of monitoring of sub-recipients for non-discrimination.

REVIEW OF EVIDENCE
See 8.1.1 and 8.6.1 above.
Both the grantee and sub-recipient have clearly defined non-discrimination policies that each staff member has read and signed-off on.

This requirement was **MET**.

9.4 Referral for Related Social Services
Projects must provide for social services related to family planning including counseling, referral to and from other social and medical services agencies, and any ancillary services which may be necessary to facilitate clinic attendance (42 CFR 59.5 (b)(2)).

Evidence that this requirement has been met includes documentation that social service and medical needs of the community has been assessed and relevant services identified, sub-recipients are required to develop and implement plans to address relevant service needs, and current, written agreements with relevant referral agencies exist.

REVIEW OF EVIDENCE
PPNNE has a comprehensive referral data base which is managed by the Centralized Clinical Specialists (CCS) and is accessible by all PPNNE staff. At present, the data base is primarily comprised of Medical referrals and can be retrieved by states (in the surrounding area), county, and discipline. The social service referrals are maintained at each site and were reviewed. At the Rutland site, for example, there was a very thorough and well organized binder which included an extensive list of social service referrals.

This requirement was **MET**.

Recommendation #2 (Administrative):
The grantee should consider, over time, extending the database, with input from each site, to include a comprehensive list of social service agencies that could also be accessed by all staff.

9.5 Referral Arrangements
Projects must provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs (42 CFR 59.5 (b)(8).

Evidence that this requirement has been met includes written policies requiring plans to coordinate with other service providers and current, written agreements with relevant referral agencies exist.

REVIEW OF EVIDENCE
See 9.4 above.
PPNNE currently has eight (8) MOUs throughout the state of VT. These MOU's are with three (3) high schools, and five (5) primary care practices or other social service agencies. PPNNE is working to expand their number of MOUs. PPNNE administrative staff, with the assistance of the VDH, has been working with the site managers to explore ways to develop more relationships in the community. Through relationships with staff at the local Health Department – Maternal and Child Health division, PPNNE has been able to expand their visibility and inclusion in community coalitions. It is through these coalitions that PPNNE has been able to develop MOUs and is hoping to expand.

This process is seen as a BEST PRACTICE.

This requirement was **MET**.

9.9 Residency Requirements
Services must be provided without the imposition of any durational residency requirement or requirement that the client be referred by a physician (42 CFR 59.5(b)(5)).

Evidence that this requirement has been met includes written policies prohibiting imposition of residency requirement at the grantee and sub-recipient level.

REVIEW OF EVIDENCE
See 8.1.1 and 8.6.1 above.
Trainings and documentation of training indicates that staff have been informed that services must be provided without the imposition of a durational residency requirements. Additionally, the contract requires adherence to all Title X requirements and links to the Title X requirements.

This requirement was **MET**.

Recommendation #3 (Administrative):
It is strongly recommended that the grantee develop its own Title X Policy and Procedure Manual that addresses all Title X requirements The Policy and Procedure Manual should include

a policy that specifies that services must be provided without the imposition of any durational residency requirement or requirement that the client be referred by a physician.

9.12 Legislative Mandates
Title X grantees must comply with applicable legislative mandates set out in the HHS appropriations act. Grantees must have written policies in place that address these legislative mandates:

> "None of the funds appropriated in the Act may be made available to any entity under Title X of the Public Health Service Act unless the applicant for the award certifies to the Secretary of Health and Human Services that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities."
>
> "Notwithstanding any other provision of law, no provider of services under Title X of the Public Health Service Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest."

Evidence that this requirement has been met includes written policies and procedures informing staff on a periodic basis of these requirements and documentation that staff have been formally informed of this requirement at least once during the project period, medical records document adolescents are encouraged to seek family participation.

REVIEW OF EVIDENCE
See 8.1.1 and 8.6.1 above.
This mandate is very clearly addressed in PPNNE's policies and procedures and each staff member signs-off on this policy at initial hire and then annually.

This requirement was **MET**.

10. Confidentiality
Every project must have safeguards to ensure client confidentiality. Information obtained by project staff about an individual receiving services may not be disclosed without the individual's documented consent, except as required by law or as may be necessary to provide services to the individual, with appropriate safeguards for confidentiality. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual (42 CFR 59.11).

Evidence that this requirement has been met includes written policies and procedures requiring safeguarding of client confidentiality, documentation that staff have been formally informed of this requirement at least once during the project period , clinical protocols have statements regarding client confidentiality, record systems adequately ensure privacy and confidentiality, clients are informed of HIPAA privacy forms, consent form or other documentation indicates

clients are informed, materials regarding the availability of confidentiality are available to clients, and the physical layout allows for confidentiality and privacy.

REVIEW OF EVIDENCE
See 8.1.1 and 8.6.1 above.
This mandate is very clearly addressed in PPNNE policies and procedures and each staff member signs-off on this policy at initial hire and then annually.

This requirement was **MET**.

11.1 Community Participation
Title X grantees and sub-recipient agencies must provide an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served; and by persons in the community knowledgeable about the community's needs for family planning services (42 CFR 59.5(b)(10)).

Evidence that this requirement has been met includes written policies and procedures to ensure participation of individuals broadly representative of the community in the project plan, a community engagement plan, and documentation of the implementation of the community engagement plan.

REVIEW OF EVIDENCE
Client satisfaction questionnaires are distributed to patients throughout the PPNNE network and are reviewed by both Center Managers and Administrative staff. Input from the surveys is used to make changes in service delivery as needed.

VDH staff participate in the Maternal Child Health (MCH) Coalition – Community Advisory Board, where an exchange of information is shared and state wide goals are set and monitored.

VDH and PPNNE staff sit on multiple community based coalitions representing a broad range of providers and community representatives. The local MCH Coordinators often take the lead in coordinating these groups, and meet at least quarterly. Minutes are taken and shared with all members.

This requirement was **MET**.

11.2 Community Assessment Programs
Projects must establish and implement planned activities to facilitate community awareness of and access to family planning services (42 CFR 59.5(b)(3)). Each family planning project must provide for community education programs (42 CFR 59.5(b)(3)).

The community education program(s) should be based on an assessment of the needs of the community and should contain an implementation and evaluation strategy.

Evidence that this requirement has been met includes documentation of a periodic community needs assessment, a written community education and service promotion plan, documentation of an evaluation and modification to plan as needed.

REVIEW OF EVIDENCE
In the PPNNE annual plan, each service site is expected to participate in community coalitions and to provide a minimum of three community outreach education programs each quarter. Each site manager provides a quarterly report, including information on their outreach activities. At the two service sites that were observed, the Center Manager demonstrated that they met these criteria through both our conversations and documentation. Activities included: tabling at community events, meetings with school nurses, and presentations at local schools/colleges.

This requirement was **MET**.

11.3 Goals of Community Education

Community education should serve to:

- enhance community understanding of the objectives of the project,
- make known the availability of services to potential clients,
- encourage continued participation by persons to whom family planning may be beneficial

(42 CFR 59.5 (b)(3)

Evidence that this requirement has been met includes a plan that:
(a) states that the purpose is to enhance community understanding of the objectives of the project, make known the availability of services to potential clients, and encourage continued participation by persons to whom family planning may be beneficial
(b) promotes the use of family planning among those with unmet need,
(c) utilizes an appropriate range of methods to reach the community
(d) includes an evaluation strategy.
and that such a plan has been implemented.

REVIEW OF EVIDENCE
In the PPNNE Site Manager's Manual there is a section entitled: *Outreach Q & A,* which includes a section on "Tips and Resources." The Manual defines what constitutes outreach and education. PPNNE maintains an internal outreach tracking system, "pePPer" – which monitors all outreach activity.

This requirement was **MET**.

12. Information and Education (I&E) Materials Approval

12.1 The Approval Process

Title X grantees and sub-recipient agencies are required to have a review and approval process, by an Advisory Committee, of all informational and educational (I&E) materials developed or

made available under the project prior to their distribution (Section 1006 (d)(2), PHS Act; 42 CFR 59.6(a)).

Evidence that this requirement has been met includes written policies and procedures regarding the review of all materials prior to use with clients and documentation that the committee has reviewed and approved them.

REVIEW OF EVIDENCE
The sub-recipient has a written I&E Policy and coordinates the I&E committee with representation from the VDH. Using Survey Monkey, members of the committee evaluate materials. A spreadsheet is then developed with the feedback and a determination is made in the appropriateness of the material. PPNNE primarily uses educational materials prepared by PPFA, although occasionally other handouts may be reviewed and made available.

This requirement was **MET**.

Recommendation #4 (Administrative):
As mentioned earlier, the grantee should consider developing or compiling a Title X Policy and Procedure Manual to be maintained at the grantee level. Within that manual, it is recommended that the relationship between VDH and I&E committee be clearly specified along with the expectations of the committee. Although this information is included in the contract with the sub-recipient, it is recommended that the grantee also have this in their own Title X Policy and Procedure Manual.

12.2 The I&E Committee
The committee must include individuals broadly representative (in terms of demographic factors such as race, color, national origin, handicapped condition, sex and age) of the population or community for which the materials are intended (42 CFR 59.6 (b)(2).

Evidence that this requirement has been met includes an established board that is broadly representative of the population served, a process is in place for sub-recipients, documentation exists that the committee meets the representation requirement.

REVIEW OF EVIDENCE
The I&E committee roster was reviewed. All of the members of the committee are either PPNNE or VDH staff.

This requirement was **NOT MET**.

Finding #2 (Administrative):
The I&E committee, although diverse, does not include representation from individuals broadly representative of the demographics served.
Corrective Action #2 (Administrative):
The grantee must work with PPNNE to broaden representation of the I&E committee to include greater diversity in representing the demographics served. This may include teens, males,

representation from the LGBTQ community or other patient populations served. While staff may be diverse, by virtue of being employed in the field of family planning, they possess specialized knowledge that may not exist in the general population.

12.3 Composition of the I&E Committee

Each Title X grantee must have an Advisory Committee of five to nine members, except that the size provision may be waived by the Secretary for good cause shown (42 CFR 59.6 (b)(1)). The Advisory Committee must review and approve all informational and educational (I&E) materials developed or made available under the project prior to their distribution to assure that the materials are suitable for the population and community for which they are intended and to assure their consistency with the purposes of Title X (Section 1006(d)(1), PHS Act; 42 CFR 59.6(a)).

Evidence that this requirement has been met includes policies and procedures regarding the committee, the roster/list of committee members is current, written meeting minutes are available and current.

REVIEW OF EVIDENCE
See 12.1 above

This requirement was **MET**.

12.5 Delegation of I&E Functions

The grantee may delegate I&E functions for the review and approval of materials to sub-recipient agencies; however, the oversight of the I&E review process rests with the grantee.

Evidence that this requirement has been met includes policies and procedures cover such delegation and monitoring and documentation of such monitoring.

REVIEW OF EVIDENCE
The grantee has delegated the I&E responsibility to the sub-recipient and does monitor all activity.

This requirement was **MET**.

12.6 I&E Committee Responsibilities

The I&E Advisory Committee(s) must:

- Consider the educational and cultural backgrounds of the individuals to whom the materials are addressed;
- Consider the standards of the population or community to be served with respect to such materials;
- Review the content of the material to assure that the information is factually correct;

- Determine whether the material is suitable for the population or community to which it is to be made available; and
- Establish a written record of its determinations

(Section 1006(d), PHS Act; 42 CFR 59.6(b))

Evidence that this requirement has been met includes policies and procedures addressing these elements and documentation that all components are reviewed.

REVIEW OF EVIDENCE
See 12.1 above
The sub-recipient has written policy for the I&E committee.

This requirement was **MET**.

13. Additional Administrative Requirements

13.1 Limited English Proficiency

Title X clinics must have written policies that are consistent with the HHS Office for Civil Rights policy document, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (August 4, 2003) (HHS Grants Policy Statement 2007, II-23).

Evidence that this requirement has been met includes policies regarding the provision of language assistance and documentation that staff are aware of such policies.

REVIEW OF EVIDENCE
Both the VDH and PPNNE have written LEP policies which are reviewed and signed-off on by all staff. At one of the sites visited, there was a poster at the front desk with approximately 20 languages listed saying (in that language) that an interpreter can be provided for you at no cost. The patient could point to their preferred language, letting the staff know their wishes.

This requirement was **MET**.

13.1 Prohibition of Disability Discrimination

Projects may not discriminate on the basis of disability and, when viewed in their entirety, facilities must be readily accessible to people with disabilities (45 CFR 84).

Evidence that this requirement has been met includes policies and procedures ensure those with a disability can access services, documentation exists regarding accommodations to disabled clients, and project sites are free of any obvious barriers.

REVIEW OF EVIDENCE
Both the VDH and PPNNE have written policies pertaining to the ADA laws against discrimination based on disability. These policies are reviewed and signed-off on by all staff.

During the site visits, no barriers were observed.

This requirement was **MET**.

13.2 Emergencies Management
All grantees, sub-recipients and Title X clinics are required to have a written plan for the management of emergencies (29 CFR 1910, subpart E) and clinical facilities must meet applicable standards established by Federal State and local governments (e.g. local fire, building, and licensing codes).

Evidence that this requirement has been met includes disaster plans exist, staff can identify emergency evacuation routes, staff are trained and know their roles, exits are recognizable and free from barriers, and documentation exists that sub-recipients are in compliance.

REVIEW OF EVIDENCE Policies at both the VDH and PPNNE included sections on emergency management. In addition, both sites visited had good signage (for exits) and were free from barriers.

This requirement was **MET**.

13.3 Prohibition of Personal Gain
Projects are required to establish policies to prevent employees, consultants, or members of governing/advisory bodies from using their positions for purposes that are, or give the appearance of being motivated by a desire for private financial gain for themselves or others (HHS Grants Policy Statement 2007, II-7).

Evidence that this requirement has been met includes policies exist that prohibit personal financial gain and documentation exists that grantees have assured sub-recipients are in compliance.

REVIEW OF EVIDENCE
See 8.1.1 and 8.6.1 above
Personnel policies at both the VDH and PPNNE prohibit personal financial gain on the part of all staff in the provision of services.

This requirement was **MET**.

13.4 Human Subjects Research
Research conducted within Title X projects may be subject to Department of Health and Human Services regulations regarding the protection of human subjects (45 CFR Part 46). The grantee/sub-recipient should advise their Regional Office in writing of any research projects that involve Title X clients (HHS Grants Policy Statement 2007, II-9).

Evidence that this requirement has been met includes written policies regarding the use of human subjects and documentation exists that grantees have assured sub-recipients are in compliance.

REVIEW OF EVIDENCE See 8.1.1 and 8.6.1 above
Both the VDH and PPNNE have written policies on human subject research. At the time of the site review, no research projects were taking place.

This requirement was **MET**.

8.2 Prohibition on Abortion
Title X grantees and sub-recipients must be in full compliance with Section 1008 of the Title X statute and 42 CFR 59.5(a) (5), which prohibit abortion as a method of family planning.

Systems must be in place to assure adequate separation of any non-Title X activities from the Title X project.

8.2.3 Financial documentation at service sites demonstrates that Title X funds are not being used for abortion services and adequate separation exists between Title X and non-Title X activities. (42 CFR 59.5(a) (5))

REVIEW OF EVIDENCE
The grantee does not provide abortion services. However, the sub-recipient does provide these services. The sub-recipient has established policies, procedures, and practices to ensure the adequate separation of Title X activities from non-Title X activities. Staff separates their time, after the fact, into clearly defined cost centers in the TimeForce system. This is done each day, is checked by the site supervisor, and is further checked through an analysis of the number and type of services provided each day in the clinic setting by administrative staff.

The sub-recipient demonstrated that no abortion-related activities were provided as part of the Title X project. This included policies and procedures and the actual practices in the clinic setting, counseling and service protocols, intake and referral procedures, and fiscal and other administrative procedures.

This requirement was **MET**.

8.3 Structure and Management

8.3.3 Purchase Authorization
The grantee must ensure that all services purchased for project participants will be authorized by the project director or his designee on the project staff (42 CFR 59.5(b) (7)).

Evidence that this requirement has been met includes policies and procedures providing for a purchase approval process and documentation of purchases following appropriate policies and procedures.

REVIEW OF EVIDENCE
The grantee has policies and procedures to ensure purchases are authorized by the project director or designee. A review of documents demonstrates these policies and procedures are implemented.

This requirement was **MET**.

8.3.4 Contracted Services Follow Established Schedule of Fees

The grantee must ensure that services provided through a contract or other similar arrangement are paid for under agreements that include a schedule of rates and payment procedures maintained by the grantee. The grantee must be prepared to substantiate that these rates are reasonable and necessary (42 CFR 59.5(b) (9)).

1. Evidence that this requirement has been met includes: a schedule of rates and payment procedures as part of the contract and the costs for services have a documented basis for rates.
2. The grantee can substantiate that the rates are reasonable and necessary; including demonstration of the process and/or rationale used to determine payments, examples of financial records, applicable internal controls.

REVIEW OF EVIDENCE

The grantee has included a schedule of rates and payment procedures as part of the contract with the sub-recipient. Attachment "b" of the contract specifies the payment provisions. This attachment states the total contract amount and instructs the sub-recipient to invoice the grantee on a monthly basis with, essentially, equal monthly payments. Invoices are reconciled with performance measures. The rates are consistent with the work to be provided.

This requirement was **MET**.

8.3.6 Financial Management System

The grantee and each sub-recipient must maintain a financial management system that meets Federal standards, as applicable, as well as any other requirements imposed by the Notice of Award, and which complies with Federal standards that will support effective control and accountability of funds, as required (45 CFR parts 74.20 and 92.20).

Evidence that this requirement has been met includes financial policies and procedures references to appropriate federal regulations and records and other documentation indicate practices align with Title X and other federal regulations.

8.3.6(1) Grantee financial policies and procedures can be referenced back to federal regulations as applicable.

REVIEW OF EVIDENCE

The grantee has extensive policies and procedures that are referenced to both Federal and State requirements.

This requirement was **MET**.

8.3.6(2) Grantee financial records and oversight documentation demonstrates that the financial management practices are aligned with Title X and other applicable regulations and grant requirements.

REVIEW OF EVIDENCE
The grantee and the sub-recipient must maintain a financial management system that meets Federal standards, as applicable, as well as any other requirements imposed by the Notice of Award, and which complies with Federal standards that will support effective control and accountability of funds. The non-Federal entity (grantee) must monitor its activities, including the activities of Pass-through entities (sub-recipients), under Federal awards, to assure that compliance with applicable Federal requirements and performance expectations are being achieved. Monitoring by the non-Federal entity must cover each program, function or activity (2 CFR 200.328).

The grantee does not have a monitoring system to ensure the sub-recipients are reporting all sources of funds used to provide the Title X family planning services (2 CFR 200.302 (b) (1)). The sub-recipient is not reporting donations or in-kind funds contributed by the agency in providing the full Title X Family Planning Program. This means the FFR (SF 425) and FPAR reports do not accurately represent the total program income and expenses and are incomplete.

A review of the SF-425 reports showed they have not been completed correctly. This appears to be due to a misunderstanding of the reporting requirements. Technical assistance was provided to the staff completing these reports.

This requirement was **NOT MET**.

Finding #3 (Financial):

A. The grantee does not have a fiscal review tool and has not established a schedule to monitor the sub-recipient agency to ensure compliance with federal regulations and statute.
B. The grantee did not complete the Federal Financial Reports (FFR SF-425) for the last budget period in accordance with OGM guidelines and requirements. The grantee did not report any amount for drawdowns from the PMS (45 CFR 75.341). The grantee did not have complete and accurate information from the sub-recipient regarding income elements that should be reported on the SF 425.

Corrective Action #3 (Financial):

A. The grantee must establish a monitoring system to ensure compliance with applicable Federal fiscal requirements and performance expectations. This monitoring should ensure that all funds relate to the Title X program are reported to the grantee and expended in accordance with the provision of the grant and/or the Code of Federal Regulations (CFR). The grantee might consider utilizing the financial tools available on the Family Planning National Training Center website (www.fpntc.org) or modifying the OPA program review tool to accomplish this monitoring.
B. The grantee must review how to report fiscal information on the FFR and report correctly during the current budget period. This must include complete and correct information from the sub-recipient.

Recommendations #5 (Financial):

1. During the budget process, the grantee should ensure the SF- 424's included in the application for funding include all revenue sources: the federal award, any state dollars, program generated income, and all other funds supporting the title x project (i.e. title xx, SSBG funding, STD funds, and any other funds helping to support the Family planning program. The grantee should revise the current budget period SF 424 to include all sources of funds.
2. The grantee is responsible for completing the FPAR table 14. To complete this correctly the grantee should ensure information reported by the sub-recipient includes donations and any other cash received as a result of the Title X funding. Further, the grantee should ensure the report from the sub-recipient does not include other funds designated for outreach and education only.
3. The sub-recipient does not have an approved indirect cost rate but is claiming indirect costs on their budget request and on their reports to the grantee. Any non-Federal entity that has never received a negotiated indirect cost rate … may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. As described in § 200.403, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate for a rate, which the non-Federal entity may apply to do at any time. (2 CFR 200.414(f)). The grantee should have the sub-recipient reference they are using a de minimis rate on indirect costs line of budget request.

8.4 Charges, Billings, and Collections

This section deals with charges, billing and collections and relies on written policies and procedures to ensure the grantee and sub-recipients have initiated appropriate methodologies to meet the requirements of the section. The grantee and sub-recipients must show they have written copies of the required policies and procedures and demonstrate at the service site level that the policies and procedures are being followed.

REVIEW OF EVIDENCE

VDH through the sub-recipient has established policies and procedures on their own without guidance from the grantee.

This requirement was **MET**.

Recommendation #5 (Financial) (Response Required):

Although the sub-recipient has an established policies and procedures manual, the grantee does not have a manual for fiscal activities that includes the necessary policies and procedures to meet the requirements of Section 8.4. The grantee should adopt or establish and implement its own, at a minimum, policies and procedures on:

- Policies and procedures assuring that clients whose documented income is at or below 100% FPL are not charged for services and that third party payers are billed.

- Policy and procedures for verifying client income does not present a barrier to receipt of services.
- A policy and procedure documenting the process for waiving fees for individuals with family incomes above 100% of the FPL who, as determined by the service site project director, are unable, for good cause, to pay for family planning services (42 CFR 59.2).
- Policies and procedures requiring sub-recipients and service sites to have a sound rationale and process for determining the cost of services.
- Policies require service sites to have a process for determining whether a minor is seeking confidential services and stipulates that charges to adolescents seeking confidential services will be based solely on the adolescent's income.
- Policies and procedures requiring that all project sites bill insurance in accordance with Title X regulations.
- A system to ensure that, with regard to insured clients, clients whose family income is at or below 250% FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied.
- A determination on whether or not and how to collect voluntary donations from clients.
- How income verification is requested and completed. This must include a section on self-declaration.

8.4.1 Charges to Those Below 100% of Federal Policy Levels and Third-Party Payers

Clients whose documented income is at or below 100% of the Federal Poverty Level (FPL) must not be charged, although projects must bill all third parties authorized or legally obligated to pay for services (Section 1006(c)(2), PHS Act; 42 CFR 59.5(a)(7)).

Evidence that this requirement has been met includes financial policies and procedures regarding collection of clients' income data, including legally accessing income information from another program or clients self-reported income; documentation that those below 100% FPL are not charged; and the income reporting process does not create a barrier to receipt of services.

REVIEW OF EVIDENCE

The sub-recipient is not charging clients whose documented income is at or below 100% of the FPL. They are billing all third parties legally obligated to pay for services.

This requirement was **MET**.

8.4.2 Schedule of Discounts

A schedule of discounts, based on ability to pay, is required for individuals with family incomes between 101% and 250% of the Federal Poverty Level (FPL) (42 CFR 59.5(a)(8)).

Evidence that this requirement has been met includes financial policies and procedures regarding development of a schedule of discounts and documentation that these discounts are applied appropriately

REVIEW OF EVIDENCE

The sub-recipient has established an appropriate schedule of discounts (SOD) and it is implemented in the clinics.

This requirement was **MET**.

8.4.3 Waiving of Fees
Fees must be waived for individuals with family incomes above 100% of the FPL who, as determined by the service site project director, are unable, for good cause, to pay for family planning services (42 CFR 59.2).

Evidence that this requirement has been met includes policies and procedures for waiving fees and documentation that any determination to waive the fee is made by the service site director, is documented and the client is informed of the determination.

REVIEW OF EVIDENCE
The grantee has established an appropriate SOD and it is implemented in the clinics.

This requirement was **MET**.

8.4.4 Determining the Cost of Services
For persons from families whose income exceeds 250% of the FPL, charges must be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services. (42 CFR 59.5(a) (8)).

Evidence that this requirement has been met includes policies and procedures for determining the cost of services and documentation that charges are applied appropriately.

REVIEW OF EVIDENCE
The sub-recipient has established an appropriate system to implement charges in the family planning program designed to recover the reasonable cost of providing services.

This requirement was **MET**.

8.4.5 Charges for Confidential Services
Eligibility for discounts for un-emancipated minors who receive confidential services must be based on the income of the minor (42 CFR 59.2).

Evidence that this requirement has been met includes policies and procedures for determining if the minor is seeking confidential services and charging the minor based on his/her own income and documentation that charges are applied appropriately.

REVIEW OF EVIDENCE

The sub-recipient has a system to allow minors seeking confidential services to receive discounts based on the income of the minor.

This requirement was **MET**.

8.4.6 Third Party Payment

Where there is legal obligation or authorization for third party reimbursement, including public or private sources, all reasonable efforts must be made to obtain third party payment without the application of any discounts (42 CFR 59.5(a)(9)).

Family income should be assessed before determining whether copayments or additional fees are charged. With regard to insured clients, clients whose family income is at or below 250% FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied.

Evidence that this requirement has been met includes policies and procedures regarding billing third parties and assessing co-pays, contracts with third party payers, and a review of records indicates appropriate assessment and charges.

REVIEW OF EVIDENCE
The sub-recipient has policies and procedures to comply with the requirements of Title X regarding fee collection. They are able to access all public and private third party payers.

This requirement was **MET**.

8.4.7 Title XIX and Title XX Reimbursements

Where reimbursement is available from Title XIX or Title XX of the Social Security Act, a written agreement with the Title XIX or the Title XX state agency at either the grantee level or sub-recipient agency is required (42 CFR 59.5(a)(9)].

Evidence that this requirement has been met includes up-to-date written agreements at both the grantee and/or sub-recipient level.

REVIEW OF EVIDENCE
Reimbursement at the sub-recipient is available from Title XIX. They have a letter of determination for eligibility on file.

This requirement was **MET**.

8.4.8 Fee Collection

Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.

Evidence that this requirement has been met includes policies and procedures include safeguards that protect client confidentiality, particularly in cases where sending an explanation of benefits could breach client confidentiality and documentation at service sites demonstrates the sites maintain confidentiality when billing and collecting payments.

REVIEW OF EVIDENCE
The sub-recipient has procedures in place to collect charges without jeopardizing client confidentiality. This is built into their patient management system.

This requirement was **MET**.

8.4.9 Voluntary Donations
Voluntary donations from clients are permissible; however, clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies.

Evidence that this requirement has been met includes policies and procedures provide for voluntary donations and documentation and observation of requests for donations indicate no pressure for such payments.

REVIEW OF EVIDENCE
The sub-recipient has procedures in place for voluntary donations and documentation and observation of requests for donations indicate no pressure for such payments.

This requirement was **MET**.

8.5 Project Personnel

8.5.5 Salary Limits
Appropriate salary limits will apply as required by law.

Evidence that this requirement has been met includes budgets and payroll records correspond to the most current family planning services Funding Opportunity Announcement (FOA).

REVIEW OF EVIDENCE
Neither the grantee nor the sub-recipient exceeds the $187,000 annual salary limit (2017) for an individual's direct salary. The rate limitation does not exceed the amount that may be awarded and charged to the grant. The grantee and sub-recipient are aware of this requirement.

This requirement was **MET**.

10. Confidentiality
Every project must have safeguards to ensure client confidentiality. Information obtained by project staff about an individual receiving services may not be disclosed without the individual’s

documented consent, except as required by law or as may be necessary to provide services to the individual, with appropriate safeguards for confidentiality. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual (42 CFR 59.11).

Evidence that this requirement has been met includes third-party billing does not breach confidentiality.

REVIEW OF EVIDENCE
The sub-recipient has developed procedures to ensure third party billing does not compromise client confidentiality.

This requirement was **MET**.

8.1.2 Prohibition of Prerequisite for Other Services
Clients are aware that receipt of family planning services is not used as a prerequisite to receipt of other services from the service site.

Medical record review demonstrates that each client has signed a general consent form or other documentation indicating they are aware that receipt of family planning services receipt of family planning services is not a prerequisite to receipt of any other services offered.

REVIEW OF EVIDENCE
A signed general consent was found in each medical record reviewed within both clinic sites. Although the consent form does not stipulate that "receipt of family planning services is not a prerequisite to receipt of any other services offered," it does include language acknowledging that the client is requesting services. There is no suggestion that any prerequisites for family planning services exist. Staff training includes the acknowledgement that receipt of family planning services is not a prerequisite to receipt of any other services offered.

This requirement was **MET**.

Recommendation #6 (Clinical):
The grantee should encourage PPNNE to add language to the general consent specifying that receipt of family planning services is not a prerequisite to receipt of any other services offered.

8.5 Project Personnel

8.5.4 Medical Director
Projects must provide that family planning medical services will be performed under the direction of a physician with special training or experience in family planning (42 CFR 59.5 (b)(6)).

Evidence that this requirement has been met includes documentation that 1) a physician is involved in medical/clinical services, 2) the Medical is involved in program operations, 3) the curriculum vitae indicates training or experience in family planning, and 4) clinical protocols are approved by the Medical Director

REVIEW OF EVIDENCE
An interview with the PPNNE Medical Director and a review of her vitae established that she is a family practice physician with special training and experience in family planning, reproductive and sexual health care. She reviews and updates the clinical protocol manual, *Medical Standards and Guidelines* (MS&G) annually to ensure current standards of care are addressed. Quality Improvement meetings' and Clinical Services meetings' notes substantiate the Medical Director's involvement in all program clinical care components. She meets regularly with

PPNNE's Regional Directors of Clinical Care and collaborates with the grantee's Medical Director regarding the Title X program. Both Medical Directors serve on the Family Planning Workgroup, comprised of community partners, which identifies and addresses barriers to the family planning system in the state. Additionally, PPNNE's Medical Director reviews all midlevel clinicians' annual performance evaluations and inputs as indicated.

This requirement was **MET**.

9.4 Referral for Related Social Services

Projects must provide for social services related to family planning including counseling, referral to and from other social and medical services agencies, and any ancillary services which may be necessary to facilitate clinic attendance (42 CFR 59.5 (b)(2)).

Evidence that this requirement has been met includes documentation that referrals were made based on specific conditions/issues.

REVIEW OF EVIDENCE

The medical record review indicated that referrals were made appropriately when indicated. Referral resources were reviewed in each of the clinic sites and include a broad representation of clinical and social service agencies and providers. Rutland Health Center is in the process of employing a 0.5 FTE Social Worker to address patient needs for follow-up and community referrals. This clinic also has been proactive in engaging referral resources in MOAs. The MS&G outlines specific processes for referrals for condition related to family planning. Agency-wide audits of the referral follow-up system occur at least annually.

This requirement was **MET**.

Recommendation #7 (Clinical):

Insofar as Rutland Health Center's Site Manager acknowledges a collaborative working relationship with the local adoption agency, the grantee should encourage this health center, as well as all sub-recipient health centers, to secure formal MOAs with local adoption agencies as well as Urgent Care centers in the community.

9.6 Clinical Protocols

All grantees should assure services provided within their project operate within written protocols that are in accordance with nationally recognized standards of care, approved by the grantee, and signed by the physician responsible for the service site.

Evidence that this requirement has been met includes written clinical policies and procedures are aligned with nationally recognized standards of care and signed by a responsible physician, the grantee monitors sub-recipients' policies for alignment with nationally recognized standards of care, and client records indicate services follow protocols.

REVIEW OF EVIDENCE

The Medical Director approves and signs the MS&G which are primarily generated by Planned Parenthood Federation of America with input from Department of Health and Human Services. MS&G are meticulously aligned with nationally recognized standards of care and best practices. They are available electronically through PPNNE's intranet, which can be accessed from all PPNNE Health Centers. The clinical protocol manual was last revised and signed by the Medical Director December, 2016. PPNNE provides annual training to practitioners on the MS&G upon their revision/release each calendar year.

The grantee relies on self-reporting from the sub-recipient (topic-specific medical record and site facility audits) to monitor clinical care. Site reviews are conducted by the grantee without clinical staff representation insofar as the grantee does not have designated clinical staff for the Title X program.

This requirement was **MET**.

Recommendation #8 (Clinical) (Response Required):
Although the grantee requires the sub-recipient to self-report monitoring information, the grantee does not adequately monitor the sub-recipient's clinical services through observation of care or medical record review to ensure that services follow *MS&G* and *QFP*. The grantee should strongly consider employing direct monitoring of the clinical component of the Title X Program in order to ensure:

- services align with *MS&G*;
- clinical care is provided in a manner consistent with *QFP* as confirmed through direct observation;
- medical records' inspections validate clinical services are consistent with *MS&G*, *QFP* (including reproductive life planning discussions) and referrals are made when indicated;
- a broad range of contraceptives are available onsite;
- adolescents have been counseled about abstinence, condom use, and other contraceptives including LARCs, as evidenced through medical record reviews (and observation when possible);
- pregnancy testing is available and medical record documentation (and observation when possible);
- confirms non-directive counseling per clients' requests, and referrals as appropriate.

  (Note: During the review, the grantee's Medical Director and the Title X Program Administrator enthusiastically proposed several possibilities for employing a clinician to meet this requirement.)

9.7 Provision of Family Planning Related Medical Services
All projects must provide for medical services related to family planning and the effective usage of contraceptive devices and practices (including physician's consultation, examination, prescription, and continuing supervision, laboratory examination, contraceptive supplies) as well as necessary referrals to other medical facilities when medically indicated (42 CFR 59.5(b)(1)). This includes, but is not limited to emergencies that require referral.

Evidence that this requirement has been met includes written policies and procedures requiring family planning-related medical services, provision of breast and cervical cancer screening on-site, and written agreements with relevant referral agencies exist.

REVIEW OF EVIDENCE
Review of medical records, contraceptive supplies and referral resource lists, and observation of clinical care substantiate that the program provides medical services related to the Title X program. These services include patient education and counseling, breast and pelvic examinations, cervical cancer screening, STI and HIV screening and prevention education, pregnancy diagnosis and counseling. Confidential HIV testing is offered to all patients as part of routine annual visits and at all STI screening visits. Written agreements exist with community partners (e.g., two "free" clinics, a Federally Qualified Health Center, a drug rehabilitation center, and a HIV/AIDS Center) to facilitate ongoing client needs. Emergency protocols at each site visited include emergency transfer of clients needing additional care.

This requirement was **MET**.

Recommendation #9 (Clinical):
The grantee should add to the sub-recipient contract's list of services "help for clients who desire to achieve pregnancy" as these services are an integral component of family planning.

9.8 A Broad Range of Contraceptives
All Projects must provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents).

If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of family planning services. (42 CFR 59.5(a)(1)).

Evidence that this requirement has been met includes medical records indicate provision of a broad-range of contraceptives; services, when viewed as a whole, provide a broad range, current stock indicates a broad range are available on-site or by referral; clinical protocols include contraception, pregnancy testing and counseling, services for achieving pregnancy, STD services and preconception health services; and documentation exists that the grantee ensures sub-recipients comply with these requirements.

REVIEW OF EVIDENCE
PPNNE provides a broad range of contraceptives including Liletta, Mirena, Paragard and Skyla IUDs, Nexplanon, and education materials related to fertility awareness methods. All Physician Assistants and Nurse Practitioners are trained in LARC insertions and removals. PPNNE uses a computerized simulated pelvic model to facilitate training new clinicians in IUD insertions. All health center staff are trained (and two were observed) to offer tiered contraceptive method counseling, and utilize the Bedsider *How Well Does Birth Control Work* tool as well as the

STARS method of contraceptive counseling which highlight methods according to effectiveness and ease of use.

This requirement was **MET**.

9.10 Pregnancy Diagnosis and Counseling
Projects must provide pregnancy diagnosis and counseling to all clients in need of these services (42 CFR 59.5(a)(5)).

Evidence that this requirement has been met includes a written policy requiring provision of pregnancy diagnosis and counseling and clinic inventory and a review of client records indicate the services were available and offered to all clients.

REVIEW OF EVIDENCE
MS&G related to pregnancy diagnosis and counseling is in accordance with *QFP* and include specific plans for clients with positive and negative tests responsive to their individual desires for pregnancy. Pregnancy testing is available to clients on a walk-in basis and Health Care Assistants, who perform the majority of pregnancy testing and counseling, are trained in this service. Clients are referred to a clinician when indicated.

This requirement was **MET**.

9.11 Pregnancy Options Counseling
Projects must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- Prenatal care and delivery;
- Infant care, foster care, or adoption; and
- Pregnancy termination.

If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any options(s) about which the pregnant woman indicates she does not wish to receive such information and counseling (42 CFR 59.5(a)(5)).

Evidence that this requirement has been met includes written policies and procedures regarding options counseling that are neutral and factual, referrals provided as requested, medical records document such counseling and referrals.

REVIEW OF EVIDENCE
MS&G's pregnancy counseling protocols stipulate that all clients testing positive for pregnancy and undecided about pregnancy resolution "**MUST** be offered non directive counseling on all pregnancy options." Five medical records of pregnancy testing and counseling visits, reviewed within each agency, revealed patients desiring to continue pregnancy were counseled about

prenatal considerations according to the *MS&G*. In cases where documentation indicated a client's attempting pregnancy, an electronic health record (EHR) prompt for "counseled regarding all options" was checked. Pregnancy packets are given to patients relative to the option of their choice (patients undecided about an option are given all three packets) which contain option-specific and appropriate referral information.

This requirement was **MET**.

Recommendation #10 (Clinical):
The *MS&G* Pregnancy Counseling protocol and the electronic health record template should be modified to read that patients are given the opportunity to be given information, counseling and referral about the options(s) she wishes to receive. Patients who are undecided about pregnancy resolution should be given counseling and packet information only for the options for which they request information.

Quality Family Planning Implementation Assessment

Administrative Aspects

This portion of the assessment follows the recommendations detailed in *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs (QFP)*, which focuses on service provision consistent with the best available scientific evidence.

8.7 Planning and Evaluation
Grantees should evaluate implementation of quality family planning services following the QFP framework, monitoring performance and improving efforts on an on-going basis.
QI activities should include:

1) Monitoring the use of most- or moderately-effective contraceptive methods and long-acting reversible contraceptives
2) On-going QI processes related to contraceptive use
3) Monitoring contraceptive use at the service-site level
4) On-going QI processes at the service site level to respond to contraceptive use findings
5) QI efforts at the service site level related to other aspects of quality care
6) Use of HIT data to increase QI efforts

REVIEW OF EVIDENCE
The grantee's sub-recipient, PPNNE, has a comprehensive QI program as articulated in their Policies and QI Monitoring Tools. Using NextGen as their HIT software, data is collected and managed by the IT department, then monitored by the Medical Director and other key staff. As mentioned, all center mangers prepare a quarterly report, and benchmarks are reviewed. If not meeting benchmarks (as identified in their work plans), corrective action plans are developed.

This Quality Aspect is **HIGHLY DEVELOPED**.

9.2 Client-Centered Services
(*NOTE: In the tool, this section is titled Link to QFP: Cultural Competency and Client Dignity)*
Quality services are client-centered, which includes providing services in a respectful and culturally competent manner, and are evidenced by:

1) A needs assessment to determine groups needed culturally competent care
2) Written policies and procedures requiring training in culturally competent care
3) Documentation that staff have received such training
4) Observation of a welcoming clinic environment
5) Client surveys document respectful treatment

REVIEW OF EVIDENCE
All sites visited for this site review demonstrated exceptional care and service, both at the administrative site and health center locations. PPNNE has a comprehensive new staff "on-boarding" training, which includes customer service and cultural competence. On-going trainings are provided and tracked, including face-to-face training events and on-line courses.

Through observation, it was apparent that the staff treat one another as well as their patients with respect and dignity and offer a warm and welcoming environment.

This Quality Aspect is **HIGHLY DEVELOPED**.

9.8 Adolescent Services (see Clinical QFP also)
The special needs of adolescents are addressed by:

1) Offering all services listed in the QFP
2) No out-stock of routinely offered contraceptives occurred in the past 6 months
3) FPAR data indicate services to adolescents close to or above the national average
4) FPAR data indicate services to males close to or above the national average
5) Medical records indicate adolescents have been counseled about abstinence, condoms and LARCs

REVIEW OF EVIDENCE
Teens made up 20% of VDH's clients served in 2016. The number and percentage of male clients has increased consistently over the past 10 years and has more than doubled, now representing approximately 11% of their patient population.
Clinical observation and review of services showed that the sub-recipient is offering all services listed in QFP. Medical record review indicates that adolescents are consistently counseled about abstinence, condoms, and LARCs.

This Quality Aspect is **HIGHLY DEVELOPED**.

13.1 Limited English Proficiency (see Clinical QFP also)
Providing services or materials to those with Limited English Proficiency include:

1) Materials are clear and easy to understand (e.g. 4^{th}-6^{th}-grade reading level)
2) Observation demonstrates that information is presented in a way that emphasizes essential points
3) Observation demonstrates that information on risks and benefits of different contraceptives or procedures are communicated in a way that is easily understood
4) Information provided during counseling is culturally appropriate
5) Educational materials are tailored to literacy

REVIEW OF EVIDENCE

Most of the educational materials distributed are developed by PPFA and at times, may require a higher reading level. However, this criterion is reviewed by the I&E committee in determining the appropriateness of the materials both in literacy level and cultural appropriateness. Whenever possible, materials are available in Spanish.

This Quality Aspect is **FULLY DEVELOPED**.

8.1 Voluntary Participation

8.1.1 Client-Centered Services

A core premise of Recommendations for Providing Quality Family Planning Services is that quality services are client-centered.
The key principles of providing quality, client-centered counseling include:

1) establish and maintain rapport with the client
2) assess the client's needs and personalize discussions accordingly
3) work with the client interactively to establish a plan
4) provide information that can be understood and retained by the client
5) confirm client understanding (See Appendix C of QFP for additional detail.)

REVIEW OF EVIDENCE
Effective communication points are defined in the *MS&G* that replicate those in the *QFP* document. Four observations of client care within the clinics visited confirmed that Physician Assistants and Health Care Assistants (HCAs), alike, offer highly skilled client-centered education and counseling, assessment of individual needs, and personalized discussions in planning care. Orientation for HCAs includes education topics addressing empathy in communicating with clients. Medical records consistently documented confirmation of clients understanding of education given.

This Quality Aspect is **HIGHLY DEVELOPED**.

9.6 Clinical Protocols

Protocols follow *QFP* and are evidenced by:

1) Covering the full scope of *QFP*-defined family planning services
2) Sub-recipient protocols reflect latest *QFP* recommendations
3) Documentation of *QFP* training
4) Client records indicate services per *QFP* Tables 2 and 3

REVIEW OF EVIDENCE
MS&G cover the full scope of *QFP*-defined family planning services and recommendations. Training records of clinical employees indicate training on multiple topics relative to elements identified in *QFP* but not the specific *QFP* training offered by The National Training Center. Medical records indicate family planning and preventive health care services per *QFP* for men and women. A registered nurse provider in one of the reviewed agencies did not have familiarity with the *QFP* document.

This Quality Aspect is **PARTIALLY DEVELOPED**.

Recommendation #11 (Clinical):
The grantee should encourage PPNNE to incorporate National Family Planning Center's *QFP* training into their plans for all newly hired midlevel clinicians and HCAs and ensure that all clinical staff familiarize themselves with the *QFP* which PPNNE has available on-line.

9.8 Adolescent Services (See Administrative *QFP* also)
The special needs of adolescents are addressed by:
1) Offering all services listed in the *QFP*
2) No out-stock of routinely offered contraceptives occurred in the past 6 months
3) FPAR data indicate services to adolescents close to or above the national average
4) FPAR data indicate services to males close to or above the national average
5) Medical records indicate adolescents have been counseled about abstinence, condoms and LARCs

REVIEW OF EVIDENCE
PPNNE offers same day appointment scheduling and hours that are geared toward the convenience of teens. All health center staff members are trained upon hire and annually thereafter regarding PPNNE's mandated reporting policy, state regulations regarding mandated reporting, and the PPNNE policy on family involvement.
Medical records reviewed indicate that all adolescents are provided services required by Title X (encouragement of family involvement and counseling regarding ways to resist sexual coercion) as well as *QFP* related services (abstinence counseling and condom use). No out of stock routinely offered contraceptives occurred in the past 6 months and medical records reviewed documented that LARCs are provided to adolescents. Training for HCAs, upon hiring, includes the topics of abstinence, parental involvement, sexual coercion resistance, and reproductive life planning in their adolescent education training module. MOAs with three high schools are in place for a peer education program. The percentages of the program's adolescent and male clients served during year 2016 are above the national average.

This Quality Aspect is **HIGHLY DEVELOPED**.

9.10 Pregnancy Testing and Counseling
Pregnancy testing and counseling services should include:
1) Written protocols follow *QFP* recommendations, including reproductive life planning
2) Medical records indicate clients with positive pregnancy tests receive prenatal counseling and social support assessment
3) Medical records indicate clients with a negative pregnancy test who wish not to become pregnant are offered same-day contraception
4) Staff are trained in *QFP* pregnancy testing and counseling recommendations
5) Medical records and observation indicate pregnancy counseling follows *QFP* recommendations, including reproductive life planning

REVIEW OF EVIDENCE
Reproductive life planning discussions are an integral part of the *MS&G*. Observation of client care included addressing reproductive life plans for all four clients observed. Only one of the 50 reviewed medical records lacked documentation of reproductive life planning discussions. All clients' medical records with positive pregnancy tests had documented prenatal counseling and social support assessment. Health Care Assistant staff training records indicate that pregnancy

testing and counseling training is conducted upon hiring. Records of this training were not available for midlevel clinician staff.

This Quality Aspect is **FULLY DEVELOPED**.

Recommendation #12 (Clinical):
The grantee should encourage PPNNE to incorporate National Family Planning Center's pregnancy counseling training into their plans for all newly hired midlevel clinicians.

13.1 Limited English Proficiency (see Administrative *QFP* also)
Providing services or materials to those with Limited English Proficiency include:

1) Materials are clear and easy to understand (e.g. 4^{th}-6^{th}-grade reading level)
2) Observation demonstrates that information is presented in a way that emphasizes essential points
3) Observation demonstrates that information on risks and benefits of different contraceptives or procedures are communicated in a way that is easily understood
4) Information provided during counseling is culturally appropriate
5) Educational materials are tailored to literacy

REVIEW OF EVIDENCE
According to the grantee's 2016 FPAR data, less than 1.5% of clients are LEP users and anecdotally the grantee reports that the majority of these are Spanish speaking. PPNNE has all contraceptive information available in Spanish. All materials, otherwise, are clear and easy to understand and standardized throughout the PPNNE system. Observation of client education confirmed that information is presented with an emphasis on essential points and in a way that is easily understood. The HCAs provide the majority of contraceptive and STI prevention education and the two HCAs observed were exceptionally skilled in client-centered communication.

This Quality Aspect is **HIGHLY DEVELOPED**.

U.S. Department of Health and Human Services
Region I
Office of the Regional Health Administrator
Office of the Assistant Secretary for Health

JFK Federal Building
15 New Sudbury Street, Suite 2126
Boston, MA 02203

Vermont Department of Health

Vermont Family Planning Program
Title X Program Review Report: Executive Summary

July 20, 2017

Table of Contents

I. Introduction

The Region I, Office of the Regional Health Administrator (ORHA), on behalf of the Office of Population Affairs (OPA), conducted the program review for the Vermont Department of Health (VDH) from May 15 through May 19, 2017. The grantee's project period is 04/01/16 – 03/31/19 and received $775,000 for the current budget period. The grantee's administrative office is located in Burlington, VT, and has one sub-recipient, Planned Parenthood of Northern New England, that delivers family planning services through ten service sites. According to 2016 Family Planning Annual Report (FPAR) data, the project provided family planning services to 10,053 clients.

a. Program Review Participants

i. Program Review Team Members

HHS Region I Office of the Regional Health Administrator

Natalia Guevara, Public Health Advisor - Review Team Leader

Program Review Consultant Team

Gerry Christie (Joyce McIntyre, trainee) – Financial Reviewer
Karen Ward – Clinical Reviewer
Shelley Miller – Administrative Reviewer

ii. Grantee and Sub-Recipient/Service Site Personnel

Grantee Personnel

- Kim Bean, Maternal and Child Health Business Administrator
- Patrick Burke, VDH Financial Manager, Business Office
- Sara Chesbrough, PREP Program Coordinator
- Tracy Dolan, MPH, Deputy Commissioner
- Breena Holmes, MD, Director, Maternal & Child Health
- Karen Kelly, VDH Financial Administrator/ Grants and Contracts, Business Office
- Dr. Mark Levine, MD, Commissioner
- Ilisa Stalberg, Deputy Director, Maternal and Child Health
- Kim Swartz, Director, Preventive Reproductive Health (Title X Program Administrator)

Service Site/Sub-Recipient

Planned Parenthood of Northern New England Administrative Headquarters
784 Hercules Drive
Colchester VT 05446

Planned Parenthood of Northern New England, St. Albans Health Center
80 Fairfield St
St Albans City, VT 05478

Planned Parenthood of Northern New England, Rutland Health Center
11 Burnham Ave
Rutland, VT 05701

II. Findings and Required Corrective Actions

a. Project Management and Administration

Finding #1 (Administrative):
9.1 Low-Income Families. *Priority for project services is to persons from low- income families (Section 1006(c)(1), PHS Act; 42 CFR 59.5(a)(6)).*
The data indicates that 44% of the patients seen fall at or below 100% of poverty. In order to show that priority for project services is to persons from low-income families, the clients a grantee serves must be comprised of 50% or more clients who are at or below 100% FPL.
Corrective Action to Finding #1 (Administrative):
VDH and PPNNE must explore ways to increase the number and percentage of low-income families being served. One way to achieve this goal would be to expand Title X to a Burlington site, where there is a large refugee population.

Finding #2 (Administrative):
12.2 The I&E Committee. *The committee must include individuals broadly representative (in terms of demographic factors such as race, color, national origin, handicapped condition, sex and age) of the population or community for which the materials are intended (42 CFR 59.6 (b)(2).*
The I&E committee, although diverse, does not include representation from individuals broadly representative of the demographics served.
Corrective Action to Finding #2 (Administrative):
The grantee must work with PPNNE to broaden representation of the I&E committee to include greater diversity in representing the demographics served. This may include teens, males, representation from the LGBTQ community or other patient populations served. While staff may be diverse, by virtue of being employed in the field of family

planning, they possess specialized knowledge that may not exist in the general population.

Finding #3 (Financial):
8.3.6 Financial Management System. *The grantee and each sub-recipient must maintain a financial management system that meets Federal standards, as applicable, as well as any other requirements imposed by the Notice of Award, and which complies with Federal standards that will support effective control and accountability of funds, as required (45 CFR parts 74.20 and 92.20).*

A. The grantee does not have a fiscal review tool and has not established a schedule to monitor the sub-recipient agency to ensure compliance with federal regulations and statute.
B. The grantee did not complete the Federal Financial Reports (FFR SF-425) for the last budget period in accordance with OGM guidelines and requirements. The grantee did not report any amount for drawdowns from the PMS (45 CFR 75.341). The grantee did not have complete and accurate information from the sub recipient regarding income elements that should be reported on the SF 425.

Corrective Action to Finding #3 (Financial):

A. The grantee must establish a monitoring system to ensure compliance with applicable Federal fiscal requirements and performance expectations. This monitoring should ensure that all funds relate to the Title X program are reported to the grantee and expended in accordance with the provision of the grant and/or the Code of Federal Regulations (CFR). The grantee might consider utilizing the financial tools available on the Family Planning National Training Center website (www.fpntc.org) or modifying the OPA program review tool to accomplish this monitoring.
B. The grantee must review how to report fiscal information on the FFR and report correctly during the current budget period. Fiscal reports must include complete and correct information from the sub recipient.

III. Analysis

The review found VDH to be in general compliance with key Title X requirements, regulations, and guidelines. This report contains three (3) findings, which indicate areas where VDH must take action to come into full and ongoing compliance with Title X. One key component of this compliance is improved oversight of the sub-recipient. The VDH and PPNNE staffs have a well-established working relationship; the VDH Project Manager and the PPNNE Grants Manager meet monthly to review the status of the grant and the Medical Directors and staff from both agencies meet twice annually. These processes could be improved in two ways: First, by including the grantee's Title X manager, along with the relevant VDH staff, in routine and periodic reviews of the financial information submitted by the sub-recipient. Second, VDH must be more directly involved in clinical observation and clinical health record audits. The clinical site reviews completed by the sub-recipient show that the clinic sites are in compliance

with all Title X and State requirements, but the VDH grant manager must participate in these reviews in the future.

Grantee Name: Vermont Department of Health (VDH)
Grantee Number: FPHPA016246
Project Name: Title X Family Planning Services, Vermont

Site Visit Dates: May 15, 2017 – May 19, 2017

Sites Visited: VDH – Administrative Office, Burlington, VT
PPNNE – Administrative Office, Colchester, VT
PPNNE – St. Albans Health Center, St. Albans, VT
PPNNE – Rutland Health Center, Rutland, VT

Program Review Team Members:
Leader: Natalia Guevara
Financial Services: Gerry Christie (Joyce McIntyre, Trainee)
Clinical Services: Karen Ward
Administrative: Shelley Miller

Submitted by Kim Swartz, Title X Program Director, on October 2, 2017
All Findings and Recommendations that require a response will be addressed by December 31, 2017, or April 1, 2018, unless otherwise noted.

FINDINGS

Finding #1 (Administrative):
9.1 Low-Income Families. *Priority for project services is to persons from low- income families (Section 1006(c)(1), PHS Act; 42 CFR 59.5(a)(6)).*
The data indicates that 44% of the patients seen fall at or below 100% of poverty. In order to show that priority for project services is to persons from low-income families, the clients a grantee serves must be comprised of 50% or more clients who are at or below 100% FPL.
Corrective Action to Finding #1 (Administrative):
VDH and PPNNE must explore ways to increase the number and percentage of low-income families being served. One way to achieve this goal would be to expand Title X to a Burlington site, where there is a large refugee population.

RESPONSE:

Improvements in the collection of income:
In March of 2017, VT's Title X subrecipient, Planned Parenthood of Northern New England (PPNNE), introduced a revised Patient Information Form (PIF) that allows patients who struggle to provide an exact income to select from income ranges outlined on the form. PPNNE also provided robust training to health center staff to coincide with the Patient Information Form update, which oriented staff to the importance of collecting patient's self-attested income. This training was also accompanied with some talking points. We anticipate that such revisions

will lead to an increase in overall income collection, and improve the reporting of patients living below 100% of the federal poverty level.

In response to the suggestion that Title X be expanded to the Burlington Health Center, located in Chittenden County, when PPNNE analyzed the data, they identified that although Burlington serves a lot of patients, the percentage under 100% FPL is low. An addition of the Burlington health center in fact would not increase the percentage of patients living at or below 100% FPL. Therefore, we believe that improved targeted outreach is needed to reach a larger population at or below 100% FPL.

More targeted outreach efforts: VDH and PPNNE continue to brainstorm ways to better reach patients who may be living at or below 100% FPL, including more targeted outreach & marketing. Several approaches have been discussed and these include:

1) Informing Office of Local Health Maternal and Child Health Coordinators (MCHCs) of the need to reach more of this population and raise awareness of the availability of Title X family planning services, so that they can reinforce this information in their local communities. MCHCs are the "face" of public health at the local level in our state and are engaged with a range of local health and community providers, as well as directly with clients through programs provided at the local level, such as WIC. We will work to ensure that they have materials and information available to them to share with the target population, as well as with other partners working closely with the target population. The first opportunity to have a conversation with MCHCs about this issue will be on October 30th, 2017 as part of our annual Title X community advisory meeting with them.
2) Similarly, we will disseminate this information to other community partners and entities with which MOUs have been developed, as well as other community partners, such as Parent Child Centers.
3) Utilize the Access Plan (Medicaid look alike FP program) intern to help identify specific areas and communities in the state where there are larger numbers of people at or below 100% FPL, to conduct more targeted outreach and marketing of available services.
4) Conduct regular data checks to track the effectiveness of these efforts and make adjustments as needed.

Finding #2 (Administrative):

12.2 The I&E Committee. *The committee must include individuals broadly representative (in terms of demographic factors such as race, color, national origin, handicapped condition, sex and age) of the population or community for which the materials are intended (42 CFR 59.6 (b)(2).*

The I&E committee, although diverse, does not include representation from individuals broadly representative of the demographics served.

Corrective Action to Finding #2 (Administrative):

The grantee must work with PPNNE to broaden representation of the I&E committee to include greater diversity in representing the demographics served. This may include teens, males, representation from the LGBTQ community or other patient populations served. While staff may be diverse, by being employed in the field of family planning, they possess specialized knowledge that may not exist in the general population.

RESPONSE:
VDH will work with PPNNE to identify additional avenues for recruiting members for the I & E Committee to ensure more diverse representation on the committee. Initial strategies identified include conducting targeted outreach to groups already engaged in health improvement initiatives, who either work directly with specific populations, or who are members of underrepresented groups. Initial groups we will reach out to are outlined below:

- Members of the Youth Health Council that has formed as part of an Adolescent and Young Adult Health QI initiative in Vermont. The White River Junction PPNNE Health Center was used as the best example of an environment that is adolescent friendly, and the members of the Youth Health Council have shared these qualities with other practices engaged in this QI initiative. Members of the YHC range in age from 14-26 and represent diverse communities of youth;
- PPNNE Peer Education Coordinator to identify youth peer educators working in 3 VT high schools;
- The Pride Center, a statewide LGBTQ organization that has recently developed an MOU with PPNNE;
- Health department PREP grantees (teen pregnancy prevention program) sites to identify program facilitators who may welcome the opportunity to serve on the I & EC, one of which is a refugee resettlement and New American service agency;
- Maternal and Child Health Coordinators (MCHCs) from the Offices of Local Health, mentioned previously for their connection to local public health and local communities.

Finding #3 (Financial):
8.3.6 Financial Management System. *The grantee and each sub-recipient must maintain a financial management system that meets Federal standards, as applicable, as well as any other requirements imposed by the Notice of Award, and which complies with Federal standards that will support effective control and accountability of funds, as required (45 CFR parts 74.20 and 92.20).*

A. The grantee does not have a fiscal review tool and has not established a schedule to monitor the sub-recipient agency to ensure compliance with federal regulations and statute.
B. The grantee did not complete the Federal Financial Reports (FFR SF-425) for the last budget period in accordance with OGM guidelines and requirements. The grantee did not report any amount for drawdowns from the PMS (45 CFR 75.341). The grantee did not have complete and accurate information from the sub recipient regarding income elements that should be reported on the SF 425.

Corrective Action to Finding #3 (Financial):

A. The grantee must establish a monitoring system to ensure compliance with applicable Federal fiscal requirements and performance expectations. This monitoring should ensure that all funds relate to the Title X program are reported to the grantee and expended in accordance with the provision of the grant and/or the Code of Federal Regulations (CFR). The grantee might consider utilizing the financial tools available on the Family Planning National Training Center website (www.fpntc.org) or modifying the OPA program review tool to accomplish this monitoring.
B. The grantee must review how to report fiscal information on the FFR and report correctly during the current budget period. Fiscal reports must include complete and correct information from the sub recipient.

RESPONSE

A) During our Program Review we discussed several options for identifying a fiscal monitoring tool and we have spent time reviewing the FPNTC tool as well as considering the use of a modified version of the OPA Program Review tool. We will adopt and adapt the use of the OPA Program Review tool for purposes of fiscal monitoring. To support this process, we have obtained a copy of a modified OPA tool from the Kansas Department of Health, and will also reach out to Title X partners in Maine and Rhode Island for their tools to compare. We will have a final version of a fiscal monitoring tool completed and ready for roll out by December 31, 2017.
B) We will correct and resubmit the FFR for the budget period reviewed ending in March 31, 2017. This will be resubmitted by December 31, 2017.

RECOMMENDATIONS

Recommendation #1 (Administrative) (Requires Response):
It is strongly recommended that the grantee develop its own Title X Policy and Procedure Manual that addresses all Title X requirements or formally adopts the sub-recipient's manual rather than solely relying on the contract. The Policy and Procedure Manual should define the criteria that need to be met to ensure compliance.

RESPONSE:
During the Program Review, the Title X Director did a web search for Title X Policy and Procedure manuals available online. While several were identified, the version from the Kansas Department of Health was the most current and comprehensive. Since that time, the Title X Program Director has communicated with the Title X Director in Kansas and VT has obtained permission to adopt and modify their manual VT. VT has received Word copies of all relevant files and will be working on the adaptations over the next 6 months. The VT manual will then be

made available to VT's Title X subrecipient and also posted on the Health Department's website for easy access and reference.

VT will also reach out to Colorado as they have a very current manual available online. We plan to have the manual completed by the end of the current grant year, March 31, 2018. As an interim approach, we will formally adopt the sub recipient's manual. The Medical Directors of PPNNE and MCH will be meeting on October 31, 2017 and we will complete this process at that time and submit documentation to OPA by November 15, 2017.

Recommendation #2 (Administrative):
The grantee should consider, over time, extending the database, with input from each site, to include a comprehensive list of social service agencies that could also be accessed by all staff.

- VDH will work with the sub recipient to see what steps are needed in order to implement this change.

Recommendation #3 (Administrative):
It is strongly recommended that the grantee develop its own Title X Policy and Procedure Manual that addresses all Title X Requirements. The Policy and Procedure Manual should include a policy that specifies that services must be provided without the imposition of any durational residency requirement or requirement that the client be referred by a physician.

- VDH will ensure that this clarification is included in the new Policy and Procedure Manual that will be developed.

Recommendation #4 (Administrative):
As mentioned earlier, the grantee should consider developing or compiling a Title X Policy and Procedure Manual to be maintained at the grantee level. Within that manual, it is recommended that the relationship between VDH and I&E committee be clearly specified along with the expectations of the committee. Although this information is included in the contract with the sub-recipient, it is recommended that the grantee also have this in their own Title X Policy and Procedure Manual.

- VDH will ensure that this clarification is included in the new Policy and Procedure Manual that will be developed.

Recommendation #5 (Financial) (Requires Response):
Although VDH, through the sub-recipient meets the requirements, the grantee does not have a manual for fiscal activities that includes the necessary policies and procedures to meet the requirements of Section 8.4. The grantee should establish and implement its own, at a minimum, policies and procedures on:

- Policies and procedures assuring that clients whose documented income is at or below 100% FPL are not charged for services and that third-party payers are billed.

- Policy and procedures for verifying client income does not present a barrier to receipt of services.
- A policy and procedure documenting the process for waiving fees for individuals with family incomes above 100% of the FPL who, as determined by the service site project director, are unable, for good cause, to pay for family planning services (42 CFR 59.2).
- Policies and procedures requiring sub-recipients and service sites to have a sound rationale and process for determining the cost of services.
- Policies require service sites to have a process for determining whether a minor is seeking confidential services and stipulates that charges to adolescents seeking confidential services will be based solely on the adolescent's income.
- Policies and procedures requiring that all project sites bill insurance in accordance with Title X regulations.
- A system to ensure that, with regard to insured clients, clients whose family income is at or below 250% FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied.
- A determination on whether or not and how to collect voluntary donations from clients.
- How income verification is requested and completed. This must include a section on self-declaration.

RESPONSE:

Please see the response to Recommendation #1. VDH will ensure that the new Policy and Procedure manual will outline the activities necessary to meet the requirements of Section 8.4. to include the items outlined in this recommendation. This will be completed by the end of the current grant year, March 31, 2018. As an interim approach, we will formally establish that we will adopt the subrecipient's policies as outlined in Recommendation #1.

Recommendations #6 (Financial):

1. During the budget process, the grantee should ensure the SF- 424's included in the application for funding include all revenue sources: the federal award, any state dollars, program generated income, and all other funds supporting the title x project (i.e. title xx, SSBG funding, STD funds, and any other funds helping to support the Family planning program. The grantee should revise the current budget period SF 424 to include all sources of funds.
2. The grantee is responsible for completing the FPAR table 14. To complete this correctly the grantee should ensure information reported by the sub-recipient includes donations and any other cash received as a result of the Title X funding. Further, the grantee should ensure the report from the sub-recipient does not include other funds designated for outreach and education only.
3. The sub-recipient does not have an approved indirect cost rate but is claiming indirect costs on their budget request and on their reports to the grantee. Any non-Federal entity that has never received a negotiated indirect cost rate may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. As described in §

200.403, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate for a rate, which the non-Federal entity may apply to do at any time. (2 CFR 200.414(f)). The grantee should have the sub recipient reference they are using a de minimis rate on indirect costs line of budget request.

- For the upcoming FPAR submission (February 2018) and the new grant year beginning April 1, 2018, VDH will ensure consistency across all reports to include the SF-424, the FPAR table 14, and other relevant reports. We will also ensure that the subrecipient reference that they are using a de minimis rate on indirect costs. Following our Program Review visit, VDH verified via email that this clarification will be required moving forward.

Recommendation #7 (Clinical):
The grantee should encourage PPNNE to add language to the general consent specifying that receipt of family planning services is not a prerequisite to receipt of any other services offered.

- VDH will work with the sub recipient to ensure that this language is added to the general consent.

Recommendation #8 (Clinical):
Insofar as Rutland Health Center's Site Manager acknowledges a collaborative working relationship with the local adoption agency, the grantee should encourage this health center, as well as all sub-recipient health centers, to secure formal MOAs with local adoption agencies as well as Urgent Care centers in the community.

- VDH will work with the sub recipient to explore the potential for these types of MOUs to be developed in the Rutland health service area.

Recommendation #9 (Response Required) (Clinical)
Although the grantee requires the sub-recipient to self-report monitoring information, the grantee does not adequately monitor the sub-recipient's clinical services through observation of care or medical record review to ensure that services follow *MS&G* and *QFP*. The grantee should strongly consider employing direct monitoring of the clinical component of the Title X Program to ensure:

- services align with *MS&G*;
- clinical care is provided in a manner consistent with *QFP* as confirmed through direct observation;
- medical records' inspections validate clinical services are consistent with *MS&G*, *QFP* (including reproductive life planning discussions) and referrals are made when indicated;
- a broad range of contraceptives are available onsite;

- adolescents have been counseled about abstinence, condom use, and other contraceptives including LARCs, as evidenced through medical record reviews (and observation when possible);
- pregnancy testing is available and medical record documentation (and observation when possible);
- confirms non-directive counseling per clients' requests, and referrals as appropriate.

  (Note: During the review, the grantee's Medical Director and the Title X Program Administrator enthusiastically proposed several possibilities for employing a clinician to meet this requirement.)

RESPONSE:

Starting in the new grant year, April 1, 2018 our Title V Maternal and Child Health Director, Dr. Breena Holmes, will conduct health center visits with the Title X Program Director to support clinical monitoring of the sub recipient's clinical services through observation of care and/or medical record review to ensure that services follow MS&G and QFP. Dr. Holmes is a Pediatrician who served in clinical practice for several years before assuming her role as the state's MCH Director. In addition, she is a trained health educator and worked in VT schools providing health education. She is a dedicated sexual and reproductive health professional.

Here is a brief overview of some of the highlights of Dr. Holmes' work:

Breena Welch Holmes, MD is the Director of Maternal and Child Health for Vermont. After finishing her pediatric residency at Seattle Children's Hospital and a chief resident year at University of Massachusetts Medical School, she had a pediatric practice in Middlebury, Vermont, focusing on adolescent health from 1997-2008. In 2008, Breena left her clinical practice to teach Health Literacy and Decision Making at Middlebury Union High School. In 2010, Breena became director of the Maternal and Child Health division which includes the statewide WIC program, School Health, Child Development Clinic, Children with Special Health Needs as well as Family Planning, Domestic and Sexual Violence Prevention, Injury Prevention and Early Childhood systems work including federally funded Nurse Family Partnership for home visiting of first time pregnant moms, developmental screening and health/safety in early care and education programs through Early Learning Challenge-Race to the Top funding and LAUNCH grant. The Maternal and Child Health Division is part of Integrating Family Services as well as several other public health programs which focus on children and families.

Dr. Holmes is the chair of the Council on School Health for the American Academy of Pediatrics, on the pediatric faculty at University of Vermont College of Medicine and a school physician for several Middlebury area schools.

Recommendation #10 (Clinical):
The grantee should add to the sub-recipient contract's list of services "help for clients who desire to achieve pregnancy" as these services are an integral component of family planning.

- This language will be added in the upcoming grant year, April 1, 2018.

Recommendation #11 (Clinical):
The *MS&G* Pregnancy Counseling protocol and the electronic health record template should be modified to read that patients are given the opportunity to be given information, counseling and referral about the options(s) she wishes to receive. Patients who are undecided about pregnancy resolution should be given counseling and packet information only for the options for which they request information.

- VDH will work with the sub recipient, PPNNE, to ensure that this information is integrated into the pregnancy counseling protocol and the EHR template.

Recommendation #12 (Clinical):
The grantee should encourage PPNNE to incorporate National Family Planning Center's *QFP* training into their plans for all newly hired midlevel clinicians and HCAs and ensure that all clinical staff familiarize themselves with the *QFP* which PPNNE has available on-line.

- VDH will work with PPNNE to support the integration of NFPC's QFP training into their system.

Recommendation #13 (Clinical):
The grantee should encourage PPNNE to incorporate National Family Planning Center's pregnancy counseling training into their plans for all newly hired midlevel clinicians.

- VDH will work with PPNNE to support the integration of the NFPC's pregnancy counselling training into their system.

STATE OF VERMONT
DEPARTMENT OF HEALTH

Grant # 03420-6959S

SUBRECIPIENT GRANT AWARD

1. Parties: This is a Grant Agreement for services between the State of Vermont, Department of Health, Division of Maternal and Child Health (hereinafter called "State"), and **Planned Parenthood of Northern New England** with principal place of business in Colchester, VT, (hereinafter called "Grantee"). It is the Grantee's responsibility to contact the Vermont Department of Taxes to determine if, by law, the Grantee is required to have a Vermont Department of Taxes Business Account Number.

2. Subject Matter: The subject matter of this Grant Agreement is to support family planning services. Detailed services to be provided by the Grantee are described in Attachment A.

3. Maximum Amount: In consideration of the services to be performed by Grantee, the State agrees to pay Grantee, in accordance with the payment provisions specified in Attachment B, a sum not to exceed $754,387.

4. Grant Term: The period of Grantee's performance shall begin on **April 1, 2017** and end on **March 31, 2018.**

5. Source of Funds: Federal **$754,387** Other $

6. CFDA Title: Title X Family Planning Services; CFDA Number: 93.217; Award Name: Family Planning Services; Award Number: FPHPA016246-02-00; Award Year 2017; Federal Granting Agency: DHHS, Office of the Secretary; Research and Development Grant? Yes _ No X

7. Amendment: No changes, modifications, or amendments in the terms and conditions of this Grant shall be effective unless reduced to writing, numbered, and signed by the duly authorized representative of the State and Grantee.

8. Cancellation: This Grant Agreement may be suspended or cancelled by either party by giving written notice at least 30 days in advance.

9. Contact persons for this award:

   State: Kim Swartz Telephone #: 802-652-4184 E-mail Address: Kimberly.swartz@vermont.gov

   Grantee: Meagan Gallagher Telephone #: 802-448-9700 E-mail Address:Meagan.gallagher@ppnne.org

10. Fiscal year: The Grantee's fiscal year starts on (month) January 1 and ends (month) December 31

11. Attachments: This Grant consists of 32pages including the following attachments which are incorporated herein:

    Attachment A - Specifications of Work to be Performed
    Attachment B - Payment Provisions
    Attachment C - Customary State Grant Provisions
    Attachment D - Modifications of Insurance
    Attachment E - Business Associate Agreement
    Attachment F - AHS Customary Grant Provisions
    Attachment G – Other Grant Provisions – Not Applicable

STATE OF VERMONT
DEPARTMENT OF HEALTH

Grant # 03420-6959S

SUBRECIPIENT GRANT AWARD

The order of precedence of these documents shall be as follows:

This Document
Attachment D - Modifications of Insurance
Attachment C - "Customary State Grant Provisions"
Attachment A - Specifications of Work to be Performed
Attachment B - Payment Provisions
Attachment E - Business Associate Agreement
Attachment G – Other Grant Provisions – Not Applicable
Attachment F - AHS Customary Grant Provisions

WE, THE UNDERSIGNED PARTIES, AGREE TO BE BOUND BY THIS GRANT.

STATE OF VERMONT

By: _____

Mark Levine, MD
Commissioner
Vermont Department of Health

Date: APR 2 8 2017

GRANTEE

By: _____

Print Name: Meagan Gallagher

Print Title: President and Chief Executive Officer

Date: 4/24/17

Address: Planned Parenthood of Northern New England, 784 Hercules Drive, Suite 110, Colchester, VT 05446

Duns #:020664637

CCR#: 4EVG9 Registered: _X__yes ___no

Vendor #:1121

Approved as to form:

By: _____

Assistant Attorney General

Date 4/20/2017

SUBRECIPIENT GRANT AWARD

ATTACHMENT A:
SPECIFICATIONS OF WORK TO BE PERFORMED, EVALUATION, REPORTING

1. PROGRAM NAME
Title X Family Planning Services

A. Brief Program Description

The overarching goal of Vermont's Title X program is to provide high quality clinical family planning and related preventive health services, education, and counseling to Vermonters who would otherwise not have access, with a special focus on low-income and rural populations. The program ensures access to comprehensive reproductive health care, with an emphasis on services to lower income women and men. The Title X family planning program is intended to assist individuals in determining the number and spacing of their children, to promote positive birth outcomes and healthy families. Title X health centers deliver clinical, informational, educational, and referral services as appropriate for health and social needs, relating to family planning services to patients who want such services at health centers statewide.

The Title X program supports local family planning services that ensure access to a broad range of family planning and related preventive health services for Vermont women, men, and their partners. Related preventive health services are also provided and include: patient education and counseling; breast and pelvic examinations; breast and cervical cancer screening according to nationally recognized standards of care; sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) prevention education, counseling, testing and referral; and pregnancy diagnosis and counseling.

B. Program Purpose

i. Program-Specific Population
Provide clinical family planning and related preventive services to at least **10,000 patients at 10 (ten) health centers across Vermont** during the grant period. At least 77% of those patients who report an income will be at, less than or equal to 250% Federal Poverty Level. At least 21% of patients will be under the age of 20 years. At least 11% of patients will be male.

ii. Purpose(s) of the Program

1	Reduce unintended pregnancy
2	Improve access to a broad range of effective contraceptive methods
3	Provide access to emergency contraceptive services
4	Reduce sexually transmitted diseases
5	Promote healthy relationships, healthy sexual behaviors and strengthen community capacity to promote positive reproductive health

C. Scope of Work

i. Description of Strategies or Services to be Performed

SUBRECIPIENT GRANT AWARD

I. Provide comprehensive clinical and counseling services

A. Subrecipient will provide the following family planning services in accordance with the Title X guidelines described in the most current Program Requirements for Title X Funded Family Planning Projects:

http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf, the most current Recommendations for Quality Family Planning Services by CDC and OPA, http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf, and the 2016 Title X Work Plan, jointly agreed upon between the State and Subrecipient, and approved by HHS/Office of Population Affairs.

B. Client education: Education services must provide patients the information needed to:

- Make informed decisions about family planning;
- Use specific methods of contraception and identify adverse effects;
- Reduce risk of transmission of sexually transmitted diseases and HIV;
- Understand the range of available services and the purpose and sequence of health center procedures; and
- Understand the importance of recommended screening tests and other procedures involved in the family planning visit.

Additional information should include, but is not limited to, reproductive health and health promotion/disease prevention, including nutrition, exercise, smoking cessation, alcohol and drug abuse, domestic violence and sexual abuse.

C. Counseling: The primary purpose of counseling in the family planning setting is to assist patients in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods and services. Discussion topics should include, but are not limited to the following:

Method Counseling:

- Results of physical exam and lab studies;
- Effective use of contraceptive methods, including long acting reversible methods (LARCs), natural family planning, emergency contraception, and the benefit and efficacy of the methods;
- Possible side effects/complications;
- How to discontinue the method selected and information regarding back-up method use, including the use of certain oral contraceptives as post-coital emergency contraception;
- Planned return schedule;
- Emergency 24-hour telephone number;
- Location where emergency services can be obtained; and
- Appropriate referral for additional services as needed.

Sexually Transmitted Disease (STD) and HIV Counseling:

- Personal risks for STD/HIV; and
- The steps to be taken by the individual to reduce risk.

On an optional basis, clinics may also provide HIV risk assessments, counseling and testing by specially trained staff. When the project does not offer these optional services, the project must provide the patient with a list of health care providers who can provide these services.

Reproductive Life Planning:

- Talk with patients about reproductive life planning and targeted contraceptive and/or preconception health counseling and support.

D. History, Physical Assessment, and Laboratory Testing:

- History: A complete medical history must be obtained and updated as appropriate at subsequent visits.
- Physical Assessment: A complete physical exam should be performed, as indicated, to include the following:
  - Female - height and weight, examination of the thyroid, heart, lungs, extremities, breasts, abdomen, pelvis, and rectum.
  - Male - height and weight, examination of the thyroid, heart, lungs, extremities, breasts, abdomen, genitals, and rectum.
- Laboratory Testing: Various testing may be provided either onsite or by referral. Pregnancy testing must be provided onsite.

E. Fertility Regulation: Patients should be informed of both reversible and permanent contraception.

F. Infertility Services: Subrecipient must make basic infertility services available to women and men desiring such services. Basic services are categorized as Level I, which includes an initial infertility interview, education, physical examination, counselling, and appropriate referral.

G. Pregnancy Diagnosis and Counseling: Subrecipient must provide pregnancy diagnosis and counseling to all patients in need of this service.

Subrecipient must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination.

H. Adolescent services: Subrecipient must provide services specifically tailored to adolescents, such as:

- Provide adolescents with timely appointments, the same or next day of their call;
- Educate all teens on the importance of family involvement in sexual decision making and family planning;
- Screen and educate all teens on sexual coercion.

All medical services will be provided under the direction of a Medical Director, who is licensed to practice medicine in the State of Vermont. Specific family planning services may be delivered either by a physician or other health care professional, specifically trained in family planning and licensed, registered, or certified by the State of Vermont.

SUBRECIPIENT GRANT AWARD

II. Provide free and low-cost services on a sliding scale

Subrecipient must establish a fee schedule based on usual and customary fees for services. A sliding scale must be established, with the following specifications:

- Fees for minors receiving confidential services are determined based solely on the minor's income.
- Patients are not denied Title X services due to inability to pay.
- Patients with incomes at or below 100% of the federal poverty level are provided Title X services and products at no charge and regardless of any outstanding account balance.

The Subrecipient must collect household income information on all Title X patients, unless the patient refuses. The fee schedule must be submitted to VDH annually upon Subrecipient's review and update.

III. Statewide service provision

A. Subrecipient will provide Title X-funded services at the following Health Centers:

1) Barre
2) Bennington
3) Brattleboro
4) Hyde Park
5) Middlebury
6) Newport
7) Rutland
8) St. Albans
9) St. Johnsbury
10) White River Junction

IV. Offer educational programming

Subrecipient will offer educational programs as follows:

A. Contraceptive technology technical updates to the staff of the twelve VDH district offices. The nature and content of these educational sessions for VDH staff will be created via communications between VDH Division of Maternal and Child Health (MCH), VDH Office of Local Health (OLH), the Planned Parenthood of Northern New England (PPNNE) Title X Coordinator, and the local PPNNE and VDH district office leadership.

B. Maintain a teen peer education program designed to educate teens about sexual health, avoidance of sexual risk-taking behaviors, and delay of pregnancies. This program will include information that encourages families'/parents'/guardians' participation in the family planning decision making of minors. Subrecipient will demonstrate this through continuing to work with schools in at least three (3) Vermont communities and by ensuring that five (5) Peer Educators are trained during the grant year.

C. The Subrecipient will carry out the information and education materials review function as stipulated in the Program Requirements section 12.1-12.6 Information and Education Materials Approval published by the Office of Population Affairs, 2014 (or most current). The VDH Program Administrator will serve on the Information and Education Advisory Committee (IEAC) and will approve all materials before publication. Documentation of the meetings and actions of the Information and Education Advisory Committee will be provided to the State. All educational materials published using funds from this Subrecipient Grant will cite the source of the funding on the documents.

V. Project promotion and outreach to vulnerable populations

SUBRECIPIENT GRANT AWARD

Subrecipient will engage in activities to facilitate community awareness of and access to family planning services, projects must establish and implement planned activities whereby their services are made known to the community.

A. Subrecipient will hold at least three outreach activities each quarter designed to make Title X family planning clinical services known in each of the ten PPNNE health center territories.

B. Other outreach activities may include the following:

- Collaborate with VDH DO personnel or staff of local youth serving organizations, or other community partners.
- Distribute project promotion materials statewide through specialized media, direct mailings, and drop offs at key community locations and retailers
- Annually attend meeting of VDH's District Directors to discuss collaborative opportunities
- Collaborate with the Vermont Blueprint for Health medical home initiative, as well as Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) on referrals
- Offer training for appropriate PPNNE staff on conducting outreach, creating an outreach plan, review of various outreach strategies and evaluating progress
- Create outreach "kits" which are specific to each location and include print and promotional materials for one-on-one meetings or group meetings with community partners
- Create tabling "kits" for PPNNE staff who attend health fairs, expos, etc.
- Use a tracking tool to assist PPNNE staff in documenting outreach events and evaluating the effectiveness of each event. This tracking tool is available via sub recipient's intranet, and each PPNNE staff person is responsible for logging outreach activities as they occur.
- Develop talking points about the organization's Title X family planning program to inform community partners about services

VI. Develop and maintain formal linkages to comprehensive primary care and community based health and social services

Subrecipient will increase the number of formal linkages and documented partnerships established between the subrecipient agency and comprehensive primary care providers, and other health and social service providers.

VII. Training/Professional development

Subrecipient will ensure that all staff in Title X health centers are appropriately trained. Subrecipient may provide training on the following:

- Initial training to all new Title X staff through various formats and techniques (in-person, webinar, self-directed); including on Title X Program Requirements for Funded Family Planning Projects and the Recommendations for Quality Family Planning Services (QFP);

- Training to clinical and office staff on LARCs and other new and emerging technologies;
- Ongoing training on mandated reporting, intimate partner violence (IPV), screening and counseling practices with minors on sexual coercion, human trafficking and other critical and emerging health and reproductive health issues;
- Training to all health center staff on parental involvement policy;
- Ongoing training on clinical systems, protocols, Electronic Health Record (EHR);
- Clinical staff receive required Continuing Education Units (CEUs) and maintain credentialing;
- Training to clinical staff in working with patients on preconception health and reproductive life planning.

VIII. Data submission / Family Planning Annual Report (FPAR)

The Subrecipient must submit all required data for the Family Planning Annual Report (FPAR) through the Title X Region 1 Data System. Subrecipient is required to:

- Subcontract with JSI (John Snow, Inc.) for the agreed upon amount (2016 figures = $11,455.65) to collect, store, and disseminate data through the Region I Data System.
- Enter and/or upload all required data elements into the Regional I Data System, according to the guidance and timeline established by Health and Human Services (HHS) /Office of Population Affairs.
- Submit data for the FPAR to VDH Program Administrator in a timely manner for annual data submission.

D. Performance Measurement

The Grantee will report the following performance measures to the State to measure achievement of stated program purpose(s). Performance measures measure **quantity** ("how much are you doing?"), **quality** ("how well are you doing it?), and **impact** of services delivered (is anyone better off?") in accordance with grant requirements and expectations.

Table 1: Performance Measures

	Measure	Target	Time Period	Monitoring Method	Type
1	# of people served	10,000	Annually	Title X Region 1 database	Quantity

2	77% of patients with incomes at or below 250% FPL	7,700	Annually	Region 1 database	Quantity
3	21 % of patients under 20 years of age	2,100	Annually	Regions 1 database	Quantity
4	11 % of patients will be male	1,100	Annually	Region 1 database	Quantity
5	Proportion of patients that adopt or continue to use a highly or moderately effective contraceptive method	68%	Annually	Title X Region 1 database	Quality
6	Assess 100% of female patients for pregnancy intention and provide education on reproductive life planning and targeted contraceptive and/or preconception health counseling and support, annually	100%	Annually	Title X Region 1 database	Quality
7	All education materials are current, factual, and medically accurate, professionally sound, consistent with community standards, and appropriate to the educational and cultural backgrounds of patients	100%	Quarterly, as needed	Survey Monkey	Quality
8	Finalize at least one (1) memorandum of understanding (MOU) with a community based health or social service provider in each Vermont community where subrecipient provides health care services. (In years 2 and 3 of the project period of the grant).	5	Annually	MOUs	Quality
9	Staff receive annual training on mandated reporting, IPV, human trafficking, and family participation in adolescent decision making; staff receive training on new Title X Requirements upon employment and as updates/revisions are made to	100%	Annually and as needed	Quarterly reports	Quality

	requirements; staff receive training in Recommendations for Quality Family Planning Services (QFP) upon employment and as revisions/updates are made to recommendations				

E. Program-Specific Monitoring and Reporting

The following table identifies how performance measures and other data will be reported, monitored, and improved. This section meets State of Vermont Bulletin 5.0 requirements for grant monitoring.

Table 2: Monitoring Procedures

Monitoring Activities	Format	Frequency/ Due Date	Recipient/ Attendees	Purpose / Information Required
Performance measure reporting	Electronic Report	Quarterly	Kim Swartz, Maternal and Child Health; Subrecipient Government Grants Director	Performance monitoring
Work plan report	Electronic Report	Twice per year	Kim Swartz, Maternal and Child health, Subrecipient Government Grants Director	Performance monitoring
Site Visits	Site visit reports	3-4 times per year	Kim Swartz, Maternal and Child Health; Subrecipient Government Grants Director, clinic staff, Senior Operations Managers	To review delivery of the Title X family planning services at three (3) to four (4) Title X Health Center sites
Clinical Quality Improvement Review	CQI reports	Twice per year	Kim Swartz, Maternal and Child Health and Subrecipient CQI staff	To review audit reports, with a focus on high risk audits
Monitoring calls	Agenda and minutes	Bi-monthly	Kim Swartz, Maternal and Child Health; Subrecipient Government Grants Director and other staff as necessary	To track progress

SUBRECIPIENT GRANT AWARD

Federal Funds Compliance Requirements

As a recipient of Federal funds under the terms of your agreement with the Department of Health, you are responsible for meeting the compliance requirements associated with each Federal fund source. The specific requirements for each Federal fund can be found in the Federal Office of Management and Budget Circulars or Guidance. We have listed these circulars and the Guidance below.

The specific requirements for activities allowed or unallowed are unique to each Federal program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program.

In addition, for subrecipients that expend more than $500,000 in Federal subawards or $750,000 for fiscal years beginning after December 26, 2014 or the equivalent in federally funded products, from *all* sources, an audit is required as defined by OMB Circular A-133 or on or after December 26, 2014, as defined by the Uniform Guidance, Subpart F. The audit process includes a comprehensive audit by an independent auditor selected by the subrecipient. The audit report which is produced must be submitted and reviewed by AHS.

The State maintains responsibility for ensuring that our subrecipients meet the compliance requirements for each Federal program by our monitoring of your organization's activities under the terms of the grant agreements. It is the responsibility of your organization to meet each compliance requirement.

APPLICABLE CIRCULARS (before December 26, 2014):

	Public Schools & Government	Universities & Colleges Educational Inst.	Non-profit	Hospital
Costs:	*A-87*	*A-21*	*A-122*	*45CFR Part74*
Admin:	*A-102*	*A-110*	*A-110*	*45CFR Part74*
A-133 Audit	*A-133*	*A-133*	*A-133*	*A-133*

A-21: "Cost Principles for Educational Institutions" (OMB Circular A-21)
A-87: "Cost Principles for State, Local and Indian Tribal Governments" (OMB Circular A-87)
A-102: "Grants and Cooperative Agreements with State and Local Governments" (OMB Circular A-102)
A-110: "Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-Profit Organizations" (OMB Circular A-110)
A-122: "Cost Principles for Non-Profit Organizations" (OMB Circular A-122)
A-133: "Audits of States, Local Governments and Non-Profit Organizations" (OMB Circular A-133)
45CFR Part74: "Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations; and Certain Grants and Agreements with States, Local Governments and Indian Tribal Governments"

APPLICABLE GUIDANCE (on or after December 26, 2014)
2 CFR Subtitle A, Chapter II, Part 200-Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance)

AHS 12-26-14

SUBRECIPIENT GRANT AWARD

ATTACHMENT B
PAYMENT PROVISIONS

A final report on program activities and a final financial report will be due no later than 30 days after the end date of the Grant.

The Grantee will return any unexpended funds to the State or carry the funds forward at the direction of the State.

1. The maximum dollar amount payable under this subrecipient grant shall not exceed $754, 387.

2. Subrecipient shall invoice the State on a monthly basis on or about the first of each month for services provided in the previous month.

   Payment Schedule:
   - The first monthly invoice (April) shall be submitted for an amount not to exceed $62,872.
   - The remaining monthly invoices (May-March) shall be submitted for an amount not to exceed $62,865.
   - On a quarterly basis (July 2017, October 2017, January 2018, April 2018), invoices will be reconciled with performance measures.

3. Subrecipient will submit all invoices to the State within 60 days after termination of this Subrecipient Grant. Invoices should include Subrecipient Grant number, vendor number, invoice number, and dates of service. Invoices should be submitted by email to:

   Kim Swartz
   Director, Preventive Reproductive Health
   Kimberly.swartz@vermont.gov
   Vermont Department of Health
   P.O. Box 70
   Burlington, VT 05402-0070

4. Subrecipient will assure, through its accounting system, that the funds received under the terms of this Subrecipient Grant will be applied only for allowable expenditures. The Subrecipient will have a complete annual audit, a copy of which will be submitted to the State by June 30, 2017 and by June 30, 2018.

5. If Subrecipient wants to receive grant payments through direct deposit they can do so by completing the following form and submitting to the Vermont Department of Finance & Management:
   http://finance.vermont.gov/sites/finance/files/pdf/forms/vision/ACH_Authorization_Form.pdf

SUBRECIPIENT GRANT AWARD
ATTACHMENT C: STANDARD STATE PROVISIONS
FOR CONTRACTS AND GRANTS
REVISED JULY 1, 2016

1. **Definitions:** For purposes of this Attachment, "Party" shall mean the Contractor, Grantee or Subrecipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement. "Agreement" shall mean the specific contract or grant to which this form is attached.

2. **Entire Agreement:** This Agreement, whether in the form of a Contract, State Funded Grant, or Federally Funded Grant, represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.

3. **Governing Law, Jurisdiction and Venue; No Waiver of Jury Trial:** This Agreement will be governed by the laws of the State of Vermont. Any action or proceeding brought by either the State or the Party in connection with this Agreement shall be brought and enforced in the Superior Court of the State of Vermont, Civil Division, Washington Unit. The Party irrevocably submits to the jurisdiction of this court for any action or proceeding regarding this Agreement. The Party agrees that it must first exhaust any applicable administrative remedies with respect to any cause of action that it may have against the State with regard to its performance under the Agreement.
Party agrees that the State shall not be required to submit to binding arbitration or waive its right to a jury trial.

4. **Sovereign Immunity:** The State reserves all immunities, defenses, rights or actions arising out of the State's sovereign status or under the Eleventh Amendment to the United States Constitution. No waiver of the State's immunities, defenses, rights or actions shall be implied or otherwise deemed to exist by reason of the State's entry into this Agreement.

5. **No Employee Benefits For Party:** The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the state withhold any state or federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

6. **Independence:** The Party will act in an independent capacity and not as officers or employees of the State.

7. **Defense and Indemnity:** The Party shall defend the State and its officers and employees against all third party claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party in connection with the performance of this Agreement. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit. The State retains the right to participate at its own expense in the defense of any claim. The State shall have the right to approve all proposed settlements of such claims or suits. In the event the State withholds approval to settle any such claim, then the Party shall proceed with the defense of the claim but under those circumstances, the Party's indemnification obligations shall be limited to the amount of the proposed settlement initially rejected by the State.

After a final judgment or settlement the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party in connection with the performance of this Agreement.

The Party shall indemnify the State and its officers and employees in the event that the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party or an agent of the Party in connection with the performance of this Agreement.
The Party agrees that in no event shall the terms of this Agreement nor any document required by the Party in connection with its performance under this Agreement obligate the State to defend or indemnify the Party or otherwise be liable for the expenses or reimbursement, including attorneys' fees, collection costs or other costs of the Party except to the extent awarded by a court of competent jurisdiction.

8. **Insurance:** Before commencing work on this Agreement the Party must provide certificates of insurance to show that the following minimum coverages are in effect. It is the responsibility of the Party to maintain current certificates of insurance on file with the State through the term of the Agreement. No warranty is made that the coverages and limits listed herein are adequate to cover and protect the interests of the Party for the Party's operations. These are solely minimums that have been established to protect the interests of the State.
Workers Compensation: With respect to all operations performed, the Party shall carry workers' compensation insurance in accordance with the laws of the State of Vermont. Vermont will accept an out-of-state employer's workers' compensation coverage while operating in Vermont provided that the insurance carrier is licensed to write insurance in Vermont and an amendatory endorsement is added to the policy adding Vermont for coverage purposes. Otherwise, the party shall secure a Vermont workers' compensation policy, if necessary to comply with Vermont law.
General Liability and Property Damage: With respect to all operations performed under this Agreement, the Party shall carry general liability insurance having all major divisions of coverage including, but not limited to:
Premises - Operations
Products and Completed Operations Personal Injury Liability Contractual Liability

The policy shall be on an occurrence form and limits shall not be less than:
$1,000,000 Each Occurrence
$2,000,000 General Aggregate
$1,000,000 Products/Completed Operations Aggregate
$1,000,000 Personal & Advertising Injury
Automotive Liability: The Party shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Agreement. Limits of coverage shall not be less than $500,000 combined single limit. If performance of this Agreement involves construction, or the transport of persons or hazardous materials, limits of coverage shall not be less than $1,000,000 combined single limit.
Additional Insured. The General Liability and Property Damage coverages required for performance of this Agreement shall include the State of Vermont and its agencies, departments, officers and employees as Additional Insureds. If performance of this Agreement involves construction, or the transport of persons or hazardous materials, then the required Automotive Liability coverage shall include the State of Vermont and its agencies, departments, officers and employees as Additional Insureds. Coverage shall be primary and non-contributory with any other insurance and self-insurance.
Notice of Cancellation or Change. There shall be no cancellation, change, potential exhaustion of aggregate limits or non-renewal of insurance coverage(s) without thirty (30) days written prior written notice to the State.

9. **Reliance by the State on Representations:** All payments by the State under this Agreement will be made in reliance upon the accuracy of all representations made by the Party in accordance with the Contract, including but not limited to bills, invoices, progress reports and other proofs of work.

10. **False Claims Act:** The Party acknowledges that it is subject to the Vermont False Claims Act as set forth in 32 V.S.A. § 630 *et seq.* If the Party violates the Vermont False Claims Act it shall be liable to the State for civil penalties, treble damages and the costs of the investigation and prosecution of such violation, including attorney's fees, except as the same may be reduced by a court of competent jurisdiction. The Party's liability to the State under the False Claims Act shall not be limited notwithstanding any agreement of the State to otherwise limit Party's liability.

11. **Whistleblower Protections:** The Party shall not discriminate or retaliate against one of its employees or agents for disclosing information concerning a violation of law, fraud, waste, abuse of authority or acts threatening health or safety, including but not limited to allegations concerning the False Claims Act. Further, the Party shall not require such employees or agents to forego monetary awards as a result of such disclosures, nor should they be required to report misconduct to the Party or its agents prior to reporting to any governmental entity and/or the public.

12. **Federal Requirements Pertaining to Grants and Subrecipient Agreements:**
    A. **Requirement to Have a Single Audit:** In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, the Subrecipient will complete the Subrecipient Annual Report annually within 45 days after its fiscal year end, informing the State of Vermont whether or not a Single Audit is required for the prior fiscal year. If a Single Audit is required, the Subrecipient will submit a copy of the audit report to the granting Party within 9 months. If a single audit is not required, only the Subrecipient Annual Report is required.

For fiscal years ending before December 25, 2015, a Single Audit is required if the subrecipient expends $500,000 or more in federal assistance during its fiscal year and must be conducted in accordance with OMB Circular A-133. For fiscal years ending on or after December 25, 2015, a Single Audit is required if the subrecipient expends $750,000 or more in federal assistance during its fiscal year and must be conducted in accordance with 2 CFR Chapter I, Chapter II, Part 200, Subpart F. The Subrecipient Annual Report is required to be submitted within 45 days, whether or not a Single Audit is required.

    B. **Internal Controls:** In the case that this Agreement is a Grant that is funded in whole or in part by Federal funds, in accordance with 2 CFR Part II, §200.303, the Party must establish and maintain effective internal control over the Federal award to provide reasonable assurance that the Party is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States and the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).
    C. **Mandatory Disclosures:** In the case that this Agreement is a Grant funded in whole or in part by Federal funds, in accordance with 2CFR Part II, §200.113, Party must disclose, in a timely manner, in writing to the State, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Failure to make required disclosures may result in the imposition of sanctions which may include disallowance of costs incurred, withholding of payments, termination of the Agreement, suspension/debarment, etc.

13. **Records Available for Audit:** The Party shall maintain all records pertaining to performance under this agreement. "Records" means any written or recorded information, regardless of physical form or characteristics, which is produced or acquired by the Party in the performance of this agreement. Records produced or acquired in a machine readable electronic format shall be maintained in that format. The records described shall be made available at reasonable times during the period of the Agreement and for three years thereafter or for any period required by law for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved.

14. **Fair Employment Practices and Americans with Disabilities Act:** Party agrees to comply with the requirement of 21 V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement.

15. **Set Off:** The State may set off any sums which the Party owes the State against any sums due the Party under this Agreement; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.

16. **Taxes Due to the State:**
    - **A.** Party understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.
    - **B.** Party certifies under the pains and penalties of perjury that, as of the date the Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.
    - **C.** Party understands that final payment under this Agreement may be withheld if the Commissioner of Taxes determines that the Party is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.
    - **D.** Party also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Party has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Party has no further legal recourse to contest the amounts due.

17. **Taxation of Purchases:** All State purchases must be invoiced tax free. An exemption certificate will be furnished upon request with respect to otherwise taxable items.

18. **Child Support:** (Only applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date the Agreement is signed, he/she:
    - **A.** is not under any obligation to pay child support; or
    - **B.** is under such an obligation and is in good standing with respect to that obligation; or
    - **C.** has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.

    Party makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Party is a resident of Vermont, Party makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

19. **Sub-Agreements:** Party shall not assign, subcontract or subgrant the performance of this Agreement or any portion thereof to any other Party without the prior written approval of the State. Party shall be responsible and liable to the State for all acts or omissions of subcontractors and any other person performing work under this Agreement pursuant to an agreement with Party or any subcontractor.

In the case this Agreement is a contract with a total cost in excess of $250,000, the Party shall provide to the State a list of all proposed subcontractors and subcontractors' subcontractors, together with the identity of those subcontractors' workers compensation insurance providers, and additional required or requested information, as applicable, in accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54).

Party shall include the following provisions of this Attachment C in all subcontracts for work performed solely for the State of Vermont and subcontracts for work performed in the State of Vermont: Section 10 ("False Claims Act"); Section 11 ("Whistleblower Protections"); Section 14 ("Fair Employment Practices and Americans with Disabilities Act"); Section 16 ("Taxes Due the State"); Section 18 ("Child Support"); Section 20 ("No Gifts or Gratuities"); Section 22 ("Certification Regarding Debarment"); Section 23 ("Certification Regarding Use of State Funds"); Section 31 ("State Facilities"); and Section 32 ("Location of State Data").

20. **No Gifts or Gratuities:** Party shall not give title or possession of anything of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Agreement.

21. **Copies:** Party shall use reasonable best efforts to ensure that all written reports prepared under this Agreement are printed using both sides of the paper.

22. **Certification Regarding Debarment:** Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.
Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State's debarment list at:
http://bgs.vermont.gov/purchasing/debarment

23. **Certification Regarding Use of State Funds:** In the case that Party is an employer and this Agreement is a State Funded Grant in excess of $1,001, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party's employee's rights with respect to unionization.

24. **Conflict of Interest:** Party shall fully disclose, in writing, any conflicts of interest or potential conflicts of interest.

25. **Confidentiality:** Party acknowledges and agrees that this Agreement and any and all information obtained by the State from the Party in connection with this Agreement are subject to the State of Vermont Access to Public Records Act, 1 V.S.A. § 315 et seq.

26. **Force Majeure:** Neither the State nor the Party shall be liable to the other for any failure or delay of performance of any obligations under this Agreement to the extent such failure or delay shall have been wholly or principally caused by acts or events beyond its reasonable control rendering performance illegal or impossible (excluding strikes or lock-outs) ("Force Majeure"). Where Force Majeure is asserted, the nonperforming party must prove that it made all reasonable efforts to remove, eliminate or minimize such

cause of delay or damages, diligently pursued performance of its obligations under this Agreement, substantially fulfilled all non-excused obligations, and timely notified the other party of the likelihood or actual occurrence of an event described in this paragraph.

27. **Marketing:** Party shall not refer to the State in any publicity materials, information pamphlets, press releases, research reports, advertising, sales promotions, trade shows, or marketing materials or similar communications to third parties except with the prior written consent of the State.

28. **Termination:** In addition to any right of the State to terminate for convenience, the State may terminate this Agreement as follows:
    A. **Non-Appropriation:** If this Agreement extends into more than one fiscal year of the State (July 1 to June 30), and if appropriations are insufficient to support this Agreement, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriation authority. In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, and in the event federal funds become unavailable or reduced, the State may suspend or cancel this Grant immediately, and the State shall have no obligation to pay Subrecipient from State revenues.
    B. **Termination for Cause:** Either party may terminate this Agreement if a party materially breaches its obligations under this Agreement, and such breach is not cured within thirty (30) days after delivery of the non-breaching party's notice or such longer time as the non-breaching party may specify in the notice.
    C. **No Implied Waiver of Remedies:** A party's delay or failure to exercise any right, power or remedy under this Agreement shall not impair any such right, power or remedy, or be construed as a waiver of any such right, power or remedy. All waivers must be in writing.

29. **Continuity of Performance:** In the event of a dispute between the Party and the State, each party will continue to perform its obligations under this Agreement during the resolution of the dispute until this Agreement is terminated in accordance with its terms.

30. **Termination Assistance:** Upon nearing the end of the final term or termination of this Agreement, without respect to cause, the Party shall take all reasonable and prudent measures to facilitate any transition required by the State. All State property, tangible and intangible, shall be returned to the State upon demand at no additional cost to the State in a format acceptable to the State.

31. **State Facilities:** If the State makes space available to the Party in any State facility during the term of this Agreement for purposes of the Party's performance under this Agreement, the Party shall only use the space in accordance with all policies and procedures governing access to and use of State facilities which shall be made available upon request. State facilities will be made available to Party on an "AS IS, WHERE IS" basis, with no warranties whatsoever.

32. **Location of State Data:** No State data received, obtained, or generated by the Party in connection with performance under this Agreement shall be processed, transmitted, stored, or transferred by any means outside continental United States, except with the express written permission of the State.

(End of Standard Provisions)

SUBRECIPIENT GRANT AWARD

ATTACHMENT D

MODIFICATION OF CUSTOMARY PROVISIONS OF ATTACHMENT C

1. **The insurance requirements contained in Attachment C, Section 8 are hereby modified:**

   Notwithstanding Section 8 of Attachment C, the following is hereby added to the agreement:

   Professional liability: Before commencing work on this Agreement and throughout the term of this Agreement, the Party shall procure and maintain professional liability insurance for any and all services performed under this Agreement, with minimum coverage of $1,000,000 per occurrence, and $3,000,000 policy aggregate.

2. **Requirements of other Sections in Attachment C are hereby modified:**

3. **Requirements of Sections in Attachment F are hereby modified:**

4. **Reasons for Modifications:**

   Professional liability coverage is required given the nature of this agreement. The Attachment C revised on 7/1/16 does not include professional liability requirements.

Approval:

Assistant Attorney General: Margaret O. Ulrich

Date: 4/20/2017

Vermont – Attachment D
Revised AHS – 12-08-09

SUBRECIPIENT GRANT AWARD

Attachment E
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between the State of Vermont Agency of Human Services, operating by and through its Department of Health, Division of Maternal and Child Health ("Covered Entity") and Planned Parenthood of Northern New England ("Business Associate") as of April 1, 2017 ("Effective Date"). This Agreement supplements and is made a part of the contract/grant to which it is attached.
Covered Entity and Business Associate enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 ("Privacy Rule"), and the Security Standards, at 45 CFR Parts 160 and 164 ("Security Rule"), as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH), and any associated federal rules and regulations.

The parties agree as follows:

1. Definitions. All capitalized terms used but not otherwise defined in this Agreement have the meanings set forth in 45 CFR Parts 160 and 164 as amended by HITECH and associated federal rules and regulations.

"Agent" means those person(s) who are agents(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).
"Breach" means the acquisition, access, use or disclosure of protected health information (PHI) which compromises the security or privacy of the PHI, except as excluded in the definition of Breach in 45 CFR § 164.402.
"Business Associate shall have the meaning given in 45 CFR § 160.103.
"Individual" includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

"Protected Health Information" or PHI shall have the meaning given in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Agency.
"Security Incident" means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.
"Services" includes all work performed by the Business Associate for or on behalf of Covered Entity that requires the use and/or disclosure of protected health information to perform a business associate function described in 45 CFR § 160.103 under the definition of Business Associate.

"Subcontractor" means a person or organization to whom a Business Associate delegates a function, activity or service, other than in the capacity of a member of the workforce of the Business Associate. For purposes of this Agreement, the term Subcontractor includes Subgrantees.

2. Identification and Disclosure of Privacy and Security Offices. Business Associate and Subcontractors shall provide, within ten (10) days of the execution of this agreement, written notice to the Covered Entity's contract/grant manager the names and contact information of both the HIPAA Privacy Officer and HIPAA Security Officer. This information must be updated any time either of these contacts changes.

3. Permitted and Required Uses/Disclosures of PHI.

3.1 Except as limited in this Agreement, Business Associate may use or disclose PHI to perform Services, as specified in the underlying grant or contract with Covered Entity. The uses and disclosures of Business Associate are limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the underlying agreement. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

3.2 Business Associate may make PHI available to its employees who need access to perform Services provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with such restrictions. Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents and Subcontractors in accordance with Sections 9 and 17 or, (b) as otherwise permitted by Section 3.

3.3 Business Associate shall be directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Covered Entity, and for impermissible uses and disclosures, by Business Associate's Subcontractor(s), of the PHI that Business Associate handles on behalf of Covered Entity and that it passes on to Subcontractors.

4. Business Activities. Business Associate may use PHI received in its capacity as a Business Associate to Covered Entity if necessary for Business Associate's proper management and administration or to carry out its legal responsibilities. Business Associate may disclose PHI received in its capacity as Business Associate to Covered Entity for Business Associate's proper management and administration or to carry out its legal responsibilities if a disclosure is Required by Law or if Business Associate obtains reasonable written assurances via a written agreement from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the Agreement requires the person or entity to notify Business Associate, within two (2) business days (who in turn will notify Covered Entity within two (2) business days after receiving notice of a Breach as specified in Section 6.1), in writing of any Breach of Unsecured PHI of which it is aware. Uses and disclosures of PHI for the purposes identified in Section 3 must be of the minimum amount of PHI necessary to accomplish such purposes.

5. Safeguards. Business Associate, its Agent(s) and Subcontractor(s) shall implement and use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement. With respect to any PHI that is maintained in or transmitted by electronic media, Business Associate or its Subcontractor(s) shall comply with 45 CFR sections 164.308 (administrative safeguards), 164.310 (physical safeguards), 164.312 (technical safeguards) and 164.316 (policies and procedures and documentation requirements). Business Associate or its Agent(s) and Subcontractor(s) shall identify in writing upon request from Covered Entity all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.

6. Documenting and Reporting Breaches.

6.1 Business Associate shall report to Covered Entity any Breach of Unsecured PHI, including Breaches reported to it by a Subcontractor, as soon as it (or any of its employees or agents) becomes aware of any such Breach, and in no case later than two (2) business days after it (or any of its employees or agents) becomes aware of the Breach, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

6.2 Business Associate shall provide Covered Entity with the names of the individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR § 164.404(c), and, if requested by Covered Entity, information necessary for Covered Entity to investigate the impermissible use or disclosure. Business Associate shall continue to provide to Covered Entity information concerning the Breach as it becomes available to it. Business Associate shall require its Subcontractor(s) to agree to these same terms and conditions.

6.3 When Business Associate determines that an impermissible acquisition, use or disclosure of PHI by a member of its workforce is not a Breach, as that term is defined in 45 CFR § 164.402, and therefore does not necessitate notice to the impacted individual(s), it shall document its assessment of risk, conducted as set forth in 45 CFR § 402(2). When requested by Covered Entity, Business Associate shall make its risk assessments available to Covered Entity. It shall also provide Covered Entity with 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low probability that the PHI had been compromised. When a breach is the responsibility of a member of its Subcontractor's workforce, Business Associate shall either 1) conduct its own risk assessment and draft a summary of the event and assessment or 2) require its Subcontractor to conduct the assessment and draft a summary of the event. In either case, Business Associate shall make these assessments and reports available to Covered Entity.

6.4 Business Associate shall require, by contract, a Subcontractor to report to Business Associate and Covered Entity any Breach of which the Subcontractor becomes aware, no later than two (2) business days after becomes aware of the Breach.

7. Mitigation and Corrective Action. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible use or disclosure of PHI, even if the impermissible use or disclosure does not constitute a Breach. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by Covered Entity, Business Associate shall make its mitigation and corrective action plans available to Covered Entity. Business Associate shall require a Subcontractor to agree to these same terms and conditions.

8. Providing Notice of Breaches.

8.1 If Covered Entity determines that an impermissible acquisition, access, use or disclosure of PHI for which one of Business Associate's employees or agents was responsible constitutes a Breach as defined in 45 CFR § 164.402, and if requested by Covered Entity, Business Associate shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When requested to provide notice, Business Associate shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate.

8.2 If Covered Entity or Business Associate determines that an impermissible acquisition, access, use or disclosure of PHI by a Subcontractor of Business Associate constitutes a Breach as defined in 45 CFR § 164.402, and if requested by Covered Entity or Business Associate, Subcontractor shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When Covered Entity requests that Business Associate or its Subcontractor provide notice, Business Associate shall either 1) consult with Covered Entity

about the specifics of the notice as set forth in section 8.1, above, or 2) require, by contract, its Subcontractor to consult with Covered Entity about the specifics of the notice as set forth in section 8.1

8.3 The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to Covered Entity.

8.4 The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of what happened, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 CFR § 164.404(c).

8.5 Business Associate shall notify individuals of Breaches as specified in 45 CFR § 164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of Vermont, Business Associate shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR § 164.406.

9. Agreements with Subcontractors. Business Associate shall enter into a Business Associate Agreement with any Subcontractor to whom it provides PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity in which the Subcontractor agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI. Business Associate must enter into this Business Associate Agreement before any use by or disclosure of PHI to such agent. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of PHI. Business Associate shall provide a copy of the Business Associate Agreement it enters into with a subcontractor to Covered Entity upon request. Business associate may not make any disclosure of PHI to any Subcontractor without prior written consent of Covered Entity.

10. Access to PHI. Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or as directed by Covered Entity to an Individual to meet the requirements under 45 CFR § 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.

11. Amendment of PHI. Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.

12. Accounting of Disclosures. Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Business Associate shall provide such information to Covered Entity or as directed by Covered Entity to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and

manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.

13. Books and Records. Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity available to the Secretary in the time and manner designated by the Secretary. Business Associate shall make the same information available to Covered Entity, upon Covered Entity's request, in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.

14. Termination.

14.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all of the PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity is destroyed or returned to Covered Entity subject to Section 18.8.

14.2 If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide an opportunity for Business Associate to cure the breach and Covered Entity may terminate the contract or grant without liability or penalty if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate the contract or grant without liability or penalty if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under the contract or grant, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

15. Return/Destruction of PHI.

15.1 Business Associate in connection with the expiration or termination of the contract or grant shall return or destroy, at the discretion of the Covered Entity, all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity pursuant to this contract or grant that Business Associate still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of the PHI. Business Associate shall certify in writing for Covered Entity (1) when all PHI has been returned or destroyed and (2) that Business Associate does not continue to maintain any PHI. Business Associate is to provide this certification during this thirty (30) day period.

15.2 Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible for so long as Business Associate maintains such PHI. This shall also apply to all Agents and Subcontractors of Business Associate.

16. Penalties and Training. Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by Covered Entity, Business Associate shall participate in training regarding the use, confidentiality, and security of PHI.

17. Security Rule Obligations. The following provisions of this section apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.

17.1 Business Associate shall implement and use administrative, physical, and technical safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312 with respect to the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to protect such Electronic PHI.

17.2 Business Associate shall ensure that any Agent and Subcontractor to whom it provides Electronic PHI agrees in a written agreement to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into this written agreement before any use or disclosure of Electronic PHI by such Agent or Subcontractor. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of Electronic PHI. Business Associate shall provide a copy of the written agreement to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any Agent or Subcontractor without the prior written consent of Covered Entity.

17.3 Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an Agent or Subcontractor). Business Associate shall provide this written report as soon as it becomes aware of any such Security Incident, and in no case later than two (2) business days after it becomes aware of the incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

17.4 Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

18. Miscellaneous.

18.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the contract/grant, the terms of this Agreement shall govern with respect to its subject matter. Otherwise, the terms of the contract/grant continue in effect.

18.2 Business Associate shall cooperate with Covered Entity to amend this Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

18.3 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

18.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule, and the HIPAA omnibus final rule) in construing the meaning and effect of this Agreement.

18.5 As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity.

18.6 Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity or creates or receives on behalf of Covered Entity even if some of that information relates to specific services for which Business Associate may not be a "Business Associate" of Covered Entity under the Privacy Rule.

18.7 Business Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI. Business Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

18.8 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for Business Associate to return or destroy PHI as provided in Section 14.2 and (b) the obligation of Business Associate to provide an accounting of disclosures as set forth in Section 11 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

(Rev: 5/5/15)

SUBRECIPIENT GRANT AWARD

ATTACHMENT F
AGENCY OF HUMAN SERVICES' CUSTOMARY CONTRACT/GRANT PROVISIONS

1. **Definitions:** For purposes of this Attachment F, the term "Agreement" shall mean the form of the contract or grant, with all of its parts, into which this Attachment F is incorporated. The meaning of the term "Party" when used in this Attachment F shall mean any named party to this Agreement *other than* the State of Vermont, the Agency of Human Services (AHS) and any of the departments, boards, offices and business units named in this Agreement. As such, the term "Party" shall mean, when used in this Attachment F, the Contractor or Grantee with whom the State of Vermont is executing this Agreement. If Party, when permitted to do so under this Agreement, seeks by way of any subcontract, sub-grant or other form of provider agreement to employ any other person or entity to perform any of the obligations of Party under this Agreement, Party shall be obligated to ensure that all terms of this Attachment F are followed. As such, the term "Party" as used herein shall also be construed as applicable to, and describing the obligations of, any subcontractor, sub-recipient or sub-grantee of this Agreement. Any such use or construction of the term "Party" shall not, however, give any subcontractor, sub-recipient or sub-grantee any substantive right in this Agreement without an express written agreement to that effect by the State of Vermont.

2. **Agency of Human Services**: The Agency of Human Services is responsible for overseeing all contracts and grants entered by any of its departments, boards, offices and business units, however denominated. The Agency of Human Services, through the business office of the Office of the Secretary, and through its Field Services Directors, will share with any named AHS-associated party to this Agreement oversight, monitoring and enforcement responsibilities. Party agrees to cooperate with both the named AHS-associated party to this contract and with the Agency of Human Services itself with respect to the resolution of any issues relating to the performance and interpretation of this Agreement, payment matters and legal compliance.

3. **Medicaid Program Parties** (*applicable to any Party providing services and supports paid for under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver*):

   Inspection and Retention of Records: In addition to any other requirement under this Agreement or at law, Party must fulfill all state and federal legal requirements, and will comply with all requests appropriate to enable the Agency of Human Services, the U.S. Department of Health and Human Services (along with its Inspector General and the Centers for Medicare and Medicaid Services), the Comptroller General, the Government Accounting Office, or any of their designees: (i) to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under this Agreement; and (ii) to inspect and audit any records, financial data, contracts, computer or other electronic systems of Party relating to the performance of services under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver. Party will retain for ten years all documents required to be retained pursuant to 42 CFR 438.3(u).

   Subcontracting for Medicaid Services: Notwithstanding any permitted subcontracting of services to be performed under this Agreement, Party shall remain responsible for ensuring that this Agreement is fully performed according to its terms, that subcontractor remains in compliance with the terms hereof, and that subcontractor complies with all state and federal laws and regulations relating to the Medicaid program in Vermont. Subcontracts, and any service provider agreements entered into by Party in connection with the performance of this Agreement, must clearly specify in writing the responsibilities of the subcontractor or other service provider and Party must retain the authority to revoke its subcontract or service provider agreement or to impose other sanctions if the performance of the subcontractor or service provider is inadequate or if its performance deviates from any requirement of this Agreement. Party shall make available

on request all contracts, subcontracts and service provider agreements between the Party, subcontractors and other service providers to the Agency of Human Services and any of its departments as well as to the Center for Medicare and Medicaid Services.

Medicaid Notification of Termination Requirements: Party shall follow the Department of Vermont Health Access Managed-Care-Organization enrollee-notification requirements, to include the requirement that Party provide timely notice of any termination of its practice.

Encounter Data: Party shall provide encounter data to the Agency of Human Services and/or its departments and ensure further that the data and services provided can be linked to and supported by enrollee eligibility files maintained by the State.

Federal Medicaid System Security Requirements Compliance: Party shall provide a security plan, risk assessment, and security controls review document within three months of the start date of this Agreement (and update it annually thereafter) in order to support audit compliance with 45 CFR 95.621 subpart F, *ADP System Security Requirements and Review Process.*

4. **Workplace Violence Prevention and Crisis Response** (*applicable to any Party and any subcontractors and sub-grantees whose employees or other service providers deliver social or mental health services directly to individual recipients of such services*):

Party shall establish a written workplace violence prevention and crisis response policy meeting the requirements of Act 109 (2016), 33 VSA §8201(b), for the benefit of employees delivering direct social or mental health services. Party shall, in preparing its policy, consult with the guidelines promulgated by the U.S. Occupational Safety and Health Administration for *Preventing Workplace Violence for Healthcare and Social Services Workers*, as those guidelines may from time to time be amended.

Party, through its violence protection and crisis response committee, shall evaluate the efficacy of its policy, and update the policy as appropriate, at least annually. The policy and any written evaluations thereof shall be provided to employees delivering direct social or mental health services.

Party will ensure that any subcontractor and sub-grantee who hires employees (or contracts with service providers) who deliver social or mental health services directly to individual recipients of such services, complies with all requirements of this Section.

5. **Non-Discrimination**:

Party shall not discriminate, and will prohibit its employees, agents, subcontractors, sub-grantees and other service providers from discrimination, on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, and on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. Party shall not refuse, withhold from or deny to any person the benefit of services, facilities, goods, privileges, advantages, or benefits of public accommodation on the basis of disability, race, creed, color, national origin, marital status, sex, sexual orientation or gender identity as provided by Title 9 V.S.A. Chapter 139.

No person shall on the grounds of religion or on the grounds of sex (including, on the grounds that a woman is pregnant), be excluded from participation in, be denied the benefits of, or be subjected to discrimination,

to include sexual harassment, under any program or activity supported by State of Vermont and/or federal funds.

Party further shall comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, requiring that contractors and subcontractors receiving federal funds assure that persons with limited English proficiency can meaningfully access services. To the extent Party provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services, such individuals cannot be required to pay for such services.

6. **Employees and Independent Contractors**:

Party agrees that it shall comply with the laws of the State of Vermont with respect to the appropriate classification of its workers and service providers as "employees" and "independent contractors" for all purposes, to include for purposes related to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party agrees to ensure that all of its subcontractors or sub-grantees also remain in legal compliance as to the appropriate classification of "workers" and "independent contractors" relating to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party will on request provide to the Agency of Human Services information pertaining to the classification of its employees to include the basis for the classification. Failure to comply with these obligations may result in termination of this Agreement.

7. **Data Protection and Privacy:**

Protected Health Information: Party shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this Agreement. Party shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations.

Substance Abuse Treatment Information: Substance abuse treatment information shall be maintained in compliance with 42 C.F.R. Part 2 if the Party or subcontractor(s) are Part 2 covered programs, or if substance abuse treatment information is received from a Part 2 covered program by the Party or subcontractor(s).

Protection of Personal Information: Party agrees to comply with all applicable state and federal statutes to assure protection and security of personal information, or of any personally identifiable information (PII), including the Security Breach Notice Act, 9 V.S.A. § 2435, the Social Security Number Protection Act, 9 V.S.A. § 2440, the Document Safe Destruction Act, 9 V.S.A. § 2445 and 45 CFR 155.260. As used here, PII shall include any information, in any medium, including electronic, which can be used to distinguish or trace an individual's identity, such as his/her name, social security number, biometric records, etc., either alone or when combined with any other personal or identifiable information that is linked or linkable to a specific person, such as date and place or birth, mother's maiden name, etc.

Other Confidential Consumer Information: Party agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to and uses of personal information relating to any beneficiary or recipient of goods, services or other forms of support. Party further agrees to comply with any applicable Vermont State Statute and other regulations respecting the right to individual privacy. Party shall ensure that all of its employees, subcontractors and other service providers performing services under this agreement understand and preserve the sensitive, confidential and non-public nature of information to which they may have access.

Data Breaches: Party shall report to AHS, though its Chief Information Officer (CIO), any impermissible use or disclosure that compromises the security, confidentiality or privacy of any form of protected personal information identified above within 24 hours of the discovery of the breach. Party shall in addition comply with any other data breach notification requirements required under federal or state law.

8. **Abuse and Neglect of Children and Vulnerable Adults:**

Abuse Registry. Party agrees not to employ any individual, to use any volunteer or other service provider, or to otherwise provide reimbursement to any individual who in the performance of services connected with this agreement provides care, custody, treatment, transportation, or supervision to children or to vulnerable adults if there has been a substantiation of abuse or neglect or exploitation involving that individual. Party is responsible for confirming as to each individual having such contact with children or vulnerable adults the non-existence of a substantiated allegation of abuse, neglect or exploitation by verifying that fact though (a) as to vulnerable adults, the Adult Abuse Registry maintained by the Department of Disabilities, Aging and Independent Living and (b) as to children, the Central Child Protection Registry (unless the Party holds a valid child care license or registration from the Division of Child Development, Department for Children and Families). See 33 V.S.A. §4919(a)(3) and 33 V.S.A. §6911(c)(3).

Reporting of Abuse, Neglect, or Exploitation. Consistent with provisions of 33 V.S.A. §4913(a) and §6903, Party and any of its agents or employees who, in the performance of services connected with this agreement, (a) is a caregiver or has any other contact with clients and (b) has reasonable cause to believe that a child or vulnerable adult has been abused or neglected as defined in Chapter 49 or abused, neglected, or exploited as defined in Chapter 69 of Title 33 V.S.A. shall: as to children, make a report containing the information required by 33 V.S.A. §4914 to the Commissioner of the Department for Children and Families within 24 hours; or, as to a vulnerable adult, make a report containing the information required by 33 V.S.A. §6904 to the Division of Licensing and Protection at the Department of Disabilities, Aging, and Independent Living within 48 hours. Party will ensure that its agents or employees receive training on the reporting of abuse or neglect to children and abuse, neglect or exploitation of vulnerable adults.

9. **Information Technology Systems**:

Computing and Communication: Party shall select, in consultation with the Agency of Human Services' Information Technology unit, one of the approved methods for secure access to the State's systems and data, if required. Approved methods are based on the type of work performed by the Party as part of this agreement. Options include, but are not limited to:

1. Party's provision of certified computing equipment, peripherals and mobile devices, on a separate Party's network with separate internet access. The Agency of Human Services' accounts may or may not be provided.

2. State supplied and managed equipment and accounts to access state applications and data, including State issued active directory accounts and application specific accounts, which follow the National Institutes of Standards and Technology (NIST) security and the Health Insurance Portability & Accountability Act (HIPAA) standards.

Intellectual Property/Work Product Ownership: All data, technical information, materials first gathered, originated, developed, prepared, or obtained as a condition of this agreement and used in the performance of this agreement -- including, but not limited to all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video or audio), pictures, drawings, analyses, graphic representations, software

computer programs and accompanying documentation and printouts, notes and memoranda, written procedures and documents, which are prepared for or obtained specifically for this agreement, or are a result of the services required under this grant -- shall be considered "work for hire" and remain the property of the State of Vermont, regardless of the state of completion unless otherwise specified in this agreement. Such items shall be delivered to the State of Vermont upon 30-days notice by the State. With respect to software computer programs and / or source codes first developed for the State, all the work shall be considered "work for hire," i.e., the State, not the Party (or subcontractor or sub-grantee), shall have full and complete ownership of all software computer programs, documentation and/or source codes developed.

Party shall not sell or copyright a work product or item produced under this agreement without explicit permission from the State of Vermont.

If Party is operating a system or application on behalf of the State of Vermont, Party shall not make information entered into the system or application available for uses by any other party than the State of Vermont, without prior authorization by the State. Nothing herein shall entitle the State to pre-existing Party's materials.

Party acknowledges and agrees that should this agreement be in support of the State's implementation of the Patient Protection and Affordable Care Act of 2010, Party is subject to the certain property rights provisions of the Code of Federal Regulations and a Grant from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. Such agreement will be subject to, and incorporates here by reference, 45 CFR 74.36, 45 CFR 92.34 and 45 CFR 95.617 governing rights to intangible property.

Security and Data Transfers: Party shall comply with all applicable State and Agency of Human Services' policies and standards, especially those related to privacy and security. The State will advise the Party of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Party to implement any required.

Party will ensure the physical and data security associated with computer equipment, including desktops, notebooks, and other portable devices, used in connection with this Agreement. Party will also assure that any media or mechanism used to store or transfer data to or from the State includes industry standard security mechanisms such as continually up-to-date malware protection and encryption. Party will make every reasonable effort to ensure media or data files transferred to the State are virus and spyware free. At the conclusion of this agreement and after successful delivery of the data to the State, Party shall securely delete data (including archival backups) from Party's equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

Party, in the event of a data breach, shall comply with the terms of Section 6 above.

10. **Other Provisions**:

Environmental Tobacco Smoke. Public Law 103-227 (also known as the Pro-Children Act of 1994) and Vermont's Act 135 (2014) (An act relating to smoking in lodging establishments, hospitals, and child care facilities, and on State lands) restrict the use of tobacco products in certain settings. Party shall ensure that no person is permitted: (i) to use tobacco products or tobacco substitutes as defined in 7 V.S.A. § 1001 on the premises, both indoor and outdoor, of any licensed child care center or afterschool program at any time; (ii) to use tobacco products or tobacco substitutes on the premises, both indoor and in any outdoor area designated for child care, health or day care services, kindergarten, pre-kindergarten, elementary, or secondary education or library services; and (iii) to use tobacco products or tobacco substitutes on the

premises of a licensed or registered family child care home while children are present and in care. Party will refrain from promoting the use of tobacco products for all clients and from making tobacco products available to minors.

Failure to comply with the provisions of the federal law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The federal Pro-Children Act of 1994, however, does not apply to portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

2-1-1 Database: If Party provides health or human services within Vermont, or if Party provides such services near the Vermont border readily accessible to residents of Vermont, Party shall adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211 (Vermont 211), and will provide to Vermont 211 relevant descriptive information regarding its agency, programs and/or contact information as well as accurate and up to date information to its database as requested. The "Inclusion/Exclusion" policy can be found at www.vermont211.org.

Voter Registration: When designated by the Secretary of State, Party agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of state and federal law pertaining to such agencies.

Drug Free Workplace Act: Party will assure a drug-free workplace in accordance with 45 CFR Part 76.

Lobbying: No federal funds under this agreement may be used to influence or attempt to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendments other than federal appropriated funds.

AHS ATT. F 12.31.16

STATE OF VERMONT
DEPARTMENT OF HEALTH

Grant # 03420-6790S

SUBRECIPIENT GRANT AWARD

1. Parties: This is a Grant Agreement for services between the State of Vermont, Department of Health, Division of Maternal and Child Health (hereinafter called "State"), and **Planned Parenthood of Northern New England** with principal place of business in Colchester, VT (hereinafter called "Grantee"). It is the Grantee's responsibility to contact the Vermont Department of Taxes to determine if, by law, the Grantee is required to have a Vermont Department of Taxes Business Account Number.

2. Subject Matter: The subject matter of this Grant Agreement is to support family planning services. Detailed services to be provided by the Grantee are described in Attachment A.

3. Maximum Amount: In consideration of the services to be performed by Grantee, the State agrees to pay Grantee, in accordance with the payment provisions specified in Attachment B, a sum not to exceed $754,387

4. Grant Term: The period of Grantee's performance shall begin on April 1, 2016 and end on March 31, 2017.

5. Source of Funds: Federal $754,387 Other $

6. CFDA Title: Title X Family Planning Services; CFDA Number: 93.217; Award Name: Family Planning Services; Award Number: 1 FPHPA016246-01-00; Award Year 2016; Federal Granting Agency: DHHS, Office of the Secretary; Research and Development Grant? Yes _ No X

7. Amendment: No changes, modifications, or amendments in the terms and conditions of this Grant shall be effective unless reduced to writing, numbered, and signed by the duly authorized representative of the State and Grantee.

8. Cancellation: This Grant Agreement may be suspended or cancelled by either party by giving written notice at least 30 days in advance.

9. Contact persons for this award:

   State: Kim Swartz- Telephone #: 802-652-4184 E-mail: kimberly.swartz@vermont.gov

   Subrecipient: Meagan Gallagher - Telephone #: 802-448-9700 E-mail: Meagan.Gallagher@ppnne.org

10. Fiscal year: The Grantee's fiscal year starts on (month) January 1 and ends (month) December 31.

11. Attachments: This Grant consists of 27 pages including the following attachments which are incorporated herein:
    - Attachment A - Specifications of Work to be Performed
    - Attachment B - Payment Provisions
    - Attachment C - Customary State Grant Provisions
    - Attachment D - Modifications of Insurance (N/A)
    - Attachment E - Business Associate Agreement
    - Attachment F - AHS Customary Grant Provisions
    - Attachment G – Other Grant Provisions (N/A)

STATE OF VERMONT
DEPARTMENT OF HEALTH

Grant # 03420-6790S

SUBRECIPIENT GRANT AWARD

The order of precedence of these documents shall be as follows:

This Document
Attachment D - Modifications of Insurance (N/A)
Attachment C - "Customary State Grant Provisions"
Attachment A - Specifications of Work to be Performed
Attachment B - Payment Provisions
Attachment E - Business Associate
Attachment G – Other Grant Provisions (N/a)
Attachment F - AHS Customary Grant Provisions

WE, THE UNDERSIGNED PARTIES, AGREE TO BE BOUND BY THIS GRANT.

STATE OF VERMONT

By: _____

Harry Chen, MD
Commissioner
Vermont Department of Health

Date: MAY 17 2016

GRANTEE

By: _____
Meagan Gallagher

Print Name: Meagan Gallagher

Print Title: President and Chief Executive Officer

Date: 5/10/16

Address: Planned Parenthood of NNE
784 Hercules Drive
Suite 110
Colchester, VT 05446

DUNS #: 020664637
CCR #: 4EVG9 X Yes __ No

Vendor #: 1121

Approved as to form:

By: _____
Assistant Attorney General

Date 3/5/2016

SUBRECIPIENT GRANT AWARD

ATTACHMENT A
SCOPE OF WORK TO BE PERFORMED

OVERVIEW

Title X of the Public Health Service Act is designed to ensure access to comprehensive reproductive health care, with an emphasis on services to lower income women and men. Subrecipient will be responsible to the State for the operation of a voluntary family planning program in Vermont. Subrecipient will deliver Title X clinical, informational, educational, and referral services as appropriate for health and social needs, relating to family planning services to patients who want such services at health centers statewide.

These funds support local family planning services that ensure access to a broad range of family planning and related preventive health services for Vermont women, men, and their partners. Nationally, Title X-supported clinics provide a number of related preventive health services such as: patient education and counseling; breast and pelvic examinations; breast and cervical cancer screening according to nationally recognized standards of care; sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) prevention education, counseling, testing and referral; and pregnancy diagnosis and counseling.

The Title X family planning program is intended to assist individuals in determining the number and spacing of their children. This promotes positive birth outcomes and healthy families. The education, counseling, and medical services available in Title X-funded clinic settings assist in achieving these goals.

GOAL AND OBJECTIVES

The overarching goal of Vermont's Title X program is to *provide high quality clinical family planning and related preventive health services, education, and counseling to Vermonters who would otherwise not have access, with a special focus on low-income and rural populations.* Specifically, Vermont's Title X program seeks to:

- Reduce unintended pregnancies in Vermont
- Improve access to a broad range of effective contraceptive methods
- Provide access to emergency contraceptive services
- Reduce sexually transmitted diseases
- Promote healthy relationships, healthy sexual behaviors and strengthen community capacity to promote positive reproductive health

REQUIRED ACTIVITIES, DESIRED OUTCOMES AND PERFORMANCE MEASURES

I. Provide comprehensive clinical and counseling services

A. Subrecipient will provide the following family planning services in accordance with the Title X guidelines described in the most current Program Requirements for Title X Funded Family Planning Projects: http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf, the most current Recommendations for Quality Family Planning Services by CDC and OPA, http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf, and the 2016 Title X Work Plan, jointly agreed upon between the State and Subrecipient, and approved by HHS/Office of Population Affairs.

B. Client education: Education services must provide patients the information needed to:

- Make informed decisions about family planning;
- Use specific methods of contraception and identify adverse effects;
- Reduce risk of transmission of sexually transmitted diseases and HIV;
- Understand the range of available services and the purpose and sequence of clinic procedures; and

- Understand the importance of recommended screening tests and other procedures involved in the family planning visit.

Additional information should include, but is not limited to, reproductive health and health promotion/disease prevention, including nutrition, exercise, smoking cessation, alcohol and drug abuse, domestic violence and sexual abuse.

C. Counseling: The primary purpose of counseling in the family planning setting is to assist patients in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods and services. Discussion topics should include, but are not limited to the following:

Method Counseling:

- Results of physical exam and lab studies;
- Effective use of contraceptive methods, including long acting reversible methods (LARCs), natural family planning, emergency contraception, and the benefit and efficacy of the methods;
- Possible side effects/complications;
- How to discontinue the method selected and information regarding back-up method use, including the use of certain oral contraceptives as post-coital emergency contraception;
- Planned return schedule;
- Emergency 24-hour telephone number;
- Location where emergency services can be obtained; and
- Appropriate referral for additional services as needed.

Sexually Transmitted Disease (STD) and HIV Counseling:

- Personal risks for STD/HIV; and
- The steps to be taken by the individual to reduce risk.

On an optional basis, clinics may also provide HIV risk assessments, counseling and testing by specially trained staff. When the project does not offer these optional services, the project must provide the patient with a list of health care providers who can provide these services.

Reproductive Life Planning:

- Talk with patients about reproductive life planning and targeted contraceptive and/or preconception health counseling and support.

D. History, Physical Assessment, and Laboratory Testing:

- History: A complete medical history must be obtained and updated as appropriate at subsequent visits.
- Physical Assessment: A complete physical exam should be performed, as indicated, to include the following:
  - *Female* - height and weight, examination of the thyroid, heart, lungs, extremities, breasts, abdomen, pelvis, and rectum.
  - *Male* - height and weight, examination of the thyroid, heart, lungs, extremities, breasts, abdomen, genitals, and rectum.
- Laboratory Testing: Various testing may be provided either onsite or by referral. Pregnancy testing must be provided onsite.

E. Fertility Regulation: Patients should be informed of both reversible and permanent contraception.

F. Infertility Services: Subrecipient must make basic infertility services available to women and men desiring such services. Basic services are categorized as Level I, which includes an initial infertility interview, education, physical examination, counselling, and appropriate referral.

G. Pregnancy Diagnosis and Counseling: Subrecipient must provide pregnancy diagnosis and counseling to all patients in need of this service.

Subrecipient must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination.

H. Adolescent services: Subrecipient must provide services specifically tailored to adolescents, such as:

- Provide adolescents with timely appointments, the same or next day of their call;
- Educate all teens on the importance of family involvement in sexual decision making and family planning;
- Screen and educate all teens on sexual coercion.

All medical services will be provided under the direction of a Medical Director, who is licensed to practice medicine in the State of Vermont. Specific family planning services may be delivered either by a physician or other health care professional, specifically trained in family planning and licensed, registered, or certified by the State of Vermont.

<table>
<tr><td>1) Desired outcome</td><td>Provide accessible, high-quality clinical family planning and related preventive health services to individuals from low income families across Vermont.</td></tr>
<tr><td>Deliverables</td><td>Subrecipient will provide clinical family planning and related preventive services to at least 10,000 patients at 10 (ten) health centers across Vermont during the course of this Subrecipient Grant period. At least 77% of those patients who report an income will be at, less than or equal to 250% Federal Poverty Level. At least 21% of patients will be 20 years of age or younger. 11% of patients will be male.

<table><tr><td>10,000 patients served annually</td></tr><tr><td>2,500 patients served quarterly</td></tr><tr><td>7,700 patients will have incomes at or below 250% FPL</td></tr><tr><td>2,100 patients will be 20 years of age or younger</td></tr><tr><td>1,100 patients will be male</td></tr></table></td></tr>
<tr><td>Performance measures</td><td>1) Maintain the proportion of patients that adopt or continue to use a highly or moderately effective contraceptive method at 68%
2) Assess 100% of female patients for pregnancy intention and provide education on reproductive life planning and targeted contraceptive and/or preconception health counseling and support, annually</td></tr>
<tr><td>Failure to meet performance measure</td><td>▪ Failure to meet these performance measures will result in a conference between the Subrecipient and Vermont Department of Health (VDH) Program Administrator. The Subrecipient will be required to submit in writing an action plan for meeting the measure.
▪ Subrecipient may be allowed a revision to these performance measures to be determined by the VDH Program Administrator.
▪ Failure to meet these performance measures may result in a 1% deduction from the final monthly invoice for the Subrecipient Grant period.</td></tr>
</table>

Monitoring	▪ Subrecipient will report regularly to the VDH Program Administrator on the progress toward achieving performance measures via both monthly meeting, in the Subrecipient's quarterly progress reports, and submission of data to the Title X Region 1 Data System. ▪ Subrecipient will inform the VDH Program Administrator about the progress or obstacles encountered in meeting this performance measure. ▪ Subrecipient agrees to participate in a minimum of twice annual clinical program reviews, to include health center site visit and chart review, at a time and location mutually agreed upon.

II. Provide free and low-cost services on a sliding scale

Subrecipient must establish a fee schedule based on usual and customary fees for services. A sliding scale must be established, with the following specifications:

- Fees for minors receiving confidential services are determined based solely on the minor's income.
- Patients are not denied Title X services due to inability to pay.
- Patients with incomes at or below 100% of the federal poverty level are provided Title X services and products at no charge and regardless of any outstanding account balance.

The Subrecipient must collect household income information on all Title X patients, unless the patient refuses. The fee schedule must be submitted to VDH annually upon Subrecipient's review and update.

III. Statewide service provision

A. Subrecipient will provide Title X-funded services at the following Health Centers:

1) Barre
2) Bennington
3) Brattleboro
4) Hyde Park
5) Middlebury
6) Newport
7) Rutland
8) St. Albans
9) St. Johnsbury
10) White River Junction

IV. Offer educational programming

Subrecipient will offer educational programs as follows:

A. Contraceptive technology technical updates to the staff of the twelve VDH district offices. The nature and content of these educational sessions for VDH staff will be created via communications between VDH Division of Maternal and Child Health (MCH), VDH Office of Local Health (OLH), the Planned Parenthood of Northern New England (PPNNE) Title X Coordinator, and the local PPNNE and VDH district office leadership.

B. Maintain a teen peer education program designed to educate teens about sexual health, avoidance of sexual risk-taking behaviors, and delay of pregnancies. This program will include information that encourages families'/parents'/guardians' participation in the family planning decision making of minors. Subrecipient will demonstrate this through continuing to work with two local high schools and by ensuring that 5 Peer Educators are trained during the grant year.

C. The Subrecipient will carry out the information and education materials review function as stipulated in the *Program Requirements* section *12.1-12.6* Information and Education Materials Approval published by the Office of Population Affairs, 2014 (or most current).The VDH Program Administrator will serve on the Information and Education Advisory Committee (IEAC) and will approve all materials before publication.

Documentation of the meetings and actions of the Information and Education Advisory Committee will be provided to the State. All educational materials published using funds from this Subrecipient Grant will cite the source of the funding on the documents.

2) Desired outcome	**Ensure that all education materials are current, factual, and medically accurate, professionally sound, consistent with community standards, and appropriate to the educational and cultural backgrounds**
Performance measure	Subrecipient will convene and maintain an Information and Education Advisory Committee (IEAC) and will conduct surveys of informational and educational materials to ensure accuracy and quality, and to revise materials as necessary. The VDH Program Administrator will serve on the IEAC.
Failure to meet performance measure	▪ Subrecipient will notify the VDH Program Administrator when there are new educational materials to be reviewed and of the dates and time of the IEAC meetings and/or survey due dates. ▪ If this performance measure is not achieved, such as by the event of new educational materials being issued without review by the IEAC or by the VDH Program Administrator not being notified of new educational materials being considered by the Subrecipient, 1% of the monthly invoice amount will be deducted from the final invoice for the Subrecipient Grant period.
Monitoring	Subrecipient will report regularly to the VDH Program Administrator on the progress toward achieving this performance measure via both monthly meetings and in the Sub recipient's quarterly reports. Subrecipient will inform the VDH Program Administrator about the progress or obstacles encountered in meeting this performance measure.

V. Project promotion and outreach to vulnerable populations

Subrecipient will engage in activities to facilitate community awareness of and access to family planning services, projects must establish and implement planned activities whereby their services are made known to the community.

A. Subrecipient will hold at least one outreach activity each month designed to make Title X family planning clinical services known in each of the twelve VDH district offices (DO) territories. This outreach activity may be with VDH DO personnel or staff of local youth serving organizations.

B. Other outreach activities may include the following:

- Distribute project promotion materials statewide through specialized media, direct mailings, and drop offs at key community locations and retailers
- Annually attend meeting of VDH's District Directors to discuss collaborative opportunities
- Collaborate with the Vermont Blueprint for Health medical home initiative, as well as Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) on referrals
- Offer training for health center managers/staff on conducting outreach, creating an outreach plan, review of various outreach strategies and evaluating progress
- Create outreach "kits" which are specific to each location and include print and promotional materials for one-on-one meetings or group meetings with community partners
- Create tabling "kits" for site managers who attend health fairs, expos, etc.
- Use a tracking tool to assist managers in documenting outreach events and evaluating the effectiveness of each event. This tracking tool is available via sub recipient's intranet, and each site manager is responsible for logging outreach activities as they occur.

- Develop talking points about the organization's Title X family planning program to inform community partners about services

VI. Develop and maintain formal linkages to comprehensive primary care and community based health and social services

Subrecipient will increase the number of formal linkages and documented partnerships established between the subrecipient agency and comprehensive primary care providers, and other health and social service providers.

3) Desired outcome	**To ensure that Title X family planning users have access to comprehensive primary care services and other community based health and social services.**
Performance measure	1) Finalize at least one (1) memorandum of understanding (MOU) with a comprehensive primary care provider in each Vermont community where subrecipient provides health care services. 2) Finalize at least one (1) memorandum of understanding (MOU) with a community based health or social service provider in each Vermont community where subrecipient provides health care services.
Failure to meet performance measure	▪ Failure to meet either of these performance measures will result in a conference between the Subrecipient and VDH Program Administrator. The Subrecipient will be required to submit in writing an action plan for meeting the measure. ▪ Subrecipient may be allowed a revision to these performance measures to be determined by the VDH Program Administrator. ▪ Failure to meet these performance measures may result in a 1% deduction from the final monthly invoice for the Subrecipient Grant period.
Monitoring	▪ Subrecipient will report regularly to the VDH Program Administrator on the progress toward achieving this performance measure via both monthly meetings and in the Subrecipient's quarterly reports. ▪ Subrecipient agrees to participate in a minimum of once annual administrative program review, to include review of financial and administrative policies/practices and training logs.

VII. Training/Professional development

Subrecipient will ensure that all staff in Title X health centers are appropriately trained. Subrecipient may provide training on the following:

- Initial training to all new Title X staff through various formats and techniques (in-person, webinar, self-directed); including on *Title X Program Requirements for Funded Family Planning Projects and the Recommendations for Quality Family Planning Services (QFP);*
- Training to clinical and office staff on LARCs and other new and emerging technologies;

- Ongoing training on mandated reporting, intimate partner violence (IPV), screening and counseling practices with minors on sexual coercion, human trafficking and other critical and emerging health and reproductive health issues;
- Training to all health center staff on parent involvement policy;
- Ongoing training on clinical systems, protocols, Electronic Health Record (EHR);
- Clinical staff receive required Continuing Education Units (CEUs) and maintain credentialing;
- Training to clinical staff in working with patients on preconception health and reproductive life planning.

4) Desired outcome	**Ensure that all staff in Title X health centers are appropriately trained**
Performance measure	1) 100% of staff receive annual training on mandated reporting, IPV, human trafficking, and family participation in adolescent decision making 2) 100% of staff receive training on new *Title X Requirements* upon employment and as updates/revisions are made to requirements 3) 100% of staff receive training in *Recommendations for Quality Family Planning Services (QFP)* upon employment and as revisions/updates are made to recommendations
Failure to meet performance measure	▪ Failure to meet either of these performance measures will result in a conference between the Subrecipient and VDH Program Administrator. The Subrecipient will be required to submit in writing an action plan for meeting the measure. ▪ Subrecipient may be allowed a revision to these performance measures to be determined by the VDH Program Administrator. Failure to meet these performance measures may result in a 1% deduction from the final monthly invoice for the Subrecipient Grant period.
Monitoring	▪ Subrecipient will report regularly to the VDH Program Administrator on the progress toward achieving this performance measure via both monthly meetings and in the Subrecipient's quarterly reports. ▪ Subrecipient agrees to participate in a minimum of once annual administrative program review, to include review of financial and administrative policies/practices and training logs.

VIII. Data submission / Family Planning Annual Report (FPAR)

The Subrecipient must submit all required data for the Family Planning Annual Report (FPAR) through the Title X Region 1 Data System. Subrecipient is required to:

- Subcontract with JSI (John Snow, Inc.) for the agreed upon amount (2016 figures = $11,455.65) to collect, store, and disseminate data through the Region I Data System.
- Enter and/or upload all required data elements into the Regional I Data System, according to the guidance and timeline established by Health and Human Services (HHS) /Office of Population Affairs.
- Submit data for the FPAR to VDH Program Administrator in a timely manner for annual data submission.

PROGRAM OVERSIGHT AND MONITORING

The Subrecipient will allow the VDH to perform a periodic review of the administrative, fiscal, educational, and clinical systems in order to assess services related to Title X statue and Program Requirements described in

SUBRECIPIENT GRANT AWARD

Section 1 of this Subrecipient Grant document. Reviews may include health center site visits and clinical records reviews. The Subrecipient shall make corrective actions as advised by the VDH's review in order to be compliant with Title X guidelines. These reviews or certain sections of reviews may be waived at the discretion of the VDH upon submission of satisfactory reports or reviews from the Office of Family Planning (DHHS).

Subrecipient will offer every patient the services outlined in Section 1 as appropriate for the patient's needs and according to the Title X Program Requirements. The VDH Program Administrator will:

- Coordinate semi-annual meetings with sub recipient staff to review audit reports, with a focus on high risk audits.
- Conduct in-person review of delivery of the Title X family planning services at three (3) Title X Health Center sites.

Ongoing concerns about the Subrecipient's ability to adequately provide appropriate Title X family planning services according to the conditions as set forth in this Subrecipient Grant may result in the State using its option to cancel this Subrecipient grant agreement .

Subrecipient agrees to comply with:

- Title X Statute of the Public Health Act
- Code of Federal Regulations, Title 42,
  - Part 59, Subpart A—Project Grants for Family Planning Services
  - Part 50, Subpart B-- Sterilization of Persons in Federally assisted Family Planning Projects
- Title X Statute, Section 1008, Prohibition of Abortion
- Title X Program Priorities and Key Issues (2016 or most current: http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-priorities/)
- *Program Requirements for Title X Funded Family Planning Projects:*
- http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf, and the most current *Recommendations for Quality Family Planning Services* by CDC and OPA, http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf (April 2014 or most current as released by OPA, Office of Population Affairs, U.S. Department of Health and Human Services)
- Title X Program Instructions Series
- Department of Health and Human Services, Grants Administration Manual
- U.S. Public Health Service, Grants Policy Statement
- Additions, changes and revisions to the above documents

REPORTING REQUIRMENTS

Subrecipient will submit the following information to the State **each quarter**:

- A written report on the grant deliverables and performance measures;
- Income and expenditure reports will include: income from the Title X grant, state funds, fees and other income for Title X clinic sites; all expenses associated with the provision of services at the Title X clinic sites, the Title X component of education, marketing, administration and other Title X-related expenses.

Subrecipient will submit the following to the State **twice a year** at the 2nd and 4th quarter reporting periods (October and April):

- A written progress report on the Vermont Title X work plan, as submitted to HHS/Office of Population Affairs.

In addition:

- Summary reports of internal quality assurance programs, insurance company reviews, Planned Parenthood Federation of America and other site reviews that describe program services and quality. The full reports will be available for inspection upon written request by the State.
- The Subrecipient agrees to report to the State any additional information concerning Subrecipient Grant matters requested by the State.

The following outlines the report periods and due dates:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Report period	Apr 1, 2016 to Jun 30, 2016	Jul 1, 2016 to Sept 30, 2016	Oct 1, 2016 to Dec 31, 2016	January 1, 2017- March 31, 2017
Due date	July 31, 2016	October 31, 2016	January 31, 2017	April 30, 2017

Federal Funds Compliance Requirements

As a recipient of Federal funds under the terms of your agreement with the Department of Health, you are responsible for meeting the compliance requirements associated with each Federal fund source. The specific requirements for each Federal fund can be found in the Federal Office of Management and Budget Circulars or Guidance. We have listed these circulars and the Guidance below.

The specific requirements for activities allowed or unallowed are unique to each Federal program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program.

In addition, for subrecipients that expend more than $500,000 in Federal subawards or $750,000 for fiscal years beginning after December 26, 2014 or the equivalent in federally funded products, from *all* sources, an audit is required as defined by OMB Circular A-133 or on or after December 26, 2014, as defined by the Uniform Guidance, Subpart F. The audit process includes a comprehensive audit by an independent auditor selected by the subrecipient. The audit report which is produced must be submitted and reviewed by AHS.

The State maintains responsibility for ensuring that our subrecipients meet the compliance requirements for each Federal program by our monitoring of your organization's activities under the terms of the grant agreements. It is the responsibility of your organization to meet each compliance requirement.

APPLICABLE CIRCULARS (before December 26, 2014):

	Public Schools & Government	Universities & Colleges Educational Inst.	Non-profit	Hospital
Costs:	*A-87*	*A-21*	*A-122*	*45CFR Part74*
Admin:	*A-102*	*A-110*	*A-110*	*45CFR Part74*
A-133 Audit	*A-133*	*A-133*	*A-133*	*A-133*

A-21: "Cost Principles for Educational Institutions" (OMB Circular A-21)
A-87: "Cost Principles for State, Local and Indian Tribal Governments" (OMB Circular A-87)
A-102: "Grants and Cooperative Agreements with State and Local Governments" (OMB Circular A-102)
A-110: "Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-Profit Organizations" (OMB Circular A-110)

SUBRECIPIENT GRANT AWARD

A-122: "Cost Principles for Non-Profit Organizations" (OMB Circular A-122)
A-133: "Audits of States, Local Governments and Non-Profit Organizations" (OMB Circular A-133)
45CFR Part74: "Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations; and Certain Grants and Agreements with States, Local Governments and Indian Tribal Governments"

APPLICABLE GUIDANCE (on or after December 26, 2014)

2 CFR Subtitle A, Chapter II, Part 200-Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance)

AHS 12-26-14

SUBRECIPIENT GRANT AWARD

ATTACHMENT B
PAYMENT PROVISIONS

A final report on program activities and a final financial report will be due no later than 30 days after the end date of the Grant.

The Grantee will return any unexpended funds to the State or carry the funds forward at the direction of the State.

1. The maximum dollar amount payable under this subrecipient grant shall not exceed $754, 387.

2. Subrecipient shall invoice the State on a monthly basis on or about the first of each month for services provided in the previous month.

   Payment Schedule:
   - The first monthly invoice (April) shall be submitted for an amount not to exceed $62,872.
   - The remaining monthly invoices (May-March) shall be submitted for an amount not to exceed $62,865.
   - On a quarterly basis (July 2016, October 2016, January 2017, April 2017), invoices will be reconciled with performance measures. Invoices will be equal to the amount above **less any penalties to payment for not meeting performance measures** (see Attachment A for performance measures and penalties).

3. Subrecipient will submit all invoices to the State within 60 days after termination of this Subrecipient Grant. Invoices should include Subrecipient Grant number, vendor number, invoice number, and dates of service. Invoices should be submitted by email to:

   Kim Swartz
   Director, Preventive Reproductive Health
   Kimberly.swartz@vermont.gov

   Vermont Department of Health
   P.O. Box 70
   Burlington, VT 05402-0070

4. Subrecipient will assure, through its accounting system, that the funds received under the terms of this Subrecipient Grant will be applied only for allowable expenditures. The Subrecipient will have a complete annual audit, a copy of which will be submitted to the State by June 30, 2016 and by June 30, 2017.

5. If Subrecipient wants to receive grant payments through direct deposit they can do so by completing the following form and submitting to the Vermont Department of Finance & Management:
   http://finance.vermont.gov/sites/finance/files/pdf/forms/vision/ACH_Authorization_Form.pdf

SUBRECIPIENT GRANT AWARD

ATTACHMENT C: STANDARD STATE PROVISIONS
FOR CONTRACTS AND GRANTS

1. **Entire Agreement:** This agreement, whether in the form of a Contract, State Funded Grant, or Federally Funded Grant, represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.

2. **Applicable Law:** This Agreement will be governed by the laws of the State of Vermont.

3. **Definitions:** For purposes of this Attachment, "Party" shall mean the Contractor, Grantee or Subrecipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement.

4. **Appropriations:** If this Agreement extends into more than one fiscal year of the State (July 1 to June 30), and if appropriations are insufficient to support this Agreement, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriation authority. In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, and in the event federal funds become unavailable or reduced, the State may suspend or cancel this Grant immediately, and the State shall have no obligation to pay Subrecipient from State revenues.

5. **No Employee Benefits For Party:** The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the state withhold any state or federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

6. **Independence, Liability:** The Party will act in an independent capacity and not as officers or employees of the State.

   The Party shall defend the State and its officers and employees against all claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit.

   After a final judgment or settlement the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party.

   The Party shall indemnify the State and its officers and employees in the event that the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party.

7. **Insurance**: Before commencing work on this Agreement the Party must provide certificates of insurance to show that the following minimum coverages are in effect. It is the responsibility of the Party to maintain current certificates of insurance on file with the state through the term of the Agreement. No warranty is made that the coverages and limits listed herein are adequate to cover and protect the interests of the Party for the Party's operations. These are solely minimums that have been established to protect the interests of the State.

Workers Compensation: With respect to all operations performed, the Party shall carry workers' compensation insurance in accordance with the laws of the State of Vermont.

General Liability and Property Damage: With respect to all operations performed under the contract, the Party shall carry general liability insurance having all major divisions of coverage including, but not limited to:

Premises - Operations
Products and Completed Operations
Personal Injury Liability
Contractual Liability

The policy shall be on an occurrence form and limits shall not be less than:

$1,000,000 Per Occurrence
$1,000,000 General Aggregate
$1,000,000 Products/Completed Operations Aggregate
$ 50,000 Fire/ Legal/Liability

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

Automotive Liability: The Party shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Agreement. Limits of coverage shall not be less than: $1,000,000 combined single limit.

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

Professional Liability: Before commencing work on this Agreement and throughout the term of this Agreement, the Party shall procure and maintain professional liability insurance for any and all services performed under this Agreement, with minimum coverage of ***$ 1,000,000*** per occurrence, and ***$ 3,000,000*** aggregate.

8. **Reliance by the State on Representations:** All payments by the State under this Agreement will be made in reliance upon the accuracy of all prior representations by the Party, including but not limited to bills, invoices, progress reports and other proofs of work.

9. **Requirement to Have a Single Audit:** In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, the Subrecipient will complete the Subrecipient Annual Report annually within 45 days after its fiscal year end, informing the State of Vermont whether or not a Single Audit is required for the prior fiscal year. If a Single Audit is required, the Subrecipient will submit a copy of the audit report to the granting Party within 9 months. If a single audit is not required, only the Subrecipient Annual Report is required.

   For fiscal years ending before December 25, 2015, a Single Audit is required if the subrecipient expends $500,000 or more in federal assistance during its fiscal year and must be conducted in accordance with OMB Circular A-133. For fiscal years ending on or after December 25, 2015, a Single Audit is required if the subrecipient expends $750,000 or more in federal assistance during its fiscal year and must be conducted in accordance with 2 CFR Chapter I, Chapter II, Part 200, Subpart F. The Subrecipient Annual Report is required to be submitted within 45 days, whether or not a Single Audit is required.

10. **Records Available for Audit:** The Party shall maintain all records pertaining to performance under this agreement. "Records" means any written or recorded information, regardless of physical form or characteristics, which is produced or acquired by the Party in the performance of this agreement. Records produced or acquired in a machine readable electronic format shall be maintained in that format. The records described shall be made available at reasonable times during the period of the Agreement and for three years thereafter or for any period required by law for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved.

11. **Fair Employment Practices and Americans with Disabilities Act**: Party agrees to comply with the requirement of Title 21V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement. Party further agrees to include this provision in all subcontracts.

12. **Set Off**: The State may set off any sums which the Party owes the State against any sums due the Party under this Agreement; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.

13. **Taxes Due to the State**:

    a. Party understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.

    b. Party certifies under the pains and penalties of perjury that, as of the date the Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.

    c. Party understands that final payment under this Agreement may be withheld if the Commissioner of Taxes determines that the Party is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.

    d. Party also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Party has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Party has no further legal recourse to contest the amounts due.

14. **Child Support**: (Applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date the Agreement is signed, he/she:

    a. is not under any obligation to pay child support; or

    b. is under such an obligation and is in good standing with respect to that obligation; or

    c. has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.

    Party makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Party is a resident of Vermont, Party makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

SUBRECIPIENT GRANT AWARD

15. **Sub-Agreements**: Party shall not assign, subcontract or subgrant the performance of this Agreement or any portion thereof to any other Party without the prior written approval of the State. Party also agrees to include in all subcontract or subgrant agreements a tax certification in accordance with paragraph 13 above.

16. **No Gifts or Gratuities**: Party shall not give title or possession of any thing of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Agreement.

17. **Copies**: All written reports prepared under this Agreement will be printed using both sides of the paper.

18. **Certification Regarding Debarment:** Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.

    Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State's debarment list at: http://bgs.vermont.gov/purchasing/debarment

19. **Certification Regarding Use of State Funds:** In the case that Party is an employer and this Agreement is a State Funded Grant in excess of $1,001, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party's employee's rights with respect to unionization.

20. **Internal Controls:** In the case that this Agreement is an award that is funded in whole or in part by Federal funds, in accordance with 2 CFR Part II, §200.303, the Party must establish and maintain effective internal control over the Federal award to provide reasonable assurance that the Party is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States and the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

21. **Mandatory Disclosures:** In the case that this Agreement is an award funded in whole or in part by Federal funds, in accordance with 2CFR Part II, §200.113, Party must disclose, in a timely manner, in writing to the State, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Failure to make required disclosures may result in the imposition of sanctions which may include disallowance of costs incurred, withholding of payments, termination of the Agreement, suspension/debarment, etc.

22. **Conflict of Interest:** Party must disclose in writing any potential conflict of interest in accordance with Uniform Guidance §200.112, Bulletin 5 Section X and Bulletin 3.5 Section IV.B.

(End of Standard Provisions)

SUBRECIPIENT GRANT AWARD

ATTACHMENT E
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between the State of Vermont Agency of Human Services, operating by and through its Department of Health, Division of Maternal and Child Health ("Covered Entity") and Planned Parenthood of Northern New England ("Business Associate") as of April 1, 2016 ("Effective Date"). This Agreement supplements and is made a part of the contract/grant to which it is attached.

Covered Entity and Business Associate enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 ("Privacy Rule"), and the Security Standards, at 45 CFR Parts 160 and 164 ("Security Rule"), as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH), and any associated federal rules and regulations.

The parties agree as follows:

1. Definitions. All capitalized terms used but not otherwise defined in this Agreement have the meanings set forth in 45 CFR Parts 160 and 164 as amended by HITECH and associated federal rules and regulations.

"Agent" means those person(s) who are agents(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

"Breach" means the acquisition, access, use or disclosure of protected health information (PHI) which compromises the security or privacy of the PHI, except as excluded in the definition of Breach in 45 CFR § 164.402.

"Business Associate shall have the meaning given in 45 CFR § 160.103.

"Individual" includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

"Protected Health Information" or PHI shall have the meaning given in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Agency.

"Security Incident" means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

"Services" includes all work performed by the Business Associate for or on behalf of Covered Entity that requires the use and/or disclosure of protected health information to perform a business associate function described in 45 CFR § 160.103 under the definition of Business Associate.

"Subcontractor" means a person or organization to whom a Business Associate delegates a function, activity or service, other than in the capacity of a member of the workforce of the Business Associate. For purposes of this Agreement, the term Subcontractor includes Subgrantees.

2. Identification and Disclosure of Privacy and Security Offices. Business Associate and Subcontractors shall provide, within ten (10) days of the execution of this agreement, written notice to the Covered Entity's contract/grant manager the names and contact information of both the HIPAA Privacy Officer and HIPAA Security Officer. This information must be updated any time either of these contacts changes.

3. Permitted and Required Uses/Disclosures of PHI.

3.1 Except as limited in this Agreement, Business Associate may use or disclose PHI to perform Services, as specified in the underlying grant or contract with Covered Entity. The uses and disclosures of Business Associate are limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the underlying agreement. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

3.2 Business Associate may make PHI available to its employees who need access to perform Services provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with such restrictions. Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents and Subcontractors in accordance with Sections 9 and 17 or, (b) as otherwise permitted by Section 3.

3.3 Business Associate shall be directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Covered Entity, and for impermissible uses and disclosures, by Business Associate's Subcontractor(s), of the PHI that Business Associate handles on behalf of Covered Entity and that it passes on to Subcontractors.

4. Business Activities. Business Associate may use PHI received in its capacity as a Business Associate to Covered Entity if necessary for Business Associate's proper management and administration or to carry out its legal responsibilities. Business Associate may disclose PHI received in its capacity as Business Associate to Covered Entity for Business Associate's proper management and administration or to carry out its legal responsibilities if a disclosure is Required by Law or if Business Associate obtains reasonable written assurances via a written agreement from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the Agreement requires the person or entity to notify Business Associate, within two (2) business days (who in turn will notify Covered Entity within two (2) business days after receiving notice of a Breach as specified in Section 6.1), in writing of any Breach of Unsecured PHI of which it is aware. Uses and disclosures of PHI for the purposes identified in Section 3 must be of the minimum amount of PHI necessary to accomplish such purposes.

5. Safeguards. Business Associate, its Agent(s) and Subcontractor(s) shall implement and use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement. With respect to any PHI that is maintained in or transmitted by electronic media, Business Associate or its Subcontractor(s) shall comply with 45 CFR sections 164.308 (administrative safeguards), 164.310 (physical safeguards), 164.312 (technical safeguards) and 164.316 (policies and procedures and documentation requirements). Business Associate or its Agent(s) and Subcontractor(s) shall identify in writing upon request from Covered Entity all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.

6. Documenting and Reporting Breaches.

6.1 Business Associate shall report to Covered Entity any Breach of Unsecured PHI, including Breaches reported to it by a Subcontractor, as soon as it (or any of its employees or agents) becomes aware of any such Breach, and in no case later than two (2) business days after it (or any of its employees or agents) becomes aware of the Breach, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

6.2 Business Associate shall provide Covered Entity with the names of the individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR § 164.404(c), and, if requested by Covered Entity, information necessary for Covered Entity to investigate the impermissible use or disclosure. Business Associate shall continue to provide to Covered Entity information concerning the Breach as it becomes available to it. Business Associate shall require its Subcontractor(s) to agree to these same terms and conditions.

6.3 When Business Associate determines that an impermissible acquisition, use or disclosure of PHI by a member of its workforce is not a Breach, as that term is defined in 45 CFR § 164.402, and therefore does not necessitate notice to the impacted individual(s), it shall document its assessment of risk, conducted as set forth in 45 CFR § 402(2). When requested by Covered Entity, Business Associate shall make its risk assessments available to Covered Entity. It shall also provide Covered Entity with 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low probability that the PHI had been compromised. When a breach is the responsibility of a member of its Subcontractor's workforce, Business Associate shall either 1) conduct its own risk assessment and draft a summary of the event and assessment or 2) require its Subcontractor to conduct the assessment and draft a summary of the event. In either case, Business Associate shall make these assessments and reports available to Covered Entity.

6.4 Business Associate shall require, by contract, a Subcontractor to report to Business Associate and Covered Entity any Breach of which the Subcontractor becomes aware, no later than two (2) business days after becomes aware of the Breach.

7. **Mitigation and Corrective Action.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible use or disclosure of PHI, even if the impermissible use or disclosure does not constitute a Breach. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by Covered Entity, Business Associate shall make its mitigation and corrective action plans available to Covered Entity. Business Associate shall require a Subcontractor to agree to these same terms and conditions.

8. **Providing Notice of Breaches**.

8.1 If Covered Entity determines that an impermissible acquisition, access, use or disclosure of PHI for which one of Business Associate's employees or agents was responsible constitutes a Breach as defined in 45 CFR § 164.402, and if requested by Covered Entity, Business Associate shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When requested to provide notice, Business Associate shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate.

8.2 If Covered Entity or Business Associate determines that an impermissible acquisition, access, use or disclosure of PHI by a Subcontractor of Business Associate constitutes a Breach as defined in 45 CFR § 164.402, and if requested by Covered Entity or Business Associate, Subcontractor shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When Covered Entity requests that Business Associate or its Subcontractor provide notice, Business Associate shall either 1) consult with Covered Entity about the specifics of the notice as set forth in section 8.1, above, or 2) require, by contract, its Subcontractor to consult with Covered Entity about the specifics of the notice as set forth in section 8.1

8.3 The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to Covered Entity.

8.4 The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of what happened, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 CFR § 164.404(c).

8.5 Business Associate shall notify individuals of Breaches as specified in 45 CFR § 164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of Vermont, Business Associate shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR § 164.406.

9. Agreements with Subcontractors. Business Associate shall enter into a Business Associate Agreement with any Subcontractor to whom it provides PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity in which the Subcontractor agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI. Business Associate must enter into this Business Associate Agreement before any use by or disclosure of PHI to such agent. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of PHI. Business Associate shall provide a copy of the Business Associate Agreement it enters into with a subcontractor to Covered Entity upon request. Business associate may not make any disclosure of PHI to any Subcontractor without prior written consent of Covered Entity.

10. Access to PHI. Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or as directed by Covered Entity to an Individual to meet the requirements under 45 CFR § 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.

11. Amendment of PHI. Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.

12. Accounting of Disclosures. Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Business Associate shall provide such information to Covered Entity or as directed by Covered Entity to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.

13. Books and Records. Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity available to the Secretary in the time and manner designated by the Secretary. Business Associate shall make the same information available to Covered Entity, upon Covered Entity's request, in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.

14. Termination.

14.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all of the PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity is destroyed or returned to Covered Entity subject to Section 18.8.

14.2 If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide an opportunity for Business Associate to cure the breach and Covered Entity may terminate the contract or grant without liability or penalty if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate the contract or grant without liability or penalty if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under the contract or grant, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

15. Return/Destruction of PHI.

15.1 Business Associate in connection with the expiration or termination of the contract or grant shall return or destroy, at the discretion of the Covered Entity, all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity pursuant to this contract or grant that Business Associate still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of the PHI. Business Associate shall certify in writing for Covered Entity (1) when all PHI has been returned or destroyed and (2) that Business Associate does not continue to maintain any PHI. Business Associate is to provide this certification during this thirty (30) day period.

15.2 Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible for so long as Business Associate maintains such PHI. This shall also apply to all Agents and Subcontractors of Business Associate.

16. Penalties and Training. Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by Covered Entity, Business Associate shall participate in training regarding the use, confidentiality, and security of PHI.

17. Security Rule Obligations. The following provisions of this section apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.

17.1 Business Associate shall implement and use administrative, physical, and technical safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312 with respect to the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to protect such Electronic PHI.

17.2 Business Associate shall ensure that any Agent and Subcontractor to whom it provides Electronic PHI agrees in a written agreement to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into this written agreement before any use or disclosure of Electronic PHI by such Agent or Subcontractor. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of Electronic PHI. Business Associate shall provide a copy of the written agreement to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any Agent or Subcontractor without the prior written consent of Covered Entity.

17.3 Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an Agent or Subcontractor). Business Associate shall provide this written report as soon as it becomes aware of any such Security Incident, and in no case later than two (2) business days after it becomes aware of the incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

17.4 Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

18. Miscellaneous.

18.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the contract/grant, the terms of this Agreement shall govern with respect to its subject matter. Otherwise, the terms of the contract/grant continue in effect.

18.2 Business Associate shall cooperate with Covered Entity to amend this Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

18.3 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

18.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule, and the HIPAA omnibus final rule) in construing the meaning and effect of this Agreement.

18.5 As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity.

18.6 Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity or creates or receives on behalf of Covered Entity even if some of that information relates to specific services for which Business Associate may not be a "Business Associate" of Covered Entity under the Privacy Rule.

18.7 Business Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI. Business Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

18.8 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for Business Associate to return or destroy PHI as provided in Section 14.2 and (b) the obligation of Business Associate to provide an accounting of disclosures as set forth in Section 11 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

SUBRECIPIENT GRANT AWARD

ATTACHMENT F
AGENCY OF HUMAN SERVICES' CUSTOMARY GRANT PROVISIONS

1. **Agency of Human Services – Field Services Directors** will share oversight with the department (or field office) that is a party to the grant for provider performance using outcomes, processes, terms and conditions agreed to under this grant.

2. **2-1-1 Data Base:** The Grantee providing a health or human services within Vermont, or near the border that is readily accessible to residents of Vermont, will provide relevant descriptive information regarding its agency, programs and/or contact and will adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211. If included, the Grantee will provide accurate and up to date information to their data base as needed. The "Inclusion/Exclusion" policy can be found at www.vermont211.org

3. **Medicaid Program Grantees**:

   Inspection of Records: Any grants accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid program must fulfill state and federal legal requirements to enable the Agency of Human Services (AHS), the United States Department of Health and Human Services (DHHS) and the Government Accounting Office (GAO) to:

   Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and

   Inspect and audit any financial records of such Grantee or subgrantee.

   Subcontracting for Medicaid Services: Having a subcontract does not terminate the Grantee, receiving funds under Vermont's Medicaid program, from its responsibility to ensure that all activities under this agreement are carried out. Subcontracts must specify the activities and reporting responsibilities of the Grantee or subgrantee and provide for revoking delegation or imposing other sanctions if the Grantee or subgrantee's performance is inadequate. The Grantee agrees to make available upon request to the Agency of Human Services; the Department of Vermont Health Access; the Department of Disabilities, Aging and Independent Living; and the Center for Medicare and Medicaid Services (CMS) all grants and subgrants between the Grantee and service providers.

   Medicaid Notification of Termination Requirements: Any Grantee accessing payments for services under the Global Commitment to Health Waiver and Medicaid programs who terminates their practice will follow the Department of Vermont Health Access, Managed Care Organization enrollee notification requirements.

   Encounter Data: Any Grantee accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid programs must provide encounter data to the Agency of Human Services and/or its departments and ensure that it can be linked to enrollee eligibility files maintained by the State.

   Federal Medicaid System Security Requirements Compliance: All Grantees and subcontractors must provide a security plan, risk assessment, and security controls review document within three months of the start date of this agreement (and update it annually thereafter) to support audit compliance with 45CFR95.621 subpart F, *ADP* (Automated Data Processing) *System Security Requirements and Review Process.*

4. **Non-discrimination Based on National Origin as evidenced by Limited English Proficiency**. The Grantee agrees to comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, which require that Grantees and subgrantees receiving federal funds must assure

that persons with limited English proficiency can meaningfully access services. To the extent the Grantee provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services in compliance with this requirement, such individuals cannot be required to pay for such services.

5. **Voter Registration**. When designated by the Secretary of State, the Grantee agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of state and federal law pertaining to such agencies.

6. **Drug Free Workplace Act.** The Grantee will assure a drug-free workplace in accordance with 45 CFR Part 76.

7. **Privacy and Security Standards.**

   Protected Health Information: The Grantee shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this grant. The Grantee shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations.

   Substance Abuse Treatment Information: The confidentiality of any alcohol and drug abuse treatment information acquired by or provided to the Grantee or subgrantee shall be maintained in compliance with any applicable state or federal laws or regulations and specifically set out in 42 CFR Part 2.

   Other Confidential Consumer Information: The Grantee agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to information. The Grantee agrees to comply with any applicable Vermont State Statute, including but not limited to 12 VSA §1612 and any applicable Board of Health confidentiality regulations. The Grantee shall ensure that all of its employees and subgrantees performing services under this agreement understand the sensitive nature of the information that they may have access to and sign an affirmation of understanding regarding the information's confidential and non-public nature.

   Social Security numbers: The Grantee agrees to comply with all applicable Vermont State Statutes to assure protection and security of personal information, including protection from identity theft as outlined in Title 9, Vermont Statutes Annotated, Ch. 62.

8. **Abuse Registry.** The Grantee agrees not to employ any individual, use any volunteer, or otherwise provide reimbursement to any individual in the performance of services connected with this agreement, who provides care, custody, treatment, transportation, or supervision to children or vulnerable adults if there is a substantiation of abuse or neglect or exploitation against that individual. The Grantee will check the Adult Abuse Registry in the Department of Disabilities, Aging and Independent Living. Unless the Grantee holds a valid child care license or registration from the Division of Child Development, Department for Children and Families, the Grantee shall also check the central Child Protection Registry. (See 33 V.S.A. §4919(a)(3) & 33 V.S.A. §6911(c)(3)).

9. **Reporting of Abuse, Neglect, or Exploitation.** Consistent with provisions of 33 V.S.A. §4913(a) and §6903, any agent or employee of a Grantee who, in the performance of services connected with this agreement, has contact with clients or is a caregiver and who has reasonable cause to believe that a child or vulnerable adult has been abused or neglected as defined in Chapter 49 or abused, neglected, or exploited as defined in Chapter 69 of Title 33 V.S.A. shall make a report involving children to the Commissioner of the Department for Children and Families within 24 hours or a report involving vulnerable adults to the Division of Licensing and Protection at the Department of Disabilities, Aging, and Independent Living within 48 hours. This requirement applies except in those instances where particular roles and functions are exempt from reporting under state and federal law. Reports involving children shall

contain the information required by 33 V.S.A. §4914. Reports involving vulnerable adults shall contain the information required by 33 V.S.A. §6904. The Grantee will ensure that its agents or employees receive training on the reporting of abuse or neglect to children and abuse, neglect or exploitation of vulnerable adults.

10. **Intellectual Property/Work Product Ownership.** All data, technical information, materials first gathered, originated, developed, prepared, or obtained as a condition of this agreement and used in the performance of this agreement - including, but not limited to all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video or audio), pictures, drawings, analyses, graphic representations, software computer programs and accompanying documentation and printouts, notes and memoranda, written procedures and documents, which are prepared for or obtained specifically for this agreement - or are a result of the services required under this grant - shall be considered "work for hire" and remain the property of the State of Vermont, regardless of the state of completion - unless otherwise specified in this agreement. Such items shall be delivered to the State of Vermont upon 30 days notice by the State. With respect to software computer programs and / or source codes first developed for the State, all the work shall be considered "work for hire," i.e., the State, not the Grantee or subgrantee, shall have full and complete ownership of all software computer programs, documentation and/or source codes developed.

    The Grantee shall not sell or copyright a work product or item produced under this agreement without explicit permission from the State.

    If the Grantee is operating a system or application on behalf of the State of Vermont, then the Grantee shall not make information entered into the system or application available for uses by any other party than the State of Vermont, without prior authorization by the State. Nothing herein shall entitle the State to pre-existing Grantee's materials.

11. **Security and Data Transfers.** The State shall work with the Grantee to ensure compliance with all applicable State and Agency of Human Services' policies and standards, especially those related to privacy and security. The State will advise the Grantee of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Grantee to implement any required.

    The Grantee will ensure the physical and data security associated with computer equipment - including desktops, notebooks, and other portable devices - used in connection with this agreement. The Grantee will also assure that any media or mechanism used to store or transfer data to or from the State includes industry standard security mechanisms such as continually up-to-date malware protection and encryption. The Grantee will make every reasonable effort to ensure media or data files transferred to the State are virus and spyware free. At the conclusion of this agreement and after successful delivery of the data to the State, the Grantee shall securely delete data (including archival backups) from the Grantee's equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

12. **Computing and Communication:** The Grantee shall select, in consultation with the Agency of Human Services' Information Technology unit, one of the approved methods for secure access to the State's systems and data, if required. Approved methods are based on the type of work performed by the Grantee as part of this agreement. Options include, but are not limited to:

    1. Grantee's provision of certified computing equipment, peripherals and mobile devices, on a separate Grantee's network with separate internet access. The Agency of Human Services' accounts may or may not be provided.
    2. State supplied and managed equipment and accounts to access state applications and data, including State issued active directory accounts and application specific accounts, which follow the National Institutes of Standards and Technology (NIST) security and the Health Insurance Portability &

Accountability Act (HIPAA) standards.

The State will not supply e-mail accounts to the Grantee.

13. **Lobbying.** No federal funds under this agreement may be used to influence or attempt to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendments other than federal appropriated funds.

14. **Non-discrimination.** The Grantee will prohibit discrimination on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, or on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. No person shall on the grounds of sex (including, in the case of a woman, on the grounds that the woman is pregnant) or on the grounds of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination, to include sexual harassment, under any program or activity supported by state and/or federal funds.

    The grantee will also not refuse, withhold from or deny to any person the benefit of services, facilities, goods, privileges, advantages, or benefits of public accommodation on the basis of disability, race, creed, color, national origin, marital status, sex, sexual orientation or gender identity under Title 9 V.S.A. Chapter 139.

15. **Environmental Tobacco Smoke.** Public Law 103-227, also known as the Pro-children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, child care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds.

    The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

    Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

    Grantees are prohibited from promoting the use of tobacco products for all clients. Facilities supported by state and federal funds are prohibited from making tobacco products available to minors.

From: Leriche, Lucy Rose
To: Lockerby, Yvonne
Cc: Sullivan, Eileen; Spottswood, Eleanor
Subject: Re: TX question
Date: Wednesday, July 18, 2018 3:09:10 PM

Wow, that's impressive and very good to know. Thank you for finding out for us, Yvonne!
Lucy

Sent from my iPhone

On Jul 18, 2018, at 9:46 AM, Lockerby, Yvonne
<Yvonne.Lockerby@ppnne.org<mailto:Yvonne.Lockerby@ppnne.org>> wrote:

FYI

Yvonne Lockerby, Vice President of Centralized Operations
Planned Parenthood of Northern New England
784 Hercules Drive, Colchester, Vermont 05446
O: 802-448-9775 | C: 802-233-6585
www.ppnne.org|yvonne.lockerby@ppnne.org<http://www.ppnne.org|yvonne.lockerby@ppnne.org>

From: Swartz, Kimberly [mailto:kimberly.swartz@vermont.gov]
Sent: Wednesday, July 18, 2018 9:06 AM
To: Lockerby, Yvonne
Subject: RE: TX question

Hi Yvonne,

According to our business office it has probably been since 1970, when Title X was enacted. There may have been some funds to support family planning services prior to that (possibly mid to late 60s), but for Title X specifically, I think 1970 is the most accurate date.

I hope this helps.
Kim

From: Lockerby, Yvonne <Yvonne.Lockerby@ppnne.org<mailto:Yvonne.Lockerby@ppnne.org>>
Sent: Tuesday, July 17, 2018 11:41 AM
To: Swartz, Kimberly <kimberly.swartz@vermont.gov<mailto:kimberly.swartz@vermont.gov>>
Subject: TX question

Hi Kim,

Do you have any idea how long Vermont has been receiving Title X funds? It's pre-dates my time at PPNNE and I didn't know if you had an easy way of getting to that information.

Thanks
Yvonne

Yvonne Lockerby, Vice President of Centralized Operations
Planned Parenthood of Northern New England
784 Hercules Drive, Colchester, Vermont 05446
O: 802-448-9775 | C: 802-233-6585
www.ppnne.org|yvonne.lockerby@ppnne.org<http://www.ppnne.org|yvonne.lockerby@ppnne.org>

From: Leriche, Lucy Rose
To: Diamond, Joshua; Spottswood, Eleanor
Cc: Sullivan, Eileen
Subject: Presser tomorrow
Date: Tuesday, July 17, 2018 9:30:18 PM

Hi Josh and Ella,
I just wanted to let you know that we were not able to get a clinician or a patient for tomorrow's presser, but Meagan, our CEO and President will be there with prepared remarks, as you know. Looking forward to seeing you tomorrow!
Lucy

Sent from my iPhone

From: Spottswood, Eleanor
To: Clark, Charity
Subject: RE: Draft press release on Title X
Date: Tuesday, July 17, 2018 11:48:00 AM
Attachments: Title X Press Release CRC edits -elps.docx

This looks great! Just a couple of suggestions attached. And, I guess I prefer "Eleanor" for press purposes.
Thanks!
Ella

From: Clark, Charity
Sent: Tuesday, July 17, 2018 11:28 AM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: FW: Draft press release on Title X
I spelled your name wrong. Sorry!

From: Clark, Charity
Sent: Tuesday, July 17, 2018 11:27 AM
To: Donovan, Thomas <Thomas.Donovan@vermont.gov>; Diamond, Joshua <Joshua.Diamond@vermont.gov>; 'ella.spotswood@vermont.gov' <ella.spotswood@vermont.gov>
Subject: Draft press release on Title X
Hi, all,

Here is the draft press release for tomorrow's conference on Title X. Please let me know if you have any edits. Note that we are still waiting for PPNNE's quote. T.J., please let me know if you approve your quotes: "Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont." And "It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE: CONTACT: Ella Spottswood
July 18, 2018 Assistant Attorney General
802-828-3178

AG DONOVAN REQUESTS PUBLIC FEEDBACK ON RULE CHANGE AFFECTING WOMEN'S AND REPRODUCTIVE HEALTHCARE

Reproductive Health Clinics Jeopardized By Proposed Federal Regulations

MONTPELIER – Attorney General T.J. Donovan today announced the launch of a website to

allow Vermonters to provide feedback on a proposed rule affecting clinics that receive Title X funds. The U.S. Department of Health and Human Services (HHS) is writing new rules for recipients of Title X. Title X is the only nationwide program for affordable birth control and reproductive health care. The proposed rules would implement a "gag rule" on abortion referrals and redirect clinicians from the CDC's birth control recommendations to "natural family planning methods." HHS is accepting public comments on the new rules until July 31. The AG's website where the public can provide feedback is located at: http://ago.vermont.gov/act_now_for_womens_health/.

"Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont."

Vermont has relied on funding from Title X for decades. Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV. As a result of the new regulations, however, Title X providers will be forced to give incomplete and misleading information to patients—a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. But the rules don't stop there. The gag rule would also apply to any "referral partners" of Title X clinics. And, the new rules stretch Title X funding to try to cover gap in health care created by employers who opt out of providing insurance to cover contraception. The new rules also redefine "family planning" itself to promote "natural family planning methods" over more effective forms of birth control. The new rules never mention the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations. Title X funding is not used for abortions. In addition, the new rules require Title X clinic to be physically located in a separate facility from any abortion provider.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington,

Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules.

"It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

[PPNNE quote]

Vermonters who are concerned about the impact of these regulations can get more information and submit comments through a website set up by the Attorney General's Office: http://ago.vermont.gov/act_now_for_womens_health/

More information about the changes to Title X can be found at the independent Guttmacher Institute: https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State St.
Montpelier, Vermont 05609
802-828-3737

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE:
July 18, 2018

CONTACT: Eleanor~~la~~ Spottswood
Assistant Attorney General
802-828-3178

AG DONOVAN REQUESTS PUBLIC FEEDBACK ON RULE CHANGE AFFECTING WOMEN'S AND REPRODUCTIVE HEALTHCARE

Reproductive Health Clinics Jeopardized By Proposed Federal Regulations

MONTPELIER – Attorney General T.J. Donovan today announced the launch of a website to allow Vermonters to provide feedback on a proposed rule affecting clinics that receive Title X funds. The U.S. Department of Health and Human Services (HHS) is writing new rules for recipients of Title X funding. Title X is the only nationwide program for affordable birth control and reproductive health care. The proposed rules would implement a "gag rule" on abortion referrals and redirect ~~clinicians~~ funding priorities from the CDC's birth control recommendations to "natural family planning methods." HHS is accepting public comments on the new rules until July 31. The AG's website where the public can provide feedback is located at: http://ago.vermont.gov/act_now_for_reproductive_health/~~http://ago.vermont.gov/act_now_for_womens_health/~~.

"Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont."

Vermont has relied on funding from Title X for decades. Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV. As a result of the

Commented [CC1]: Ella, I think just "reptroductive healthcare" is too narrow, but I also understand your point about "women's healthcare." Should we reword this and how?

Commented [SE2R1]: This seems ok to me.

Commented [SE3]: I had Jay change the url when I did my gender edit of the website—but I'm sure he can change it back if you want.

new regulations, however, Title X providers will be forced to give incomplete and misleading information to patients—a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. But the rules don't stop there. The gag rule would also apply to any "referral partners" of Title X clinics. And, the new rules stretch Title X funding to try to cover gap in health care created by employers who opt out of providing insurance to cover contraception. The new rules also redefine "family planning" itself to promote "natural family planning methods" over more effective forms of birth control. The new rules never mention the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations. ~~Title X funding is not used for abortions.~~ In addition, the new rules require Title X clinic to be physically located in a separate facility from any abortion provider. Title X funding is not, and never has been, used for abortions.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules.

"It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

[PPNNE quote]

Vermonters who are concerned about the impact of these regulations can get more information and submit comments through a website set up by the Attorney General's Office: http://ago.vermont.gov/act_now_for_womens_health/

More information about the changes to Title X can be found at the independent Guttmacher Institute: https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x

# # #

From: Lockerby, Yvonne
To: Leriche, Lucy Rose
Cc: Spottswood, Eleanor
Subject: RE: For AG Press Conference tomorrow
Date: Tuesday, July 17, 2018 11:31:37 AM

Hi Lucy,

The audits related to Vermont Title X are actually of the direct grantee, Vermont Dept of Health. We have been the sole subgrantee for more than 15 years – I can try to find out from VDH if you need it but it might be challenging.

Thanks

Yvone

Yvonne Lockerby, Vice President of Centralized Operations
Planned Parenthood of Northern New England
784 Hercules Drive, Colchester, Vermont 05446
O: 802-448-9775 | C: 802-233-6585
www.ppnne.org|yvonne.lockerby@ppnne.org

From: Leriche, Lucy Rose
Sent: Tuesday, July 17, 2018 10:46 AM
To: Lockerby, Yvonne
Cc: Spottswood, Eleanor
Subject: For AG Press Conference tomorrow
Importance: High

Do we have a Title X audit that we can share with our friends at the AG's office?

How long has PPNNE been receiving Title X funds?

Lucy

Lucy Leriche(she/her/hers)
Vice President of Public Policy Vermont
Planned Parenthood Northern New England
784 Hercules Drive suite 110
Colchester, Vermont 05446
Cell: 802 598-4182
www.ppnne.org<http://www.ppnne.org/>
Lucy.Leriche@ppnne.org

From: Clark, Charity
To: Spottswood, Eleanor
Subject: FW: Draft press release on Title X
Date: Tuesday, July 17, 2018 11:28:20 AM
Attachments: Title X Press Release CRC edits.docx

I spelled your name wrong. Sorry!

From: Clark, Charity
Sent: Tuesday, July 17, 2018 11:27 AM
To: Donovan, Thomas <Thomas.Donovan@vermont.gov>; Diamond, Joshua <Joshua.Diamond@vermont.gov>; 'ella.spotswood@vermont.gov' <ella.spotswood@vermont.gov>
Subject: Draft press release on Title X

Hi, all,

Here is the draft press release for tomorrow's conference on Title X. Please let me know if you have any edits. Note that we are still waiting for PPNNE's quote. T.J., please let me know if you approve your quotes: "Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont." And "It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE: CONTACT: Ella Spottswood
July 18, 2018 Assistant Attorney General
802-828-3178

AG DONOVAN REQUESTS PUBLIC FEEDBACK ON RULE CHANGE AFFECTING WOMEN'S AND REPRODUCTIVE HEALTHCARE

Reproductive Health Clinics Jeopardized By Proposed Federal Regulations

MONTPELIER – Attorney General T.J. Donovan today announced the launch of a website to allow Vermonters to provide feedback on a proposed rule affecting clinics that receive Title X funds. The U.S. Department of Health and Human Services (HHS) is writing new rules for recipients of Title X. Title X is the only nationwide program for affordable birth control and reproductive health care. The proposed rules would implement a "gag rule" on abortion referrals and redirect clinicians from the CDC's birth control recommendations to "natural

family planning methods." HHS is accepting public comments on the new rules until July 31. The AG's website where the public can provide feedback is located at: http://ago.vermont.gov/act_now_for_womens_health/.

"Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont."

Vermont has relied on funding from Title X for decades. Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV. As a result of the new regulations, however, Title X providers will be forced to give incomplete and misleading information to patients—a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. But the rules don't stop there. The gag rule would also apply to any "referral partners" of Title X clinics. And, the new rules stretch Title X funding to try to cover gap in health care created by employers who opt out of providing insurance to cover contraception. The new rules also redefine "family planning" itself to promote "natural family planning methods" over more effective forms of birth control. The new rules never mention the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations. Title X funding is not used for abortions. In addition, the new rules require Title X clinic to be physically located in a separate facility from any abortion provider.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules.

"It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from

people who support evidence-based health care," Donovan said.

[PPNNE quote]

Vermonters who are concerned about the impact of these regulations can get more information and submit comments through a website set up by the Attorney General's Office: http://ago.vermont.gov/act_now_for_womens_health/

More information about the changes to Title X can be found at the independent Guttmacher Institute: https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State St.
Montpelier, Vermont 05609
802-828-3737

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE:
July 18, 2018

CONTACT: Ella Spottswood
Assistant Attorney General
802-828-3178

AG DONOVAN REQUESTS PUBLIC FEEDBACK ON RULE CHANGE AFFECTING WOMEN'S AND REPRODUCTIVE HEALTHCARE

Reproductive Health Clinics Jeopardized By Proposed Federal Regulations

Commented [CC1]: Ella, I think just "reptroductive healthcare" is too narrow, but I also understand your point about "women's healthcare." Should we reword this and how?

MONTPELIER – Attorney General T.J. Donovan today announced the launch of a website to allow Vermonters to provide feedback on a proposed rule affecting clinics that receive Title X funds. The U.S. Department of Health and Human Services (HHS) is writing new rules for recipients of Title X. Title X is the only nationwide program for affordable birth control and reproductive health care. The proposed rules would implement a "gag rule" on abortion referrals and redirect clinicians from the CDC's birth control recommendations to "natural family planning methods." HHS is accepting public comments on the new rules until July 31. The AG's website where the public can provide feedback is located at: http://ago.vermont.gov/act_now_for_womens_health/.

"Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont."

Vermont has relied on funding from Title X for decades. Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV. As a result of the new regulations, however, Title X providers will be forced to give incomplete and misleading

information to patients—a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. But the rules don't stop there. The gag rule would also apply to any "referral partners" of Title X clinics. And, the new rules stretch Title X funding to try to cover gap in health care created by employers who opt out of providing insurance to cover contraception. The new rules also redefine "family planning" itself to promote "natural family planning methods" over more effective forms of birth control. The new rules never mention the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations. Title X funding is not used for abortions. In addition, the new rules require Title X clinic to be physically located in a separate facility from any abortion provider.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules.

"It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

[PPNNE quote]

Vermonters who are concerned about the impact of these regulations can get more information and submit comments through a website set up by the Attorney General's Office: http://ago.vermont.gov/act_now_for_womens_health/

More information about the changes to Title X can be found at the independent Guttmacher Institute: https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x

# # #

From: Leriche, Lucy Rose
To: Lockerby, Yvonne
Cc: Spottswood, Eleanor
Subject: For AG Press Conference tomorrow
Date: Tuesday, July 17, 2018 10:46:00 AM
Importance: High

Do we have a Title X audit that we can share with our friends at the AG's office?
How long has PPNNE been receiving Title X funds?
Lucy

Lucy Leriche(she/her/hers)
Vice President of Public Policy Vermont
Planned Parenthood Northern New England
784 Hercules Drive suite 110
Colchester, Vermont 05446
Cell: 802 598-4182
www.ppnne.org<http://www.ppnne.org/>
Lucy.Leriche@ppnne.org

From:	Clark, Charity
To:	Diamond, Joshua
Cc:	Spottswood, Eleanor
Subject:	Fwd: Title X stats and clinic locations
Date:	Wednesday, July 11, 2018 7:16:48 PM
Attachments:	cyf_TX Needs Assessment 2015.pdf ATT00001.htm

Perhaps we should have the press conference at one of these Title X health centers? None are in Burlington, but one is in St. Albans and another in Barre.

Charity

Sent from my iPhone

Begin forwarded message:

> **From:** "Spottswood, Eleanor" <Eleanor.Spottswood@vermont.gov>
> **Date:** July 11, 2018 at 5:57:42 PM EDT
> **To:** "Clark, Charity" <Charity.Clark@vermont.gov>
> **Subject: Title X stats and clinic locations**
>
> Charity-
> For future reference: this is the most recent document with Vermont-specific Title X data in it. A (rough) map of all the Title X clinic locations is on pdf page 9.
> Thanks for your help today!
> Ella
> Eleanor L.P. Spottswood
> Assistant Attorney General
> Vermont Attorney General's Office
> 109 State Street
> Montpelier, Vermont 05609
> 802-828-3178
> eleanor.spottswood@vermont.gov

From: Spottswood, Eleanor
To: Clark, Charity
Subject: Title X stats and clinic locations
Date: Wednesday, July 11, 2018 5:57:00 PM
Attachments: cyf_TX Needs Assessment 2015.pdf

Charity-

For future reference: this is the most recent document with Vermont-specific Title X data in it. A (rough) map of all the Title X clinic locations is on pdf page 9.

Thanks for your help today!

Ella

Eleanor L.P. Spottswood
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3178
eleanor.spottswood@vermont.gov

Vermont Title X
Family Planning Needs Assessment

Prepared by JSI Research & Training Institute, Inc. for the
Vermont Department of Health

October 2015

VERMONT
DEPARTMENT OF HEALTH

Table of Contents

Executive Summary

Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. For more than 45 years, Title X-funded health centers have provided high-quality cost-effective family planning and related preventive health services to low-income, under-insured and uninsured women and men who may otherwise lack access to health care. These health centers play a critical role in ensuring access to voluntary family planning information and services for their clients based on their ability to pay.

The 2015 Vermont Title X assessment process helps to ensure that the state's safety net for sexual and reproductive health services continues to meet the needs of women 15-44 years of age, particularly the most vulnerable. The findings and considerations from the Title X Needs Assessment will guide the Vermont Department of Health (Health Department) and other stakeholders in the planning, programming, and provision of services to ensure a high quality family planning service delivery system that supports Vermont's most vulnerable populations. This report provides a demographic description of Vermont as it relates to family planning, a description of Vermont's Title X family planning system, and a description of Vermont's family planning and reproductive health services and population needs. A summary of the findings and considerations follow.

Vermont Population

- Vermont is one of the most rural states in the U.S., and one of the smallest, with about 626,630 residents in 2013.
- Over 60% of Vermonters live in rural areas of the state. By a large majority, most Vermonters are white (95%), non-Hispanic (98%).
- In 2013, 9% of the Vermont population was under 100% of the federal poverty level (FPL).

Insurance Status

- In 2014, 21% or 132,829 of Vermonters were covered by Medicaid.
- In 2014, about 3.7% or 23,000 Vermonters were uninsured.

Unintended Pregnancy & Teen Pregnancy

- About half of pregnancies among Vermonters are unintended.
- In 2013, the pregnancy rate in Vermont was 61.2 pregnancies per 1,000 women age 15 to 44. The teen pregnancy rate was 21.9 pregnancies per 1,000 women age 15 to 19 years.

Births & Infant Mortality

- In 2013, Vermont had a birth rate of 51.2 births per 1,000 women 15-44 years of age. The teen birth rate was 14.5 births per 1,000 women 15-19 years of age.
- In 2013, Vermont had a preterm birth rate of 8.1%, a low birthweight rate of 7.0%, and an infant mortality rate of 5.0%.

Sexually Transmitted Infections & HIV

- Vermont ranks 44th in rates of syphilis and 46th in rates of both chlamydia and gonorrhea among the 50 states.
- In 2012, the rate of primary and secondary syphilis was 1.0 per 100,000 Vermonters, the rate of chlamydia infections was 275.2 per 100,000 and the rate of gonorrhea was 408.1 per 100,000.
- In 2011, 12 adults and adolescents were diagnosed with HIV in Vermont. Vermont ranked 50th among the 50 states in the number of HIV diagnoses.

Title X in Vermont

The Health Department, the Title X grantee for the state of Vermont, contracts with Planned Parenthood of Northern New England (PPNNE) to provide Title X supported family planning services throughout the state, with a special focus on serving low-income and rural populations.

- In 2013, Title X family planning services helped women in Vermont avoid 2,000 unintended pregnancies, 1000 unplanned births, and 700 abortions, including 400 pregnancies to teens, 200 births to teens, and 100 abortions to teens.
- In 2014, PPNNE's Title X health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont.
    - 47% had incomes at or below 100% of the FPL
    - 77% had incomes at or below 250% of the FPL
    - 24% were uninsured
    - 21% were teens under the age of 20, and
    - 11% were men.

- In 2014, 7714 female clients not pregnant or seeking pregnancy were using the following contraceptive methods:
    - 53% Moderately effective hormonal method – pill, patch, ring, Depo
    - 16% Long-acting reversible contraception (LARC) – IUD or implant
    - 3% Permanent sterilization

- In 2014, of the 776 male clients not seeking pregnancy, 65% were using the male condom, 1% vasectomy, 1% withdrawal, and 2% relied on a female method for contraception.

Strengths & Challenges of Vermont's Family Planning Service Delivery System

- Vermont's Title X-funded health centers provide comprehensive, standardized, high-quality, timely and accessible family planning and reproductive health care throughout the state.
- Vermont's expanded Medicaid program and the Access Plan bolster access to family planning services in the state. Vermont has a relatively low proportion of uninsured individuals.
- Vermont has done good work in HIV and sexuality education within schools using research and evidence-based curricula. School Liaisons and school nurses work to coordinate with local parent child centers and providers to support student reproductive and sexual health needs.
- Energy and efforts to improve access to LARC methods in Vermont, specifically within PPNNE's network of health centers, have been successful in promoting use. Remaining challenges exist, including attitudes and beliefs on use of LARC and reimbursement barriers for providing LARC.

- Disparities in unmet family planning need and health outcomes exist in vulnerable population groups throughout the state, including individuals with low income; teens; individuals with mental health and/or substance abuse issues; lesbian, gay, bisexual, transgender and queer population; racial and ethnic minorities; and incarcerated women.

Summary & Considerations

This review of Vermont's family planning system and population needs presents a positive picture overall. The family planning system is thought to have good access with high quality, comprehensive services, and a supportive landscape. In addition to the 10 Title X funded health centers, Vermont has a broad network of safety-net providers supporting the health care needs of residents throughout the state. Key health and reproductive health indicators also present a favorable status for Vermonters. Most all Vermonters now have health insurance and Vermont's infant mortality, preterm birth, and low weight birth rates rank lower than national rates. Furthermore, the teen pregnancy rate and overall fertility rate for Vermont continue to decline while post-partum contraceptive use is high among Vermonters.

Despite these gains, this review indicates remaining challenges for Vermont. The rate of intended pregnancy remains relatively consistent at about 50%, well below the 65% Healthy Vermonters 2020 goal. Furthermore, fewer than half (49%) of mothers whose pregnancies were unintended reported using any method of birth control. Alcohol and tobacco use during pregnancy remain consistently high compared to other states. Several sub-populations of concern were noted as having disparate unmet family planning need due to financial, transportation, and cultural barriers.

In the context of the gains, strengths, and challenges for Vermont's family planning service delivery system, the following focus areas are called out for consideration and intended to guide future efforts of the Health Department and other family planning programs and stakeholders in Vermont.

I. Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding.

II. Promote awareness, implementation, and adherence to evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.

III. Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling.

IV. Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's heath centers); support innovations and solutions to promote access and awareness of LARC.

V. Facilitate linkages between primary care providers and Title X health centers in Vermont.

VI. Increase provider and consumer knowledge of covered family planning and related preventive health services.

VII. Explore potential opportunities to address family planning, reproductive and sexual health needs of adolescents within school-based health centers in Vermont.

VIII. Explore opportunities for clinical-community linkages between Vermont Title X health centers and community based organizations to establish family planning—human service referral networks.

The considerations are further described on page 25 of the full report.

Introduction

The Title X family planning program is the nation's only dedicated source of federal funding for comprehensive family planning and related preventive health services. The United States Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program and funds a network of family planning centers across the country that serve about five million low-income women and men each year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, and other private nonprofits. In addition, Title X is the only federal program that funds critical infrastructure needs not paid for under Medicaid and private insurance, such as staff salaries, patient education, and community education about family planning and sexual health issues. Title X is also used to subsidize health center rent, utilities, and health information technology.

For more than 45 years, the Title X program has supported clinics to provide family planning services and other preventive health care to low-income, under-insured and uninsured individuals who may otherwise lack access to health care. Title X family planning centers play a critical role in ensuring access to voluntary family planning information and services. They provide high quality, culturally-sensitive, and cost-effective family planning and related preventive health services for low-income women and men including a broad range of FDA-approved contraceptive methods and related counseling; as well as breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals.

Title X in a Changing Health Care Environment. Title X, like many large and historical grant programs, was significantly and positively impacted by the passage of the Patient Protection and Affordable Care Act (ACA). ACA put in place comprehensive health insurance reform expanding access to sexual and reproductive health services thus decreasing the likelihood that coverage is the predominant access issue. The law makes preventive care—including family planning and related care—more accessible and affordable for many Americans. With the implementation of the ACA and expansion of Medicaid, more Americans, including Vermonters, will have health insurance, including coverage of a full range of family planning and related preventive services without out-of-pocket costs. As the health care systems in the United States (U.S.) and Vermont reform, Title X-funded health centers will continue to be important safety-net providers, and will continue to serve: individuals who don't qualify for health insurance, underinsured individuals, insured and uninsured individuals where confidentiality cannot be ensured (e.g., adolescents), and individuals who want to continue receiving care at a family planning site.

Additionally, as our health system evolves to expand access to care, initiatives to improve and ensure quality of care are also being implemented. In 2014, the OPA and Centers for Disease Control and Prevention (CDC) released new recommendations called *Providing Quality Family Planning Services*

(QFP).[1] The QFP provides clear evidence-based clinical practice guidelines intended to improve the quality of family planning services and thereby improve reproductive health outcomes. The QFP recommendations: (1) define a core set of family planning services for women and men, including contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services; (2) describe how to provide contraceptive and other clinical services, serve adolescents, and conduct quality improvement; and (3) encourage the use of the family planning visit to provide selected preventive health services for women, in accordance with the national recommendations for guideline-based care for women. The QFP recommendations supplement the *Title X Program Requirements*[2] and are intended for all providers of family planning services, in addition to Title X-funded programs. Implementing the QFP clinical guidelines in addition to Title X Program Requirements will help Title X-funded programs improve family planning service delivery and provide the services and supports couples need to achieve their desired number and spacing of children.

Title X-funded health centers serve a fundamental role in providing health care to Vermonters. Compared to other health providers in the state, Title X centers in Vermont are ahead of the curve in providing comprehensive high-quality, guideline-based, culturally competent family planning and reproductive health care. However, there is still room for improvement. The 2015 Vermont Title X assessment process helps to ensure that the state's safety net for sexual and reproductive health services continues to meet the needs of women 15-44 years of age, particularly the most vulnerable. The findings and considerations from the Title X Needs Assessment will guide the Vermont Department of Health (Health Department), policy makers, healthcare providers, health and human service organizations, schools and communities in Vermont in their planning, programming, and provision of services to ensure a high quality family planning service delivery system that supports Vermont's most vulnerable populations. This report provides a demographic description of Vermont as it relates to family planning, a description of Vermont's Title X family planning system and services, and a description of Vermont's family planning and reproductive health services and population needs.

Needs Assessment Process

Vermont's approach to the 2015 Title X Needs Assessment was designed to examine both strengths and needs of the state's family planning service delivery system, and the family planning and reproductive health needs of Vermonters. Additionally, the QFP,[3] which provides recommendations for delivering quality family planning services, was used as a framework to inform the needs assessment and its findings and considerations.

[1] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).
[2] Office of Population Affairs. Program Requirements for Title X Funded Family Planning Projects. April 2014.
[3] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).

Overall direction for Vermont's 2015 Title X Needs Assessment was provided by the Health Department Director of Preventive Reproductive Health, including input on the assessment process, identification of stakeholders to participate in key informant interviews and group discussion, review of data as well as the development of the final report and considerations. The 2015 Title X Needs Assessment consisted of two primary information gathering processes: (1) review and analysis of public health surveillance data, including secondary quantitative data (e.g., Family Planning Annual Report) and (2) qualitative data collected through a series of key informant interviews and group discussions with Vermont's family planning and maternal and child health (MCH) stakeholders. Stakeholders represented Planned Parenthood of Northern New England (PPNNE), MCH Coordinators, Parent Child Centers, public health professionals, School Liaisons, medical providers, human service providers (e.g. early childhood) and state program administrators. Over 40 stakeholders were identified who then participated in either individual or group discussions with a total of 23 conducted. Interviews and group discussions explored family planning and related preventive health service needs, including needs of vulnerable populations; family planning systems and supports, including quality; strengths and challenges for family planning services; and, opportunities for improvements and/or assets to be leveraged. A complete list of interviewees and interview guides are available in Appendix I.

Vermont's Family Planning Safety-Net

Title X. Vermont has been funded by the Title X program since its inception, with the overarching goal to *provide high quality clinical family planning and related preventive health services, education, and counseling to Vermonters who would otherwise not have access, with a special focus on low-income and rural populations*. The Vermont Department of Health, the Title X grantee for the state of Vermont, contracts with Planned Parenthood of Northern New England (PPNNE) to provide Title X supported family planning services throughout the state. Ten of PPNNE's 12 Vermont health centers are supported with Title X funds; Title X sites are located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury

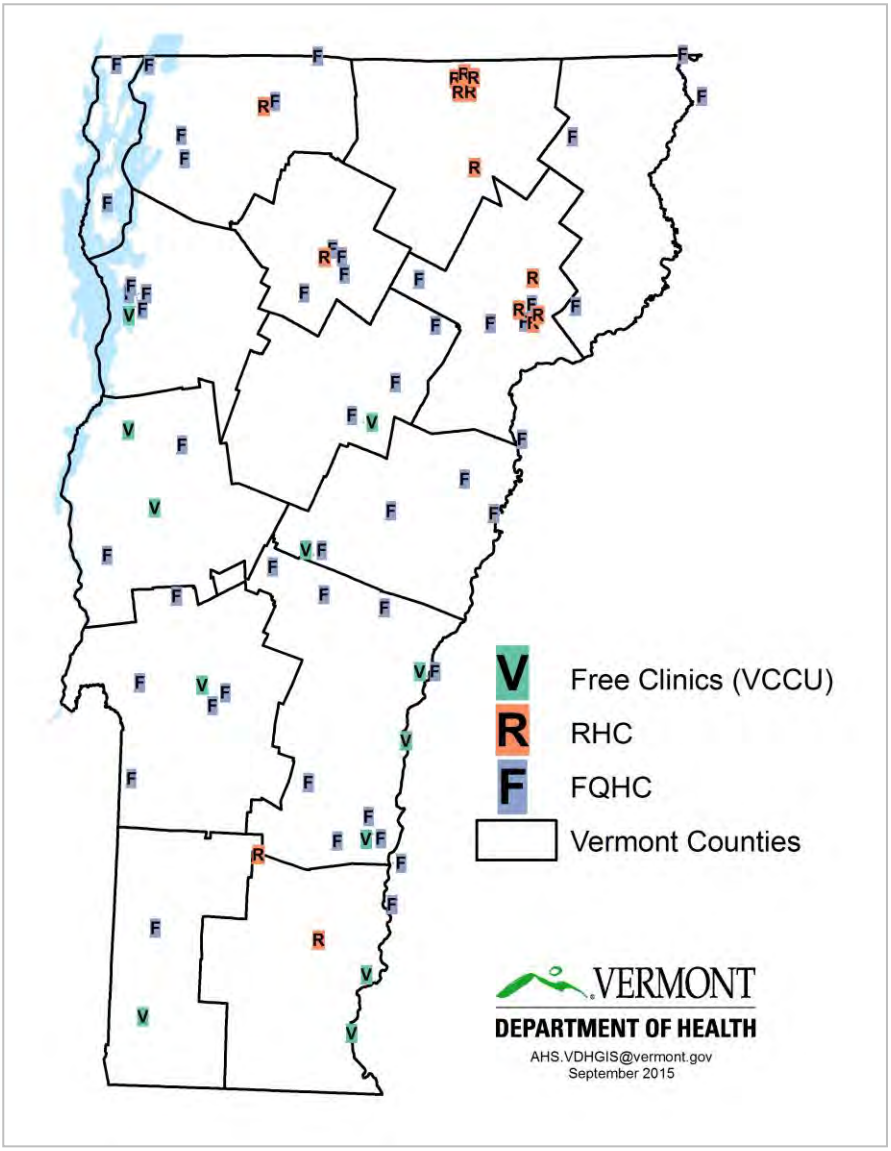
Figure 1. PPNNE Vermont Health Center Sites, 2015

and White River Junction[4] (Figure 1). At present, the PPNNE health centers in Burlington and Williston are not Title X sites. This network of health centers serves as a foundation for providing sexual and reproductive health, and related preventive health services to Vermont's low-income and vulnerable populations.

The state's Title X-funded health centers provide comprehensive family planning and related preventive health services, including contraceptive services; pregnancy testing and counseling; screening, testing, and treatment for sexually transmitted infections; rapid HIV testing; screening for breast, cervical, colorectal, and testicular cancer; preconception education and prenatal referral; basic fertility services; well woman visits; screening for high blood pressure, diabetes and obesity; and referrals for other health and social services. All services provided are based on and adhere to national clinical guidelines and recommendations.

Other Safety-Net Providers. In addition to Vermont's network of Title X health centers, several other organizations and clinics make up Vermont's safety net, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), free clinics, and Vermont's hospital system. Across the country FQHCs and RHCs play a critical role in many communities in ensuring access to care for the uninsured and underinsured. FQHCs and RHCs provide primary care in areas designated by the federal government as underserved; and benefit from an enhanced reimbursement for Medicaid and Medicare services.

There are 12 FQHCs and 12 RHCs located throughout Vermont (Figure 2). FQHCs provide comprehensive



[4]The White River Junction health center site is currently funded by New Hampshire's Title X funding.

Figure 2. Vermont healthcare safety-net sites: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Vermont free clinics. 2015

primary care services across the life span. They are organized as a network of clinics or satellites with a central administration. In Vermont, FQHCs have about 50 primary care sites located in 13 of the state's 14 counties.[5] RHCs are only developed in rural areas and specialize in primary care (pediatrics, internal medicine, family practice, obstetrics).

Vermont's network of free clinics adds further strength to the state's safety net system. The Vermont Coalition of Clinics for the Uninsured (VCCU) is the association of 10 organizations serving the needs of Vermonters without adequate medical and dental insurance and without the means to pay for their health care. Six of these clinics provide onsite medical care by volunteer clinician teams, three offer dental care, and four refer patients to available local clinicians. At each clinic, adult patients are screened for eligibility for various public assistance programs including hospital affordable care programs and Medicaid extension programs.[6]

Vermont's hospitals are also an important safety-net provider of the family planning service delivery system. In particular are Vermont's eight critical access hospitals located in rural communities throughout the state and serve as the first line of defense in emergency situations. The critical access hospitals are all non-profit and required by Vermont to provide care to anyone who walks in the door without regard to insurance status or ability to pay.

Other Vermont Resources to Support Family Planning Needs

Other assets in the state intended to support the reproductive and sexual health needs of Vermonters include: "The Access Plan", the Vermont Sexual Health & Education Program (V-SHEP), the Personal Responsibility Education Program or PREP, school-based health centers, and the Department for Vermont Health Access Medicaid Obstetrical and Maternal Support (MOMS) Program.

Nationally and in Vermont, innovative Medicaid-related initiatives are being implemented to increase access to family planning services. In 2012, the Health Department initiated a program with PPNNE branded "The Access Plan". Vermont has not yet implemented the State eligibility option for family planning services and The Access Plan offers the same statewide scope of services for the same population, using funding through Vermont's 1115 Medicaid waiver. This program provides access to free, confidential and convenient family planning services and supplies to men and women in Vermont who have incomes below 200% FPL and are underinsured or uninsured. Eligible individuals can enroll in The Access Plan at any PPNNE health center in Vermont. Covered services include birth control, annual exams, STI testing and treatment, patient education and counseling, and others.

In 2013 Vermont received a CDC grant award called "Promoting Adolescent Health Through School-Based HIV/STD Prevention" to create the Vermont Sexual Health & Education Program (V-SHEP). From 2013-2018 the Agency of Education is working with 15 supervisory unions and school districts throughout Vermont to assist in improving sexual health and education for middle and high school students. There are three main components to this work: providing comprehensive sexual health

[5] Vermont State Office of Rural Health and Primary Care, 2015
[6] Vermont State Office of Rural Health and Primary Care, 2015

education, working with school nurses to ensure all students have a medical home and receive guideline-based preventive pediatric health care, and providing a learning environment in which all students can expect to feel safe and supported. The Agency of Education is partnering with several local and national partners to implement this work including Outright Vermont in Burlington, The Center for Health and Learning in Brattleboro, and Answer, which is a national sexual education organization.

In 2011, the Health Department was awarded a Personal Responsibility Education Program (PREP) grant to support comprehensive education on sexual health, abstinence, and contraception for the prevention of pregnancy and sexually transmitted infections (STIs). The program targets youth between ages 10-19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen birth rates, or come from racial or ethnic minority groups. The program also supports pregnant and parenting youth under 21 years of age. The Health Department is currently funding six community-based organizations throughout the state to implement PREP; PREP is offered at 13 sites across the state and will serve approximately 440 youth in the 2015 grant year.

School-based health centers (SBHC) have become an important method of health care delivery for youth throughout the country. They provide a variety of health care services to youth in a convenient and accessible environment. Although SBHC models vary, they are typically operated as a partnership between the school and a community health organization, such as a community health center. The services provided by SBHCs vary based on community needs and resources as determined through collaborations between the community, the school district and the health care providers. Currently, there are about five SBHCs in Vermont, including in Burlington High School and in St. Albans. The structure of SBHCs in Vermont varies depending on need and they are intended to supplement rather than replace the medical home. They assure the provision of key physical and mental health services as well as preventive health services.

The MOMS Program is administered through the Vermont Chronic Care Initiative (VCCI) at the Department of Vermont Health Access. The goal of this program is to improve pregnancy outcomes for Medicaid covered pregnant women considered high risk due to a mental health condition, substance use, and/or having had a previous pre-term delivery prior to 32 weeks gestation. Them MOMS Program provides enhanced prenatal care that includes a comprehensive psychosocial assessment, care coordination, an individualized maternity care plan, and referral to other social support services and resources that may result in improved pregnancy outcomes.

Vermont Geographic, Demographic & Socioeconomic Overview

Geography. Vermont is one of the most rural states in the U.S., and one of the smallest, with a population estimate of 626,630 in 2013.[7] Vermont has only one true urban area (i.e. metropolitan statistical area) comprised of Chittenden, Franklin, and Grand Isle counties. Over 60% of Vermont's population resides in rural areas.[8]

Demographics. In 2013, Vermont's population distribution by age was estimated as follows:[9]

- 19.6% children 0-17 years of age
- 33.8% adults 18-44 years of age
- 30.2% adults 45-64 years of age
- 16.4% 65 years of age and older

About 51% of Vermont's population is female.[10]

Although Vermont's racial and ethnic minority populations are growing, the large majority of Vermonters are white. In 2013, the population distribution by race and ethnicity was estimated as follows:[11]

- 95.2% White
- 1.2% Black or African American
- 0.4% American Indian and Alaska Native
- 1.4% Asian
- 1.8% Multiracial
- 1.7% Hispanic or Latino

Vermont's largest urban area, Chittenden County, is composed of greater racial and ethnic diversity compared to the state:[12]

- 92.2% White
- 2.3% Black or African American
- 0.3% American Indian and Alaska Native
- 3.2% Asian
- 2.0% Multiracial
- 2.0% Hispanic or Latino

Employment. Since July 2013, the Vermont economy has been steadily improving. As of May 2015, Vermont's unemployment rate was 3.6%, compared to a national rate of 5.5%. However, the

[7] Vermont Department of Health. Vermont Population Estimates 2013.
[8] Census Bureau. Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports. March 26, 2012. https://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html Accessed June 26, 2015.
[9] Vermont Department of Health. Vermont Population Estimates 2013.
[10] Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.
[11] Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.
[12] Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.

unemployment rate varies across counties, ranging from 2.5% in Chittenden County and 5.7% in Essex county, and across towns, ranging from 1.9% in Middlesex up to 17.3% in Killington.[13]

Income. In 2014, Vermont's average annual wage was $43,011, with higher wages in Chittenden County at $49,656 and the lowest wages in Grand Isle County at $31,111.[14] According to the 2014 federal poverty guidelines, an income of $23,850 for a family of four is equal to the federal poverty level (FPL).[15]

Poverty. In 2013, 9% of the Vermont population was under 100% FPL compared to 15% of the U.S. population;[16] and 19% of the Vermont population fell between 100%-199% FPL, equivalent to the U.S. population.[17]

Education. About 91% of Vermonters age 25 and older are high school graduates, compared to 86% of the U.S. population.[18] Just over three in ten (32%) Vermont adults have a college education or higher; four in ten or 39% have a high school education or less.[19]

Insurance Status. Children 0-18 years of age with a family income of 312% FPL are eligible for Medicaid in Vermont. Women who are pregnant with an income up to 208% FPL are eligible for Medicaid in Vermont. Vermont has expanded Medicaid coverage to low-income adults as well, up to 133% FPL.[20] In 2014, 21% or 132,829 Vermonters were insured by Medicaid.[21]

In 2014, it was estimated that 3.7% or 23,000 Vermonters were uninsured. Compared to 2012, the number of Vermont residents reporting no health insurance decreased by about 20,000 individuals (6.8% to 3.7%). About 1,300 of Vermont's uninsured population are under age 18, representing 1% of Vermont's children 0-17 years of age. About 2,900 or 4.6% of young adults 18-24 are uninsured and about 7,900 or 11% of adults 25-34 years of age are uninsured.[22]

[13] Vermont Department of Labor. Local Area Unemployment Statistics. May 2015.
[14] Vermont Department of Labor. Vermont Quarterly Census of Employment Wages. 2014.
[15] U.S. Department of Health and Human Services. 2014 Federal Poverty Guidelines.
[16] The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $18,751 in 2013.
[17] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[18] Census Bureau. Quick Facts Vermont. Accessed June 26, 2015.
[19] Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.
[20] Medicaid.gov. Vermont Profile. Accessed September 9, 2015.
[21] Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.
[22] Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.

Vermont Family Planning & Reproductive Health Overview

Women of Reproductive Age. In 2013 in Vermont, there were 116,335 women of reproductive age (aged 15–44).[23] According to Vermont's Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey conducted annually among adults 18 and older, in 2013:[24]

- 36% of women age 18-44 said a health care professional had ever spoken with them about ways to prepare for a healthy pregnancy and baby.
- 72% of women 18-44 said they used birth control at the last time they had sex. More than a third (36%) said it was a shot, pill, contraceptive patch or a diaphragm; 22% used a permanent method (i.e., sterilization); and 17% used a LARC.
- Women who did not use birth control during their most recent sex indicated most often it was because they were unable to get pregnant (43%) or they were seeking pregnancy (26%).

Births. In 2013, 5,951 babies were born to Vermont residents, representing a birth rate of 51.2 births per 1000 women 15-44 years of age (i.e., fertility rate), a slight decrease from 51.5 in 2012 and 51.6 in 2011. The teen birth rate in Vermont in 2013 was 14.5 births per 1000 women 15-19 years of age, compared to the U.S. rate of 26.5; 317 infants were born to Vermont mothers ages 15-19 in 2013.[25]

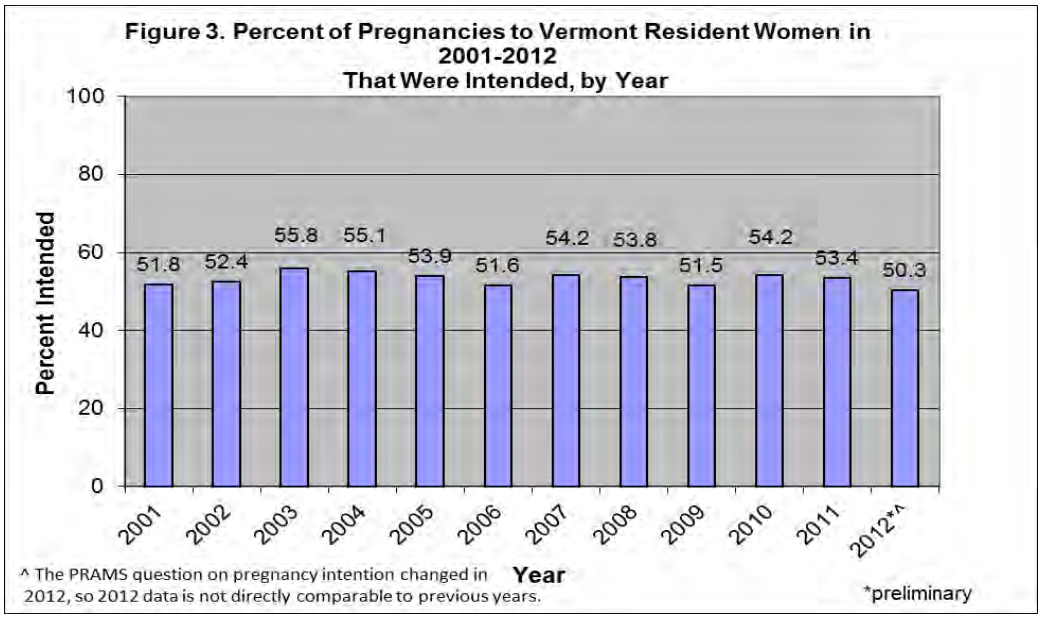
Vermont's preterm birth rate in 2013 was 8.1% compared to 11.4% among the U.S. population. Vermont's low birthweight rate in 2013 was 7% compared to 8% among the U.S. population. Vermont's infant mortality rate was 5.0% compared to 6.4% among the U.S. population.[26]

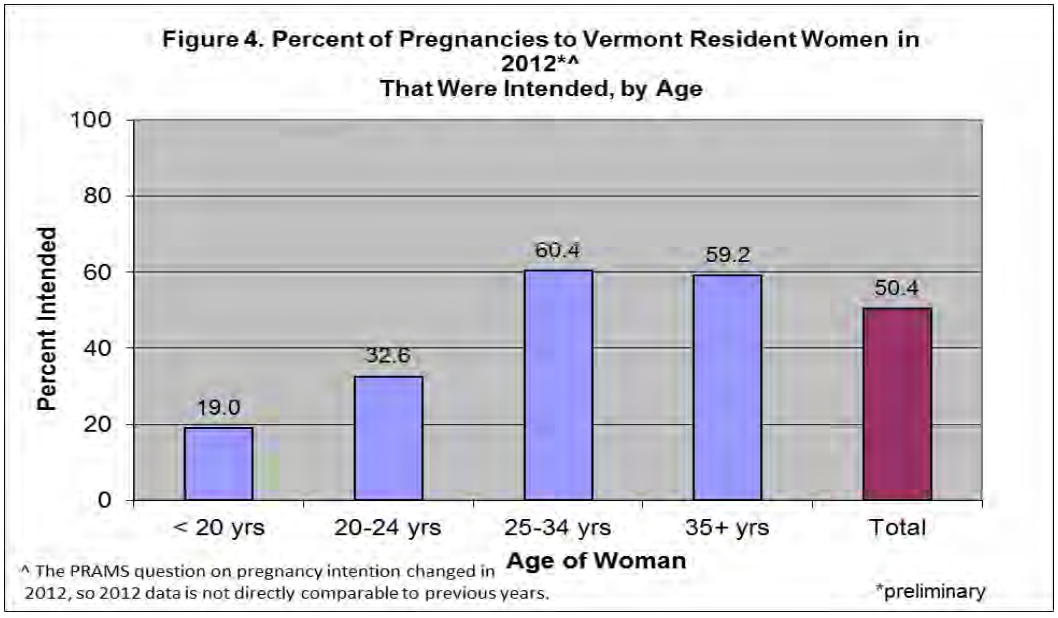
Pregnancy & Unintended Pregnancy. In 2013, the pregnancy rate in Vermont was 61.2 pregnancies per 1,000 women age 15 to 44, a decrease from 61.7 in 2012 and 62.4 in 2011. The 2013 teen pregnancy rate was 21.9 pregnancies per 1,000 women age 15 to 19 years, a decrease from 23.1 in 2012 and 25.2 in 2011. In general the teen pregnancy rate has been decreasing since 1991.[27]

Unintended Pregnancy. The Pregnancy Risk Assessment Monitoring System (PRAMS) helps public health professionals survey the population and track trends over time. The survey is of women who recently gave birth and asks about their experiences and behaviors before, during and shortly after their pregnancy. In 2012, PRAMS indicated that 39.8% of pregnancies among Vermont women who had a live birth were unintended. This is an increase from 2010 and 2011, in which 35.1% and 35.4% of Vermont pregnancies were reported as unintended, respectively. However, of note is a change in the 2012 PRAMS survey question on the intendedness of a pregnancy. The 2012 respondents were given the option of responding to the question with "I wasn't sure what I wanted". This answer option is included as unintended and therefore 2012 data are not directly comparable to previous years.[28]

[23] Vermont Department of Health. Vermont Population Estimates 2013.
[24] Vermont Behavioral Risk Factor Surveillance Survey. 2013 Data Summary.
[25] Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.
[26] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[27] Vermont Department of Health. Vital Statistics. Internal Communication.
[28] Vermont Department of Health. Pregnancy Risk Assessment Monitoring System. Internal Communication.

Using PRAMS data to estimate the percentage of women with live births who report their pregnancy was intended and applying this to Vermont's vital statistics data on the number of pregnancies, live births, and abortions (considered unwanted pregnancies), intended pregnancies among Vermont women can be further analyzed. Figure 3 displays the percent of pregnancies to Vermont women that were intended, by year, and Figure 4 displays the percent of pregnancies to Vermont women in 2012 that were intended, by age. According to 2012 data, 50.4% of pregnancies to Vermont women were intended relative to the Healthy Vermonters 2020 goal of 65%.[29]





[29] Vermont Department of Health. Pregnancy Risk Assessment Monitoring System and Vital Statistics.

Teen Sexual Behavior, Pregnancy & Birth Rate. In 2013, 43% of high school students in Vermont reported ever having sex and 44% reported ever having oral sex. Among those sexually active, 85% reported using prescription birth control or condoms at last sex. Twenty two percent of students reported using drugs or alcohol at last sex.[30]

Vermont has a relatively low teen pregnancy rate of 22 pregnancies per 1000 women 15-19 years of age, a decrease from 23.1 in 2012 and 25.2 in 2011. In 2013, there were 478 pregnancies to Vermont teens aged 15–19; 317 or 66% resulted in a live birth. Based on this data, the 2013 teen birth rate is 14.5 per 1,000 women 15-19 years of age, a decrease from a rate of 16.3 in 2012 and 16.8 in 2011.[31]

STIs & HIV.

Syphilis [32]

- In Vermont, the rate of primary and secondary syphilis was 1.8 per 100,000 in 2008 and 1.0 per 100,000 in 2012. Vermont ranks 44th in rates of syphilis among the 50 states.
- There were 0 cases of congenital syphilis from 2008 through 2012.

Chlamydia & Gonorrhea[33]

In 2012, Vermont:

- Ranked 46th among 50 states in chlamydial infections (275.2 per 100,000 persons) and ranked 46th among 50 states in gonorrheal infections (15.8 per 100,000 persons).
- Reported rates of chlamydia among women (408.1 cases per 100,000) were 2.9 times greater than those among men (138.6 cases per 100,000).

HIV

- In 2011, an estimated 12 adults and adolescents were diagnosed with HIV in Vermont. Vermont ranked 50th among the 50 states in the number of HIV diagnoses in 2011. [34]
- In 2014, 3 in 10 (31%) of Vermont adults reported every being tested for HIV, with more than half indicating their last HIV test was at a private doctor's office. Adults 25-44 were significantly more likely to have ever been tested for HIV (52%) than other age groups. Six percent of Vermont adults reported HIV testing in the past year.[35]

Family Planning Behaviors & Risk Factors. Understanding family planning behaviors and risk factors that affect reproductive and sexual health help to identify opportunities for prevention, early intervention, and education, particularly for those who experience an unintended pregnancy. The following information is from the 2011 Vermont PRAMS:[36]

[30] Vermont Youth Risk Behavior Survey. 2013.
[31] Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.
[32] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[33] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[34] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[35] Vermont Behavioral Risk Factor Surveillance System. 201.
[36] Vermont Pregnancy Risk Assessment Monitoring System. 2011.

- Half (49%) of mothers whose pregnancies were unintended reported using any method of birth control.
- Vermont has a relatively high rate of postpartum contraception use compared to other PRAM states; 88% of mothers used contraception after their most recent birth, including 95% of teen mothers.
- Although the Vermont PRAMS survey found a discussion with a health care worker about birth spacing was not associated with the likelihood of using contraception, postpartum contraception use occurred more frequently with women who had talked to a health care worker about a specific method of birth control after delivery. The most common reasons women gave for not using postpartum contraception were abstinence and "don't want to use".

Vermont 2011 PRAMS data indicate the following regarding preconception health:

Multivitamin Use and Weight Gain: 38% of women reported taking a multivitamin every day in the month prior to pregnancy; 19% of mothers age 20 - 24 took a daily multivitamin during the month prior to pregnancy. 23% of mothers were overweight prior to pregnancy, and 20% were obese. 29% of mothers were dieting to lose weight in the year prior to pregnancy, and over half (52%) reported exercising 3 or more times per week.[37]

Alcohol and Tobacco Use: 31% of women smoked in the three months prior to pregnancy; 19% smoked during the last trimester. 67% of women reported drinking at least some alcohol in the 3 months prior to pregnancy; and, 13% of women reported drinking during the last 3 months of their pregnancy, the highest rate reported among states with PRAMS data.[38]

Stress and Abuse: 70% of women reported at least one stressor during the year before giving birth, with 27% reporting at least 3 stressors, and 6% reporting 6 or more.[39]

- 53% reported financial stress
- 29% reported experiencing emotional stress
- 28% reported partner stress
- 20% reported traumatic stress

Intimate Partner Violence. The 2014 Vermont BRFSS survey included questions on intimate partner violence. Responses indicate that 13% of adults said an intimate partner had ever hit, slapped, pushed, kicked or hurt them in any way. Having ever experienced physical abuse by an intimate partner was statistically more common among women at 16% compared to 9% of men. Additionally, 12% of adults said an intimate partner had ever threatened or made them feel unsafe in some way, and 13% said that an intimate partner had ever tried to control their daily activities. These experiences

[37] Vermont Pregnancy Risk Assessment Monitoring System. 2011.
[38] Vermont Pregnancy Risk Assessment Monitoring System. 2011.
[39] Vermont Pregnancy Risk Assessment Monitoring System. 2011.

were also statistically more common among women compared to men, 19% versus 5% and 16 versus 9%, respectively.[40]

Impact of Services Provided by Title X

- In 2013, there were 68,060 women in Vermont in need of *publicly supported* contraceptive services and supplies. Of these, 9,830 were in need of publicly supported services because they were sexually active teenagers and 26,030 because they had incomes below 250% FPL.[41]
- In 2013, Title X family planning services helped women in Vermont avoid 2,000 unintended pregnancies, 1000 unplanned births, and 700 abortions, including 400 pregnancies to teens, 200 births to teens, and 100 abortions to teens.[42]

Vermont's Title X Population

In 2014, PPNNE's Title X network of health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont,[43] compared to a total of 8,872 served in 2013.[44] Of the 8,719 clients served in 2014:

- 47% had incomes at or below 100% FPL, 77% had incomes at or below 250% FPL
- 24% were uninsured
- 21% were teens under the age of 20, and
- 11% were men

The following tables further describe the 8,719 Vermont residents served by Title X in 2014.[45]

Table 1. Unduplicated Number of Family Planning Users by Age Group and Sex

Age Group	Female Users	Male Users	Total Users (%)
Under 15	96	4	100 (1%)
15 – 17	799	24	823 (9%)
18 – 19	871	49	920 (11%)
20 – 24	2193	286	2479 (28%)
25 – 29	1556	207	1763 (20%)
30 – 34	899	171	1070 (12%)
35 – 39	521	65	586 (7%)
40 – 44	376	50	426 (5%)
Over 44	485	67	552 (6%)
Total Users	7796	923	8719

[40] Vermont Behavioral Risk Factor Surveillance System. 2014.
[41] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.
[42] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.
[43] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.
[44] Vermont Title X Family Planning Annual Report. 2013.
[45] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

Table 2. Unduplicated Number of Family Planning Users by Race and Ethnicity

Race	Hispanic or Latino	Not Hispanic or Latino	Unknown/ Not Reported	Total Users (%)
American Indian or Alaska Native	0	11	1	12 (<1%)
Asian	0	44	5	49 (<1%)
Black or African American	5	91	12	108 (1%)
Native Hawaiian or Other Pacific Islander	0	3	0	3 (<1%)
White	63	5109	465	5637 (65%)
More than one race	7	29	4	40 (<1%)
Unknown/not reported	70	2533	267	2870 (33%)
Total Users	145	7820	754	8719

Table 3. Unduplicated Number of Family Planning Users by Income Level

Income Level as a Percentage of the HHS Poverty Guidelines	Number of Users (%)
100% and below	4110 (47%)
101% - 150%	1275 (15%)
151% - 200%	885 (10%)
201% - 250%	433 (5%)
Over 250%	929 (11%)
Unknown / Not Reported	1087 (12%)
Total Users	8719

Table 4. Unduplicated Number of Family Planning Users by Principal Health Insurance Coverage Status

Principal Health Insurance Covering Primary Medical Care	Number of Users (%)
Public Health Insurance	3342 (38%)
Private Health Insurance	3278 (38%)
Uninsured	2099 (24%)
Unknown / Not Reported	0
Total Users	8719

Contraceptive Methods Used. PPNNE health centers provide contraceptive counseling to all clients as part of a family planning visit and/or for all clients at risk for pregnancy. In 2014, 7714 female clients not pregnant or seeking pregnancy were using the following contraceptive methods:[46]

- 53% Moderately effective hormonal method – pill, patch, ring, Depo
- 16% Long-acting reversible contraception (LARC) – IUD or implant
- 3% Permanent sterilization
- 3% Abstinence

Table 5. Unduplicated Number of Female Family Planning Users by Primary Method of Contraception

Primary Contraceptive Method	Total Female Users
Female Sterilization	235
Intrauterine Devise or System	797
Hormonal Implant	445
Hormonal Injection	726
Oral Contraceptive	2918
Contraceptive Patch	139
Vaginal Ring	311
Cervical Cap or Diaphragm	8
Contraceptive Sponge	0
Female Condom	7
Spermicide (used along)	5
Fertility Awareness or Lactational Amenorrhea Method	0
Abstinence	206
Withdrawal or other method	74
Rely on Male Method	
Vasectomy	37
Male Condom	543
No Method	854
Unknown/Not Reported	409
Total Female Users	7714

Similar to national trends, LARC use among Vermonters is growing, particularly among women served by Title X clinics in Vermont. In 2010, 7.2% of the females served by Title X clinics and using contraception reported a LARC as their primary method of contraception. In 2014, LARC use grew to 17.5% among females served by Title X clinics and using contraception (Figure 5.)[47]

[46] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

[47] Vermont Title X Family Planning Annual Report. 2010 -2013; Preliminary Data 2014. Denominator excluded female clients reporting pregnant or seeking pregnancy, refraining from sexual intercourse, and whose primary method was unknown.

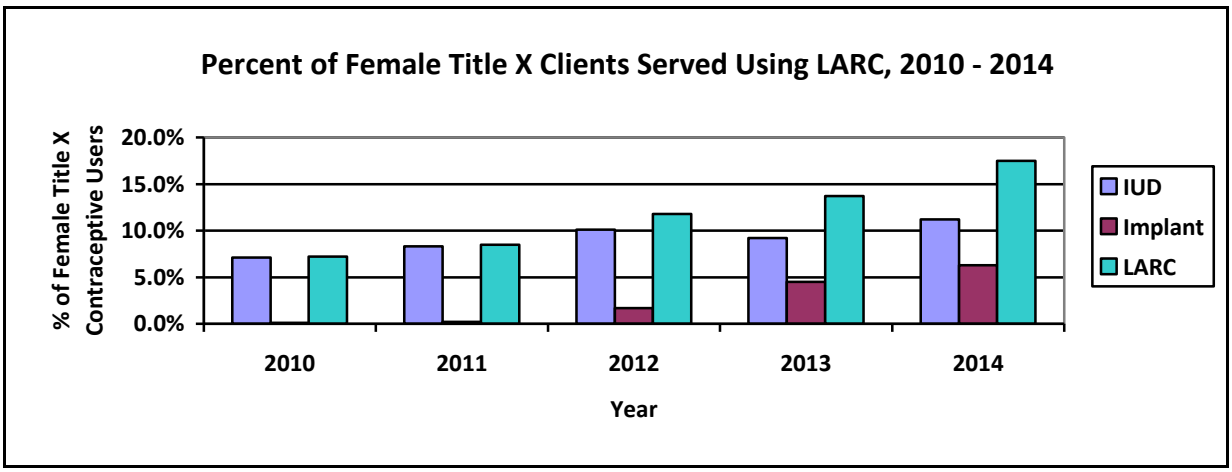


Figure 5. Percent of Title X Female Family Planning Users Reporting use of LARC, 2010 –2014.

In 2014, the 776 male clients not seeking pregnancy were using the following contraceptive methods:[48]

- 65% Male condom
- 1% Vasectomy
- 1% Withdrawal
- 2% Rely on female method

Table 6. Unduplicated Number of Male Family Planning Users by Primary Method of Contraception

Primary Contraceptive Method	Total Male Users
Vasectomy	7
Male Condom	508
Fertility Awareness Method	0
Abstinence	41
Withdrawal or other method	10
Rely on Female Method	14
No Method	136
Unknown/Not Reported	60
Total Male Users	776

STI & HIV Testing. PPNNE provides evidence-based STI screening, testing, and counseling. In 2014, PPNNE Vermont Title X health centers performed the following tests:

- 5,281 Chlamydia tests
- 5,283 Gonorrhea tests
- 1,544 HIV tests
- 403 Syphilis tests

[48] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

- 1030 HSV tests
- 1544 rapid HIV tests

Furthermore, 60% of all female patients under 25 years of age received a chlamydia test in 2014.

Preventive Health Services. In 2014, 15% of all female clients received a Pap test for cervical cancer screening and 24% received a clinical breast exam.[49]

Findings from the Field

To assess the strengths, challenges, and needs of Vermont's family planning service delivery system, with a particular focus on Title X-funded health centers and services, key informant interviews and discussion groups were conducted with organizations and stakeholders such as PPNNE (e.g., Medical Director, Senior Operations Manager, Director of Government Grants); Vermont's Primary Care Public Health Integration group, Department for Vermont Health Access, and School Liaisons from Vermont's Office of Local Health. A summary of findings and themes related to quality, access, needs, and high priority populations is provided.

Strengths of Vermont's Family Planning System. As the sole Title X provider in Vermont, PPNNE is a valued asset in the state, according to interviewees. PPNNE interviews indicated they provide comprehensive, standardized, high-quality family planning and reproductive health care across all of their health centers throughout the state. To ensure accessible and timely services, health center sites are maintained regionally throughout the state. As a result, access to PPNNE's services is considered strong, even in the very rural parts of the state. Vermont's Medicaid program and the Access Plan further bolster access to family planning services, according to interviewees. The Medicaid income eligibility limit for Vermont adults is 138% FPL and 213% FPL for women who are pregnant.[50] For children 0-18, the Medicaid income eligibility limit is set at 242% FPL and 317% FPL for the Children's Health Insurance Program (CHIP).[51] The Access Plan, sponsored by the Health Department, supports PPNNE's delivery of family planning services to low-income Vermonters living at less than 200% FPL. Interviewees were optimistic that as health care reform is implemented in Vermont, there will increasingly be more people with access to private health insurance and have no cost-sharing for most of the services PPNNE provides (i.e. preventive services).

Vermont has a relatively low number and proportion of uninsured individuals compared to other states and as more become insured, PPNNE expects it will benefit from a business perspective because there will be fewer men and women to cover via a sliding fee. As the health care system in Vermont evolves in response to health care reform, interviewees indicated a need to establish the role of family planning within the strategies for improved population health, which currently focuses on chronic conditions. Interviewees have found it challenging to weave family planning strategies (e.g., LARC) into health reform conversations that focus on exploring high impact opportunities to promote

[49] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.
[50] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[51] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org

preventive care and wellness as a mechanism to improve overall population health. One challenge noted is conveying the long-term shared savings from family planning interventions relative to providers being limited to capturing savings from attributable patients. As one interviewee noted, "…the savings needs to be shared more broadly". It was suggested that accountable communities of health may be an opportunity to better address the health impact and savings of family planning strategies within the context of improving population health while reducing costs to the health care system.

To ensure accessible high-quality systems and services, PPNNE shared that they have established practices to monitor, assess and improve their clinical and administrative workflows, workforce capacity, and better address patient needs. Specific initiatives include:

- Transitioning all health centers to an electronic health record system (EHR), with a final rollout to be complete by September 2015.
- Enhanced staffing models (e.g., Health Care Associates), flexible staffing (e.g., telecommute), and telemedicine initiatives (e.g., contraceptive counseling and options, urinary tract infection visit, and STI/HIV screening) to maximize capacity, and to support a feasible and financially sustainable business model, high-quality staffing and retention, and a work environment supportive of work-life balance.
- Rebranding of all health centers to have an aligned look and feel that speaks to the quality of care PPNNE provides. This initiative is intended to support a change in PPNNE's tagline to a provider of choice rather than a provider of last resort. The rebranding initiative is expensive and has been supported by private donations to date.
- Efforts to ensure culturally competent care, such as recruiting a diverse workforce representative of the patient population PPNNE serves, and providing ongoing training of staff to increase culturally competent care (e.g., PPNNE human resources Inclusivity Project).
- Strategic collaboration with community partners to best serve the needs of vulnerable populations (e.g., maintain same day access to services at the St. Albans health center to support needs of population with substance abuse issues).
- Addition of a centralized nurse care coordinator to provide care coordination for clients across PPNNE Vermont health centers and other primary care or specialty providers.

Other strengths reported beyond the Title X funded health centers focused on schools and potential for SBHCs to address sexual and reproductive health. Interviewees reported that Vermont has done good work in HIV and sexuality education within schools using research and evidence-based curricula. PREP and V-SHEP are examples. School Liaisons and school nurses throughout the state make efforts to coordinate with local parent child centers and providers to support students' reproductive and sexual health needs. For example, in Brattleboro the School Liaison makes efforts to coordinate with the local PPNNE health center to facilitate student contraceptive needs; in Morrisville the Coordinated School Health Team is currently focusing on sexuality education across grades K-12. Building on this work, interviewees feel there is further need and opportunity to do more systems-level work to address barriers (e.g., transportation, financial, and attitudes and beliefs on providing sexual and reproductive health education and services within the school setting), and to create linkages between schools, communities, and health care providers in support of student health, including reproductive and sexual health. Interviewees suggested the *Whole School, Whole Community, Whole Child* model

is an opportunity to address student reproductive and sexual health more broadly within schools and communities, as this model emphasizes collaboration among the school, health, and community sectors to improve each child's learning and health.[52]

SBHCs were also noted as strength where they exist in the state. Some health care providers have looked at how SBHCs could provide services for specific areas of need in concert with primary care providers. Burlington High School has a SBHC in which primary care providers see students at the SBHC for acute visits. The providers are currently working more on connecting students with primary care for regular routine visits, such as adolescent health visits. However, providers noted that not all students are receptive to following up with a primary care provider or medical home, and therefor there is need to provide primary care services to students at the SBHC (e.g., vaccines).

The SBHC in St. Albans was indicated as a long-standing example of a SBHC in which a local community provider goes to the high school once a week to see patients to provide health services such as followup on asthma and depression. In Burlington's SBHC, providers find that mental health and behavioral health issues are the most prevalent issues they address with students. Providers work closely with the guidance counselors and the Community Health Team to support student counseling needs. Reproductive health and sexual health services are not currently provided by SBHCs, according to those interviewed.

Challenges for Vermont's Family Planning System. Although PPNNE has implemented several innovative strategies to enhance access to services throughout the state and to target populations, interviewees feel there is room for improving access. They reported that maintaining access in the very rural areas of the state has been difficult due to challenges related to financial sustainability and staff recruitment and retention. Thus, some of PPNNE Vermont health centers are very small and open on a limited basis (e.g., fewer hours and/or days per week).

Interviewees are interested in improving access to services for teens, particularly for teens insured under their parents' health care plans but who may be reluctant to use their insurance due to concerns about confidentiality.

Gaps in access to family planning services were reported for other vulnerable populations in Vermont as well, such as the immigrant and migrant populations, both due to barriers in access related to lack of insurance and barriers related to outreach, engagement, transportation, and health literacy.

Interviewees reported there are gaps in the system on engagement and access for individuals with substance abuse issues. Although PPNNE health centers and community based organizations are making efforts to better reach these individuals to meet their family planning needs, they find it is a difficult population to reach as family planning is often a secondary priority relative to substance use and treatment.

[52] Centers for Disease Control and Prevention. Whole School, Whole Community, Whole Child. http://www.cdc.gov/healthyyouth/wscc/ Accessed October 2, 2015.

Long-Acting Reversible Contraception (LARC). Interviewees felt strongly that increasing awareness, access, and availability to long-acting reversible contraception (LARC) is a key strategy to reducing unintended pregnancy. LARC includes intrauterine devices (IUD) and implants, which are highly effective contraceptive methods for preventing pregnancy. Energy and efforts to improve access to LARC in Vermont, specifically within PPNNE's network of health centers, are felt to have been successful in promoting use of LARC. Interviewees reported the following initiatives have been important factors in improving access and uptake of LARC over recent years:

- All PPNNE clinicians are trained to provide LARC
- A centralized supply chain for LARC ensures adequate supplies at each site to provide same-day services as needed
- Bulk purchase of LARC supports affordability
- Establishing referral relationships and processes with other providers to support access to LARC
- Tiered counseling for all patients promotes awareness and uptake of LARC
- Establishment of a LARC Workgroup (e.g., Health Department, PPNNE, Primary Care Public Health Integration group members, UVM Medical Center Departments of Obstetrics and Gynecology and Family Medicine, and VCHIP)
- Conducting a needs assessment, provider survey and mapping of LARC services in Vermont to inform LARC training to providers. Training will be provided by the Vermont Child Health Improvement Program, a maternal and child health services research and quality improvement program of the University of Vermont.

Remaining barriers and challenges to promoting access and use of LARC were identified and include addressing (1) misperceptions, attitudes, and beliefs on LARC, and (2) the low margins of reimbursement most providers realize for providing LARC, which lends to low financial incentive for promoting provision of LARC. One emerging solution noted to reduce the financial burden of providing LARC is a new alternative IUD, Liletta. PPNNE reported that Liletta is recently available at an improved pricing structure for Title X grantees and FQHCs. PPNNE has replaced the Mirena IUD with Liletta to ease the financial burden of stocking and providing these devices.

Another reported barrier to expanding access to LARC post-partum is the bundled reimbursement mechanism for providing an IUD. In general, both public and private insurers have a global reimbursement rate for hospital care and services during the time of delivery. Provision of LARC post-partum after delivery is included in this bundled rate, resulting in a financial loss to hospitals that provide an IUD post-partum.

As Vermont works to expand access to LARC, particularly for adolescents, interviewees feel that strengthening relationships and referrals from the pediatric community will be important. Interviewees feel the pediatric community is currently not comfortable with providing LARC. PPNNE feels their well-established systems and skilled workforce could serve as an important resource to meet the LARC need among interested Vermont adolescents. In addition to relationship building, it is felt that culture change regarding the perception and role of PPNNE health centers among the medical community will be necessary to facilitate collaborative agreements and referral networks.

The Community Health Centers of Burlington, an FQHC, noted they too have strong systems in place to provide LARC. Staff are trained to provide LARC, including mid-level providers, they stock LARC supplies, and have found they have good uptake of LARC among their patient population.

High Priority Populations. Interviewees noted several populations in Vermont they prioritized as vulnerable and in need of family planning services. These included individuals of low income; teens; men; individuals with mental health and/or substance abuse issues; the lesbian, gay, bisexual, transgender and queer population (LGBTQ); racial and ethnic minorities; and women who are incarcerated.

Low Income. Interviewees indicated that PPNNE health centers serve clients across all incomes, but the majority of their clients are of low income, at or below 100% FPL. Interviewees expressed concern around fully meeting the many social needs of low income clients, which can also influence family planning outcomes. A common example shared was that when impoverished individuals are struggling with food insecurity and housing insecurity, family planning and contraceptive use is not always a priority. To better support client needs beyond family planning and other health care needs, PPNNE is currently working with Vermont's 3 Square Program to establish referrals to and from the Program in an effort to ensure food security among their clients.

Teens. Interviewees indicate need to improve access for teens, particularly teens with health insurance that choose not to use their health insurance for services due to confidentiality concerns. Although this group is a small subset of the population served, PPNNE would like to determine how to best serve this population.

The majority of PPNNE's population served is 16-26 years of age. In their outreach and engagement efforts, PPNNE works to meet teens where they are at, for example, using multiple social media platforms and exploring potential opportunity to use telemedicine to serve teens and mitigate transportation barriers. PPNNE is also starting to work with the school system again and currently has a condom program at their White River Junction site.

Another resource called out to support teens' family planning, reproductive and sexual health needs are SBHCs in Vermont. Interviewees feel they offer an effective mechanism to reach adolescents and provide contraceptive services and/or refer students to other providers to address family planning and other health care needs.

Many interviewees noted concern on maintaining engagement in the health care system as adolescents transition to young adulthood. Continued engagement and use of the health system was indicated as an important facilitator in ensuring continuity of care and preventive care. This is considered important because family planning services are often a primary entry point and use of the health care system for adolescents and young adults, and interviewees indicated that young adults in Vermont experience challenges in obtaining timely access to primary care. Some interviewees felt that integrating well-woman care into family planning and preconception care may be promising strategy to maintain access and engagement in the health system as adolescents transition to adulthood.

Men. PPNNE indicated they are growing the number of male clients served each year, and have made intentional efforts to better reach and serve men. PPNNE's recent rebranding included marketing campaigns inclusive of men (i.e., messaging that in addition to serving women, PPNNE is a place for men to receive high-quality family planning and reproductive health services, too), and the redesign of health centers that are intended to be a comfortable environment for men and women. PPNNE has also tailored services to better reach men and ensure services are inclusive of men's family planning and reproductive health needs (i.e., integrating STI services into patient visits and providing expedited partner treatment).

Interviewees report that men primarily access and use the family planning service delivery system for STI screening. Providers try to segue conversations during visits to talk about contraception, reproductive life planning, and provide some basic primary care (e.g., smoking cessation counseling); transitioning the conversation from STI screening and treatment to reproductive life planning and other health needs can be difficult. Providers feel that until there are more contraceptive options for men, they will continue to serve a much smaller proportion of men than women. Furthermore, PPNNE does not provide vasectomy services, but does offer vasectomy education, counseling, and referral.

In addition to addressing the family planning and reproductive health needs of men, providers would like to expand on the level of education PPNNE provides on intimate partner violence to better reach men. It was suggested that identifying the right community partners may help facilitate this work.

Mental Health/Substance Abuse. Substance abuse was recognized as a growing problem in Vermont and often associated with a transient lifestyle. Interviewees experience that this population can be difficult to reach to address family planning needs because often times substance use or sobriety are deemed a higher priority than family planning and contraception. They would like to determine how to better reach and serve this population. One approach suggested that has been implemented at the St. Albans PPNNE health center is to provide same day access to services and consider how to best offer comprehensive and efficient services within a single visit knowing providers may not see the client again for some time. Furthermore, by coordinating with community-based organizations in select regions, PPNNE has been able to identify how to better serve and meet the needs of this vulnerable population. Regional meetings were coordinated by the Health Department in St. Albans and White River Junction. PPNNE and community-based organization participants found the meetings to be a great help in increasing awareness and building understanding of the services available within communities and the needs of the populations they serve. The Health Department plans to continue coordinating similar meetings in other regions of the state in the future.

LGBTQ. PPNNE interviewees indicated that all providers receive general cultural competency training and training on culturally competent transgender care, lending to an established comfort level with preventive care for transgender among providers. PPNNE's Burlington health center is receiving training to provide trans-care.

Although providers are well-trained to serve the family planning and reproductive health care needs of the LGBTQ population in Vermont, interviewees indicated there is need for more outreach to this population and engagement in the health care system. Additionally, interviewees remarked that while

there are several resources and supports targeting the LGBTQ community within Chittenden County, there are very few in most other parts of the state. This makes it difficult to reach this population as well as provide appropriate supports to this population.

Racial & Ethnic Minorities. As the racial and ethnic minority population in Vermont grows, particularly immigrants and refugees residing in Chittenden County, interviewees are identifying more need to outreach to these populations and to provide culturally sensitive services. For example, providers indicated challenges with addressing family planning needs of some immigrant and refugee patients due to cultural and religious beliefs and attitudes on contraception. The Hispanic/ migrant worker population in Addison County was also called out has a population with unmet health and family planning needs, partly due to cultural barriers and partly due to financial and transportation barriers.

PPNNE interviewees noted efforts to better service racial and ethnic minority populations by way of coordinating with other organizations, including Community Health Centers of Burlington who sees a significant proportion of the immigrant and refugee population in Chittenden County, to establish referrals to PPNNE to serve the family planning and reproductive health needs of this population. PPNNE's Cultural Inclusivity Project has benefited staff in becoming more aware of cultural attitudes, behaviors and beliefs related to family planning. Providers have found their tiered counseling approach works well when broaching contraceptive counseling with the recent immigrant and refugee population. Use of phone interpreters has also facilitated serving the needs of this population.

Incarcerated. Women who are incarcerated in Vermont were noted by PPNNE interviewees as a population of interest with unmet family planning need. The Vermont Department of Corrections reported that approximately 85% (about 850 of 1000 women annually) of their female incarcerated population are 18-44 years of age. PPNNE has initiated conversations with the Department of Corrections to determine if there is a role for PPNNE to support the family planning and reproductive health needs of this population or if there is a better solution to the system.

Considerations

This review of Vermont's family planning system and population needs presents a positive picture overall. Interviewees described a family planning system with high access, high quality, comprehensive services, and a supportive landscape. In addition to the 10 Title X funded health centers, Vermont has a broad network of safety-net providers supporting the health care needs of residents throughout the state. Key health and reproductive health indicators also present a favorable status for Vermonters. Most all Vermonters now have health insurance and Vermont's infant mortality, preterm birth, and low weight birth rates rank lower than national rates. Furthermore, the teen pregnancy rate and fertility rate for Vermont continue to decline and post-partum contraceptive use is high among Vermonters.

Despite these gains, this review indicates remaining challenges for Vermont. The rate of intended pregnancy remains relatively consistent at about 50%, well below the 65% Healthy Vermonters 2020 goal. Furthermore, about half (49%) of mothers whose pregnancies are unintended report using any method of birth control. Alcohol and tobacco use during pregnancy remain consistently high

compared to other states. Several sub-populations of concern were noted as having disparate unmet family planning need due to financial, transportation, and cultural barriers. These sub-populations include adolescents, individuals with mental health and/or substance abuse issues, LGBTQ individuals, and racial and ethnic minorities.

In the context of the gains, strengths, and challenges for Vermont's family planning service delivery system, the following focus areas are called out for consideration and intended to guide future efforts of the Health Department and other family planning programs and stakeholders in Vermont.

I. Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding. Interviewees indicated limited understanding as to why the Burlington and Williston sites, which serve the largest number of clients in the state relative to other sites, are not included as Title X sites. There is also uncertainty on whether this exclusion impacts access to services among low-income and other vulnerable populations being served by these sites.

II. Promote awareness, implementation, and adherence to the QFP's evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.
   - Disseminate QFP guidelines and related resources (e.g., job aids, webinars, e-learning courses) to providers, programs and organizations. Refer to OPA's National Family Planning Training Centers for existing resources. Explore dissemination mechanisms such as developing a resource hub for providers to access information, announcements, and tools.
   - Identify, coordinate, and support opportunities for provider education and training on QFP guidelines, with a focus on contraceptive effectiveness counseling and informed choice.

III. Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling. Providers should offer contraceptive services for women and men who want to prevent pregnancy and space births, including contraceptive counseling services. For individuals who might want to get pregnant in the future and prefer a reversible method of contraception, providers should use a tiered approach to presenting a broad range of contraceptive methods, presenting the most effective methods before less effective methods.[53]
   - Explore the use of family planning quality measures among health care organizations to monitor on an ongoing basis (e.g., percentage of patients using moderately or highly effective contraceptive methods; or percentage of patients using LARC methods). Refer to

[53] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).

the QFP and OPA National Family Planning Training Centers for guidance on performance measures.

IV. Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's heath centers); support innovations and solutions to promote access and awareness of LARC.
- Work with Medicaid to establish reimbursement for post-partum provision of IUD
- Coordinate with ACOs to include LARC use as a payment measure
- Assess access and provision of LARC via other safety net providers such as FQHCs and RHCs
- Explore use of quality improvement initiatives with safety net providers (e.g., FQHCs, RHCs) and primary care providers to promote a broad range of contraceptive method availability, and guideline-based contraceptive counseling and education
- Establish collaborative agreements and referrals systems with PPNNE and other safety net providers well-equipped to provide LARC (e.g., Community Health Centers of Burlington)

V. Facilitate linkages between primary care providers and Title X health centers in Vermont. Vermont's network of Title X health centers provides access to comprehensive guideline-based family planning services throughout the state. Coordinate with primary care providers and practices, such as community health centers, to better understand: (1) their capacity for providing guideline-based contraceptive services and other family planning services; (2) existing referral systems; and (3) opportunities to support or strengthen referral systems with Title X health centers to ensure access to comprehensive high-quality family planning services and continuity of care.

VI. Increase provider and consumer knowledge of covered family planning and related preventive health services. The Affordable Care Act has expanded health payer coverage of contraception and a wide range of preventive services, including well-woman visits (Pap tests, cancer screenings, etc.). To promote high utilization of expanded health care benefits, disseminate information on covered family planning and related preventive health services to providers and consumers throughout Vermont. Explore dissemination and repackaging of existing information and education resources as well as developing resources specific to Vermont's health payer member benefits.

VII. Explore potential opportunities to address family planning, reproductive, and sexual health needs of adolescents within SBHCs in Vermont.
- Establish understanding of existing SBHCs in Vermont, including location, model of care, scope of services, and community linkages
- Coordinate with SBHCs to identify prominent family planning, reproductive health, and sexual health needs within communities and related services that could be feasibly integrated into SBHCs scope of services
- Assess other state models of SBHCs and scope of family planning services offered

VIII. Explore opportunities for clinical-community linkages between Vermont Title X health centers and community based organizations to establish family planning—human service referral networks.

- Continue Health Department coordination of regional meetings convening PPNNE Title X sites and community programs and organizations to build awareness and understanding of community specific needs and available resources.
- Establish referral networks of social support services within Title X sites; PPNNE recently added centralized care coordinator may be an opportunity to facilitate this effort
- Identify and reach out to programs or organizations currently working with high priority populations to increase awareness of Title X site family planning services and opportunities for outreach and engagement of priority populations (e.g., DVHA MOMS Program, Howard Center, Pride Center, Vermont Refugee Resettlement Program)

Appendix I: Key Informant Interview Participants & Guides

The following table includes the list of organizations, programs, and groups represented in the series of interviews and discussion groups conducted for the 2015 Title X needs assessment interviews. Examples of the guides used to facilitate discussion during interviews follow.

Title X Needs Assessment Key Informant Groups and Organizations	
1	Community Health Centers of Burlington
2	Department of Vermont Health Access, Integrated Family Services
3	Department of Vermont Health Access, Medicaid Obstetrical and Maternal Support Program
4	Department of Vermont Health Access, Policy
5	Parent Child Centers
6	Planned Parenthood of Northern New England
7	University of Vermont
8	UVM Pediatric Primary Care
9	Vermont Center for Health and Learning
10	Vermont Department of Health School Liaisons
11	Vermont Department of Health, Health Promotion Disease Prevention
12	Vermont Department of Health, Maternal and Child Health
13	Vermont Family Network
14	Vermont Federation of Families for Children's Mental Health
15	Vermont PREP Grantees
16	Vermont Primary Care and Public Health Integration Group

Title V Strengths and Needs Assessment
Key Informant Interview Guide

For the 2015 Title V strengths and needs assessment states must identify 7 among the 15 National Performance Measures they will prioritize to improve the health and wellbeing of Vermont's women, mothers, children and families.

Title V of the Social Security Act reflects our nation's commitment to improving the health and well-being of mothers, children, and their families, and is operationalized through a block grant. Every five years, as a part of the federal Title V Block Grant, states are required to complete a comprehensive assessment of the needs, desired outcomes, and system capacity for the maternal and child health population, including children and youth with special health care needs. The results of this assessment will be used to establish the priorities that will guide our Title V program for the next five years (2015-2020).

Background: This is an exciting time in the field of Maternal and Child Health, as the Title V MCH Block Grant is currently undergoing a transformation. One of the primary goals of this transformation is to demonstrate the vital leadership role that state Title V programs play in assuring and advancing public health systems that address MCH population health needs. To achieve this goal, the federal Maternal and Child Health Bureau has defined a core set of national health priority areas that Title V programs across the country will work on to collectively "move the needle." Fifteen national health priority areas have been identified (see Table 1), from which states must select seven to ten to address through their Title V program along with any state specific priority areas. Collectively, these priority areas represent six MCH population domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; 5) CYSHCN; and 6) Cross-cutting or Life course. You have been identified as someone with expertise in the _____population domain(s). Throughout the interview, I will be referring to this domain and the corresponding national priority areas (see Tale 1). VDH is also currently conducting their 2015 Title X Needs Assessment. Vermont's Title X program provides high quality clinical family planning (e.g., a broad range of FDA-approved contraceptive methods and related counseling) and related preventive health services, including breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals to women and men in Vermont who would otherwise not have access, with a special focus on low-income and rural populations. You have been identified by VDH as well suited to speak to 1) the _____ domain to inform the VDH'S 2015 Title V Needs Assessment, and 2) the family planning needs ands and services in Vermont for VDH's 2015 Title X Needs Assessment.

---

1. Let's begin by setting the context for the interview. Can you briefly describe your organization and its role in addressing the needs of Vermont's women, mothers, children and families?
    a. Describe specific programs
    b. Reach/ Population focus
    c. Partnerships across the state

2. Now let's turn to thinking about the quality of the system of care for Vermont's women, mothers, children and families. Components of a quality system include *accessible*, *equitable*, *timely*, *coordinated*, *client-centered*, and *culturally competent* care.
    a. What components of quality are well-addressed within Vermont's current system of services and supports for women, mothers, children and families?
    b. What components of quality could be better addressed within Vermont's current system of services and supports for women, mothers, children and families?

3. Thinking about [population domain] and the corresponding national priority areas identified by the federal Bureau of Maternal of Child Health….

    a. What have been some gains in this area for Vermont?
    b. What have been the challenges?
    c. What do you see as key strategies for addressing this issue?
    d. What would be some challenges encountered?
    e. What are the leverage points/opportunities that exist to address this issue (e.g., existing initiatives, coalitions, etc.)?

4. The sixth population domain is Cross-cutting or Life Course and refers to public health issues that impact multiple MCH population groups such as smoking or oral health. What do you see as significant cross-cutting issues for Vermont's MCH populations? Why?

    a. Cross-cutting or Life Course can also include social determinants of health—how where we live, learn, work and play impacts our overall health and well-being. How do you see social determinants of health playing into the health and well-being of Vermont's women, mothers, children and families?
        i. Which of those that you listed has the greatest impact for [population domain]?

<u>Title X</u>

The U.S. Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program. OPA funds a network of family planning centers which serve about five million clients a year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits. Title X family planning centers provide high quality and cost-effective family planning and related preventive health services for low-income women and men including a broad range of FDA-approved contraceptive methods and related counseling; as well as breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals. Family planning centers play a critical role in ensuring access to voluntary family planning information and services for their clients based on their ability to pay. Every three years states receiving Title X funds are required to conduct a family planning needs assessment. Title X and Title V needs assessment processes overlap for the 2015 cycle. We understand that your work interfaces with the family planning system. We would like to ask you a few questions specific to family planning.

5. Describe your involvement in the family planning system in Vermont?

6. Describe the populations most in need of family planning services in Vermont?

    a. What is Vermont currently doing on outreach and access to best meet the needs of these populations?
    b. Is the system effectively reaching and engaging vulnerable populations?
        i. What are the barriers or challenges to doing so?
        ii. What more could be done to engage vulnerable populations?
    c. What are their most pressing family planning needs?
    d. What more could providers and/or the system be doing?

Recommendations/Closing Observations

7. As we come to the close of our interview, what are the top recommendations you have for ensuring an accessible high-quality system of support and services for Vermont's women, mothers, children and families?

8. Are there any closing observations or thoughts you would like to share regarding _____ [population domain] and how Vermont can strive to ensure the overall health and well-being of_____[population domain]?

Table 1: National Priority Areas by Population Domain

MCH Population Domain	National Priority Area
Women/Maternal Health	Well Woman Care Low Risk Cesarean Deliveries
Perinatal/Infant Health	Perinatal Regionalization Breastfeeding Safe Sleep
Child Health	Developmental Screening Injury Prevention Physical Activity
Adolescent Health	Injury Prevention Physical Activity Bullying Adolescent Well Visit
Children and Youth with Special Health Care Needs	Medical Home Transition
Cross-cutting/Life course	Oral Health Smoking Adequate Insurance Coverage

Vermont Title X Needs Assessment
Key Informant Interview Guide

Background: Title X of the Public Health Service Act is designed to ensure access to comprehensive reproductive health care, with an emphasis on services to lower income women and men. The U.S. Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program. OPA funds a network of family planning centers which serve about five million clients a year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits. In Vermont, Title X services are provided by Planned Parenthood of Northern New England.

The overarching goal of Vermont's Title X program is to provide high quality clinical family planning (e.g., a broad range of FDA-approved contraceptive methods and related counseling) and related preventive health services, including breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals to women and men in Vermont who would otherwise not have access, with a special focus on low-income and rural populations. Specifically, Vermont's Title X program seeks to:

- Reduce unintended pregnancies in Vermont
- Improve access to a broad range of effective contraceptive methods
- Provide access to emergency contraceptive services
- Reduce sexually transmitted diseases
- Promote healthy relationships, healthy sexual behaviors and strengthen community capacity to promote positive reproductive health

Thank you for taking the time to participate in Vermont's 2015 Title X needs assessment process by way of this interview. The information collected from key informants will be used by the Vermont Department of Health's Division of Maternal and Child Health to inform 1) their upcoming application to OPA for continued Title X funding in Vermont, and 2) planning and priorities of their future Title X, family planning, and reproductive-health related work.

1. Let's begin by setting the context for the interview. Can you briefly describe your organization and its involvement in the family planning system in Vermont?
    a. Describe specific programs
    b. Reach/ population focus

2. Thinking about Title X and the family planning service delivery system in Vermont, what are the strengths of Vermont's Title X service delivery system and/or existing family planning services?
    a. What have been some of the gains for Vermont in recent years?
    b. To what do you attribute these gains?
    c. What partners are important to expanding or enhancing the Title X service delivery system?

d. Which of these partners do you collaborate/partner with, and how, to meet family planning needs in the state?

3. Similarly, what are some of the barriers or challenges of Vermont's Title X service delivery system and/or existing family planning services?
    a. What are potential strategies to address barriers or challenges of the system?

Access & Quality

4. Describe the populations most in need of family planning services in Vermont?
    a. What are we currently doing on outreach and access to best meet the need(s) of these populations?
    b. What more could providers and/or the system be doing?

5. Is the system adequately reaching the needs of vulnerable populations (e.g., teens, LGBT, racial and ethnic minorities, recent immigrants and refugees)?
    a. Is the system effectively reaching and engaging vulnerable populations?
        i. What are the barriers or challenges to doing so?
        ii. What more could Title X/PPNNE centers and other providers do to engage vulnerable populations?
    b. What are their most pressing family planning needs?

6. Is the system effectively reaching and engaging men?
    a. What are the barriers or challenges to doing so?
    b. What types of services are most commonly delivered to the men served in your program/organization?
    c. What more could Title X/PPNNE centers do to engage men?

7. Now let's turn to thinking about the quality of the family planning service delivery system in Vermont. Components of a quality system include *accessible*, *equitable*, *timely*, *coordinated*, *client-centered*, and *culturally competent* care.
    a. What components of quality are well-addressed within Vermont's current system of family planning and reproductive health care?
    b. What components of quality could be better addressed within Vermont's current system of family planning and reproductive health care?

Long-Acting Reversible Contraceptives (LARCs)

8. To what extent do you feel family planning patients have access to a broad range of contraceptive options, including long acting reversible contraceptives (LARCs)?
    a. What are the primary barriers to promoting use of LARCs to prevent unintended pregnancy?
        i. Provider training and skills to counsel and provide LARCS

ii. Adolescents' knowledge, attitudes, beliefs, and use of LARCs

Preconception Health & Related Preventive Health Services

9. Promoting preconception health and reproductive health planning are important components of family planning, as they influence birth outcomes and men and women's health in general. How does Vermont's family planning service delivery system fair in regard to providing recommended preconception health services (i.e., per USPSTF recommendations)?
    a. What are some of the challenges or barriers to doing so?

10. The family planning service delivery system is often a point of access into the health care system for many women and men, and therefore presents an important opportunity to provide or refer for other related preventive health care services (e.g., cervical cancer screening, breast cancer screening). Similar to the previous question, how does Vermont's family planning service delivery system fair in regard to providing or referring clients for other preventive health services?
    a. What are some of the challenges or barriers to doing so?

11. To wrap up our discussion, what are the top recommendations you have for ensuring an accessible high-quality system of family planning and reproductive health in Vermont?

From:	Spottswood, Eleanor
To:	Diamond, Joshua; Wemple, Doug
Cc:	Clark, Charity
Subject:	RE: AG constituent inquiry
Date:	Tuesday, September 18, 2018 2:42:48 PM
Attachments:	Final_Title_X_Comment_Letter_7.31.18 WAMAORVT.PDF VDH -HHS-OS-2018-0008 Vermont Comments.pdf image002.png image003.png

---

I attach the official Title X comments from TJ and the AGs of Washington, Massachusetts, and Oregon.

In case you'd like to include it, I also attach comments filed separately (against the proposed rules) from the Vermont Department of Health.

Ella

From: Diamond, Joshua
Sent: Tuesday, September 18, 2018 2:36 PM
To: Wemple, Doug <Doug.Wemple@partner.vermont.gov>
Cc: Clark, Charity <Charity.Clark@vermont.gov>; Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: FW: AG constituent inquiry

Doug,

Please prepare a response that informs Ms. Daly that Vermont is opposing the proposed Title X rules and provide a copy of the public comments that we filed. Ella, could you provide a copy of the comments for Doug?

Thanks. Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

immediately and destroy this E-mail. Vermont's lobbyist registration and disclosure law applies to certain communications with and activities directed at the Attorney General. Prior to any interactions with the Office of the Vermont Attorney General, you are advised to review Title 2, sections 261-268 of the Vermont Statutes Annotated, as well as the Vermont Secretary of State's most recent compliance guide available at https://www.sec.state.vt.us/elections/lobbying.aspx.

From: Wemple, Doug
Sent: Tuesday, September 18, 2018 1:39 PM
To: Matthews, Deborah <Deborah.Matthews@vermont.gov>; Clark, Charity <Charity.Clark@vermont.gov>; Diamond, Joshua <Joshua.Diamond@vermont.gov>
Subject: RE: AG constituent inquiry

I can follow up and let Judi know about our office's work around Title X.

Doug Wemple
Executive Assistant
Office of the Vermont Attorney General
109 State Street - Montpelier, VT
Office: (802)828-5515

From: Matthews, Deborah
Sent: Tuesday, September 18, 2018 8:13 AM
To: Wemple, Doug <Doug.Wemple@partner.vermont.gov>; Clark, Charity <Charity.Clark@vermont.gov>; Diamond, Joshua <Joshua.Diamond@vermont.gov>
Subject: FW: AG constituent inquiry

Deb Matthews
Administrative Secretary
Office of the Attorney General | GCAL
109 State Street, 3rd Floor
Montpelier, VT 05609
Phone | 802-828-3689
E-Mail | deborah.matthews@vermont.gov

From: Rubinstein, David
Sent: Monday, September 17, 2018 5:13 PM
To: AGO - Info <AGO.Info@vermont.gov>
Subject: AG constituent inquiry

Good evening,

We recently received this email at the Governor's Office – I figured I'd pass it along since it appears to fall under the AG's purview. Let me know if you would like any more information.
Best,
David

Why is Vermont not part of the group of states (12 states and the District of Columbia) urging the HHS Secretary Alex Azar NOT to implement proposed Title X rules that will effectively gag providers from advising patients on all their reproductive health options? Vermont has long supported Planned Parenthood and women's rights to family planning. The proposed rules are a disaster. Please refer to the letter written by a group of other state's attorney generals.
https://oag.ca.gov/system/files/attachments/press-docs/final-title-xcomment-letter.pdf

Judi Daly
judicdaly@yahoo.com
1061 Cobb Hill Rd
Waterbury, Vermont 05676
8022445868 (H)

David Rubinstein
Executive Assistant
Office of Governor Phil Scott

State of Vermont
P. 802.828.6438
David.Rubinstein@vermont.gov | governor.vermont.gov

Bob Ferguson
ATTORNEY GENERAL OF WASHINGTON
Administration Division
PO Box 40100 ● Olympia, WA 98504-0100 ● (360) 753-6200

July 31, 2018

VIA FEDERAL eRULEMAKING PORTAL

Secretary Alex M. Azar II
Assistant Secretary ADM Brett P. Giroir, M.D.
Deputy Assistant Secretary Diane Foley, M.D., FAAP
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

RE: HHS–OS–2018–0008, Comments on Proposed Rule: *Compliance With Statutory Program Integrity Requirements*, Docket No.: HHS-OS-2018-0008

Dear Secretary Azar, Assistant Secretary Giroir, and Deputy Assistant Secretary Foley:

The undersigned, Attorneys General for the States of Washington, Oregon, and Vermont and the Commonwealth of Massachusetts, respectfully urge the Department of Health and Human Services (the Department) to withdraw its Proposed Rule: *Compliance with Statutory Program Integrity Requirements*, 83 Fed. Reg. 25,502 (June 1, 2018). We have grave concerns with the legality of the proposed rule, and do not believe it would survive judicial review in its current form.

The Title X family planning program was created to provide access to high-quality family planning and related preventive health care for low-income and underserved individuals. The proposed rule has a host of legal flaws. In some states, if implemented, it will eliminate from the Title X program many Title X providers and leave thousands of residents without reasonable options for critical family planning services. In other states, it will frustrate the ability of providers to deliver high-quality and complete care to their patients and will undermine the efficacy of the network as a whole. The proposed rule thus frustrates rather than promotes the purposes of Title X. The proposed rule shifts the burden and costs to the states, including myriad reproductive health services related to unintended pregnancies, treatment of sexually transmitted infections (STIs), cervical and breast cancer screening and treatment, and other public health

services that the Title X program currently covers. The public health impact will fall the heaviest on our States' most vulnerable populations – including low-income and rural women and families, immigrants and people of color that the program is intended to help.

Further, the proposed rule requires directive counseling, which is in violation of a federal statute governing Title X.[1] It illegally injects the government into the Title X medical examination room, and it violates the constitutional rights of providers and patients under the First and Fifth Amendments. The proposed rule also violates the Department's current statutory interpretation of "acceptable and effective family planning methods and services" without mentioning the current interpretation or the evidence justifying it. Various parts of the rule are unsupported by any evidence and are thus arbitrary and capricious. Finally, the proposed rule violates Executive Orders 12866 and 13562.

A. Relevant Background of Title X to the Public Health Service Act, 42 U.S.C. §§ 300-300a-6

The Family Planning and Services Population Research Act of 1970, which added Title X to the Public Health Service Act, authorizes the Secretary of Health and Human Services:

> to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services . . . .

42 U.S.C. § 300(a).

Title X projects serve an estimated four million women annually.[2] In 2015, 64 percent of U.S. counties had at least one safety-net family planning center supported by Title X, and 90 percent of women in need of publicly funded family planning care lived in those counties.[3] Title X clients are among the nation's most vulnerable populations: two-thirds have incomes at or below the Federal Poverty Level (FPL)($20,090 for a family of three in 2015), nearly half are uninsured—even after implementation of the Affordable Care Act's (ACA) major insurance

---

[1] Public Law No. 115-141, § 118, https://www.congress.gov/bill/115th-congress/house-bill/1625/text.

[2] Fowler CI et al., Family Planning Annual Report: 2015 National Summary, Research Triangle Park, NC: RTI International, 2016, http://www.hhs.gov/opa/sites/default/files/title-x-fpar-2015.pdf (last accessed 7/17/18).

[3] Frost JJ and Zolna MR, Response to inquiry concerning the availability of publicly funded contraceptive care to U.S. women, memo to U.S. Senator Patty Murray, Senate Health, Education, Labor and Pensions Committee, New York: Guttmacher Institute, May 3, 2017, https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017 (last accessed 7/17/18).

expansions—and another 35 percent have coverage through Medicaid and other public programs.[4]

In 2015, the contraceptive care delivered by Title X–funded providers helped women avoid 822,000 unintended pregnancies, which would have resulted in 387,000 unplanned births and 278,000 abortions.[5] Without the contraceptive care provided by these health centers, the U.S. rates of unintended pregnancy and abortion would have been 31 percent higher, and the teen unintended pregnancy rate would have been 44 percent higher.[6] Title X is a vital program, especially for low-income women and teens as:

> access to and consistent use of the most effective contraceptive methods are not enjoyed equally by all U.S. women. Disparities in contraceptive use are a major reason why half of U.S. pregnancies—3.2 million each year—are unplanned. . . . [U]nplanned and teen pregnancies occur disproportionately to poor women (those with incomes below the federal poverty level), whose unplanned pregnancy rate is five times that of higher income women.[7]

Concern for low-income women led President Nixon to push for national family planning assistance in the 1960s, stating that "unwanted or untimely childbearing is one of the several forces which are driving many families into poverty or keeping them in that condition."[8] That remains a driving concern today. Studies have shown that access to family planning assistance makes it more likely that a teen will graduate high school, that a woman will achieve her educational and career goals, and that a woman will earn more money (positively impacting not only her life, but the lives of her family).[9] Access to family planning also leads to healthier

---

[4] Fowler CI et al., Family Planning Annual Report: 2015 National Summary, Research Triangle Park, NC: RTI International, 2016, http://www.hhs.gov/opa/sites/default/files/title-x-fpar-2015.pdf (last accessed 7/17/18).

[5] Frost JJ, et al., Publicly Funded Contraceptive Services at U.S. Clinics, 2015, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015 (last accessed 7/17/18).

[6] Hasstedt K, Why We Cannot Afford to Undercut the Title X National Family Planning Program, Guttmacher Institute, Jan. 30, 2017, https://www.guttmacher.org/gpr/2017/01/why-we-cannot-afford-undercut-title-x-national-family-planning-program (last accessed 7/17/18).

[7] Adam Sonfield, *What Women Already Know: Documenting the Social and Economic Benefits of Family Planning*, Guttmacher Institute (Mar. 2013), *available at* https://www.guttmacher.org/gpr/2013/03/what-women-already-know-documenting-social-and-economic-benefits-family-planning.

[8] Special Message to the Congress on Problems of Population Growth (Jul. 18, 1969), *available at* http://www.presidency.ucsb.edu/ws/?pid=2132.

[9] Adam Sonfield et al., *The Social and Economic Benefits of Women's Ability To Determine Whether and When to Have Children*, Guttmacher Institute, *available at* https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children, and *Staff of J. Economic Comm., 114th Cong. The Economic Benefits of Access to Family Planning*, *available at*

relationships, better health outcomes, and better parenting.[10] Title X is critical in assuring that teens and low-income women can achieve these same positive outcomes.

For many women, a visit to a family planning provider is about far more than birth control. During a visit for contraceptive services at a Title X site, women commonly receive other preventive sexual and reproductive health services, including preconception health care and counseling, STI testing and treatment, human papillomavirus (HPV) vaccinations, cancer screening, Pap tests for early detection of cervical cancer, and referrals for mammograms. Title X providers also screen for a host of other potential health issues, such as high blood pressure, diabetes, and depression, connecting clients to further care when needed.[11] For four in 10 women who obtain their contraceptive care from a safety-net family planning center that focuses on reproductive health, that provider is their only source of care.

Title X improves the health of our States' residents beyond helping them plan for their pregnancies. In 2010, the services provided within the Title X network prevented 87,000 preterm or low-weight births, 63,000 STIs and 2,000 cases of cervical cancer.[12]

B. Title X Is a Critical Program That Provides High-Quality Care To Thousands of Residents of Washington, Massachusetts, Oregon, and Vermont Every Year.

1. *Washington*

The Washington State Department of Health (DOH) is the sole grantee of Title X funds in Washington State and runs the program. Washington's current grant project period is one year and six months and ends August 31, 2018.

Washington's Title X expenditure for 2017 was approximately $13 million. The state-funded amount was approximately $9 million, and the federally funded amount was approximately $4 million.

---

https://www.jec.senate.gov/public/_cache/files/d0a67745-74ff-439c-a75a-aacc47e0abc1/jec-fact-sheet---economic-benefits-of-access-to-family-planning.pdf.

[10] *Id.*

[11] Frost JJ, Gold RB and Bucek A, Specialized family planning clinics in the United States: why women choose them and their role in meeting women's health care needs, Women's Health Issues, 2012, 22(6):e519–e525, http://www.whijournal.com/article/S1049-3867(12)00073-4/pdf (last accessed 7/17/18).

[12] Sonfield A, Beyond preventing unplanned pregnancy: the broader benefits of publicly funded family planning services, *Guttmacher Policy Review*, 2014, 17(4):2–6, http://www.guttmacher.org/gpr/2014/12/beyond-preventing-unplanned-pregnancy-broader-benefits-publicly-funded-family-planning (last accessed 7/17/18). 2010 is the most recent year for which these data are available.

Washington served 91,284 patients through Title X in 2017, with 128,296 patient visits. In 2017, 57 percent of Washington's Title X-funded patients were at or below the FPL, and 81 percent had incomes below 200 percent of the FPL. Sixteen percent of Title X clients were women of color. Nine percent of patients were under the age of 18. The DOH projects that Title X services prevented 16,233 unintended pregnancies in 2017; the resulting cost savings for Title X services (including STI, HIV, HPV, and Pap tests) was $113,434,910.

DOH distributes Washington's Title X funds by an approved allocation process. DOH broadly distributes information about an upcoming competition for Title X funds toward the end of the project period. It conducts a formal Request for Proposals process to select providers. After the due date for proposals is past, they are reviewed by objective reviewers and scored on criteria that includes choosing the entities that can best utilize the available funding to carry out Title X requirements.

In addition to Title X funds, Washington separately funds contracted Title X health care providers for Title X-allowable services. Further, some Medicaid providers in Washington offer Title X-allowable services but are not Title X projects. The funding from Title X and Medicaid is separate and distinct. However, if an entity receives Title X funding, all clients that have received services according to Title X guidelines are counted as Title X clients in the data system regardless of their funding source.

There are 12 Title X sub-grantee agencies with 70 clinic sites across Washington State. Five of the 12 agencies that receive Title X funds in Washington perform abortions outside of the Title X project. There are several counties in Washington that only have one Title X provider, including Clallam, Grays Harbor, Pacific, Kitsap, Wahkiakum, Lewis, Thurston, Mason, Jefferson, Whatcom, Skagit, Clark, Skamania, Kittitas, Chelan, Ferry, Pend Oreille, Whitman, and Walla Walla. All sites have physicians on staff as medical directors, but nurse practitioners primarily provide care to patients. All sites have nurse practitioners accessible during all business hours.

Washington subjects Title X providers to numerous contractual requirements. These include: (1) they must be non-profit agencies; (2) they must be able to meet reporting requirements (including the ability to extract data from their Electronic Medical Records system to report to the contracted data vendor); (3) they must follow all regulations; (4) they must be able to separate abortion activities from Title X funding; and (5) they must have qualified personnel and licensed providers.

2. *Massachusetts*

Approximately $6,155,000 in Title X funding flows into Massachusetts annually. These funds support, either directly or indirectly, 90 family planning providers. In 2016 alone, Title X

providers in Massachusetts served 66,072 people.[13] Data from fiscal year 2017 shows that 88 percent of all Title X visits were made by female patients, 50 percent of all patients were between 18 and 29 years old, and 88 percent of all patients were at or below 200 percent of the FPL.

Title X providers in Massachusetts offer a wide range of services and care, including pregnancy testing and options counseling; contraceptive services and supplies; pelvic exams; screenings for cervical and breast cancer; screenings for high blood pressure, anemia, and diabetes; screenings and treatment for STIs; infertility services; health education; and referrals for other health and social services. These services not only have a profound and positive impact on patients' lives, but also save Massachusetts and the federal government money. In fact, according to one estimate, Title X services save Massachusetts and the federal government approximately $140 million per year in Massachusetts alone.[14] Beyond the significant fiscal impact, the services provided have a real and profound impact on the lives of Massachusetts women and their families. In 2014, Title X-funded centers met 15 percent of all contraceptive needs in Massachusetts[15] and helped avert 13,600 unintended pregnancies.[16]

Title X funds are crucial and must be spent wisely. Programs that currently receive these funds do so in a culturally competent and welcoming manner. They offer an array of services. They understand the health needs of their patients. The proposed rule does not advance Title X's purpose and undermines the ability of its recipients to do the important work that they do every day on behalf of some of Massachusetts' most vulnerable patients.

3. *Oregon*

The state of Oregon has been the umbrella grantee for Title X services throughout Oregon since 1970. The Oregon Health Authority's Reproductive Health Program administers the state's Title X grant. In fiscal year 2018, Oregon's Title X award was $3,076,000. This funding provides direct support to a network of 35 agencies with 106 clinic sites and is comprised of local public

---

[13] *Title X in Massachusetts: Improving Public Health and Saving Taxpayer Dollars*, National Family Planning & Reproductive Health Association, at 1 (Dec. 2017), available at https://www.nationalfamilyplanning.org/file/state-snapshots-2017/Massachusetts.pdf.

[14] *Contraception, Cost Savings at Title X-Funded Centers: From Contraceptive Services*, Guttmacher Institute Data Center, https://data.guttmacher.org/states/table?state=MA&dataset=data&topics=96 (last visited July 30, 2018).

[15] *Contraception, Title X-Funded Centers: Percentage of Need Met By Title X-Funded Centers*, Guttmacher Institute Data Center, https://data.guttmacher.org/states/table?state=MA&dataset=data&topics=257 (last visited July 30, 2018).

[16] *Contraception, Outcomes Averted By Title X-Funded Centers: From Contraceptive Services*, Guttmacher Institute Data Center, https://data.guttmacher.org/states/table?state=MA&topics=120&dataset=data (last visited July 30, 2018).

health authorities, federally qualified health centers (FQHCs), Planned Parenthood clinics, rural health centers, and other community health centers. Almost every county has at least one Title X Program provider, often with multiple clinic sites per provider.

A total of 37,012 unduplicated clients were served by Title X sub-recipient clinics in 2017. Of these clients, 15,225 (41 percent) were uninsured, meaning they have limited options for accessing affordable reproductive health services.

Oregon's Title X clinics provide essential, high-quality preventive reproductive health services to underserved individuals. Data from 2017 show that of the 37,012 clients served by Oregon's Title X clinics:

- 93 percent were female;
- 47 percent were females between the ages of 18 and 29;
- 95 percent were at or below 250 percent of the FPL and 66 percent were at or below 100 percent of the FPL; and
- 60,647 clinic visits were provided, including:
  - 6,511 cervical cancer screenings
  - 49,366 STI screenings
  - 12,649 annual/well-woman exams

Further evidence of the high quality of care in Oregon's Title X clinics comes from clients themselves. According to Oregon's 2015 Reproductive Health Client Satisfaction Survey, 99 percent of clients reported the following: that medical staff respected their values, they trust the medical staff to help them make decisions, and they would recommend the clinic to friends or family.

In addition to offering high quality care, Oregon's Title X program is also cost effective. In 2017, over 6,000 unintended pregnancies were averted through the provision of effective contraceptive methods and high-quality counseling services in Oregon's Title X clinics. Using a conservative estimate of $16,000 for an average delivery and the first year of infant health care under Oregon's Medicaid program, even if less than half of these 6,000 unintended pregnancies resulted in births, the savings to the state were in excess of $40 million in taxpayer funds in Oregon alone in 2017.

4. *Vermont*

The Vermont Department of Health, the sole grantee for Vermont, has relied on Title X grant funding for decades. The Vermont Department of Health receives about $775,000 annually from Title X, of which the majority is passed on directly to the sole sub-grantee, Planned Parenthood of Northern New England (PPNNE). With these funds, PPNNE provides reproductive health

services at 10 different clinics located throughout Vermont. These clinics serve a largely rural population—none are located in Chittenden County, the most populous county of Vermont.

Through these clinics, Title X provided family planning services to 9,808 Vermonters in 2016. Of these, 44 percent reported income of less than 100 percent of the FPL, and 76 percent had income less than 250 percent of the FPL. Vermont's Title X patients were 11 percent male, and 20 percent were under age 20. And 22 percent had no health insurance.[17]

Services provided by Title X funds in Vermont include "a broad range of family planning and related preventive health services for Vermont women, men, and their partners."[18] As required in 42 C.F.R. Part 59, all pregnancy counseling at Title X clinics in Vermont is nondirective.[19] In addition, Title X funds provided "patient education and counseling; breast and pelvic examinations; breast and cervical cancer screening according to nationally recognized standards of care; STI and Human Immunodeficiency Virus (HIV) prevention education, counseling, testing and referral; and pregnancy diagnosis and counseling."[20]

Title X funding has been an essential part of the success that Vermont has seen in reproductive health outcomes over time. For example, while the current Title X rules and program have been in place, the number of teen pregnancies in Vermont has steadily declined.[21] And, the number of teen abortions occurring in Vermont has steadily declined.[22] This is consistent with the overall drop in abortion rates in Vermont and nationwide.[23] Title X-specific analyses show that these trends over time are at least partly attributable to Title X funding. One estimate shows that approximately 1900 unintended pregnancies were averted by Title X-funded clinics in Vermont

---

[17] Office of Population Affairs, Title X Family Planning Annual Report: Vermont (April 2017) (on file with Vermont Attorney General's Office).

[18] Office of Population Affairs, Program Review: Title X Family Planning Project: Vermont Department of Health, 1, 33 (May 2017) (on file with Vermont Attorney General's Office).

[19] *Id.* at 34-35.

[20] *Id.* at 1.

[21] Kathryn Kost et al., *Pregnancies, Births and Abortions Among Adolescents and Young Women in the United States, 2013: National and State Trends by Age, Race and Ethnicity*, 36 (Guttmacher Inst. Aug. 2017) (data going back to 1988), *available at* https://www.guttmacher.org/sites/default/files/report_pdf/us-adolescent-pregnancy-trends-2013.pdf

[22] *Id.* at 40.

[23] Vt. Dept. of Health, "Fig. 11: Vermont and U.S. Abortion Ratios 1980 – 2016," *2016 Vital Statistics: 132nd Report Relating to the Registry and Return of Births, Deaths, Marriages, Divorces, and Dissolutions*, 129 (Agency of Human Servs. 2016) (data going back to 1980), *available at* http://www.healthvermont.gov/sites/default/files/documents/pdf/Vital%20Statistics%20Bulletin%202016.pdf

in 2014.[24] Of those, 400 would have been teen pregnancies.[25] In addition, Title X's successes have not been limited to pregnancy outcomes. Although Title X is not the only public health program addressing these issues, cervical cancer rates[26] and new HIV/AIDS diagnoses[27] in Vermont have been generally declining as well. In 2016, Title X clinics screened 1,344 clients for cervical cancer and 2,834 clients for HIV.[28]

The successes of the Title X program translate from public health to the public fisc. By one estimate, Title X services in Vermont saved the state and federal governments $7,868,000 in 2010.[29] Of that money, the majority ($7,520,000) was saved in annual maternity and birth-related costs as a result of contraceptive services.[30] An additional $215,000 was saved in annual miscarriage and ectopic pregnancy costs.[31] Tens of thousands of dollars in public health costs were saved from STI and cancer screening at Title X clinics.[32]

C. The Fatal Deficiencies in the Proposed Rule

---

[24] *Number of Unintended Pregnancies Averted by Title X-Funded Centers*, Data Ctr., Guttmacher Inst., https://data.guttmacher.org/states/table?state=VT&topics=114 (last visited July 30, 2018).

[25] *Number of Unintended Pregnancies Averted to Clients Aged <20 by Title X-Funded Centers*, Data Ctr., Guttmacher Inst., https://data.guttmacher.org/states/table?state=VT&topics=114 (last visited July 30, 2018).

[26] Vermont Cancer Registry, *HPV Associated Cancers—Data Brief*, 1 (Vt. Dept. of Health May 2018) (data going back to 1994), *available at* http://www.healthvermont.gov/sites/default/files/documents/pdf/stat_cancer_HPV_Assoc_Ca_Data_Brief.pdf.

[27] Decrease seen since the height of the epidemic, and the introduction of the first effective treatments, in the early 1990s. Vt. Dept. of Health, "History of the HIV/AIDS epidemic, Vermont residents at diagnoses 1984 – 2014," *Vermont HIV/AIDS Annual Report*, 2 (May 2015), *available at* http://www.healthvermont.gov/sites/default/files/documents/pdf/ID_HIV_surveillance_Vt%20HIV%20Annual%20Rep%202014.pdf; *see also* Vt. Dept. of Health, *2016 Vermont HIV Annual Report*, 2-3 (May 2018), *available at* http://www.healthvermont.gov/sites/default/files/documents/pdf/ID_HIV_VermontHIVAnnualReport2016.pdf.

[28] Office of Population Affairs, Title X Family Planning Annual Report: Vermont, 10, 13 (April 2017) (on file with Vermont Attorney General's Office).

[29] *Total Annual Gross Savings from Services Provided During Family Planning Visits at Title X-Funded Centers*, Guttmacher Institute Data Center, https://data.guttmacher.org/states/table?state=VT&topics=98 (last visited July 30, 2018).

[30] *Annual Maternity and Birth Related Costs (Through 60 Months) Saved from Contraceptive Services*, Guttmacher Institute Data Center, https://data.guttmacher.org/states/table?state=VT&topics=96 (last visited July 30, 2018).

[31] *Annual Miscarriage and Ectopic Pregnancy Costs Saved from Contraceptive Services*, Guttmacher Institute Data Center, https://data.guttmacher.org/states/table?state=VT&topics=96 (last visited July 30, 2018).

[32] *Annual Costs Saved From Chlamydia, Gonorrhea and HIV Testing at Title X-Funded Centers; Annual Costs Saved from Pap and HPV Testing at Title X-Funded Centers,* Guttmacher Institute Data Center, https://data.guttmacher.org/states/table?state=VT&topics=97 (last visited July 30, 2018).

1. *The proposed rule requires directive counseling in violation of the Consolidated Appropriations Act, 2018.*

In numerous ways, the proposed rule imposes unethical requirements to provide directive, mandatory patient counseling. This is contrary to the Consolidated Appropriations Act, 2018, which states that, with respect to the amounts appropriated "for carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, . . . all pregnancy counseling shall be nondirective."[33] While Congress is free to "make a value judgment favoring childbirth over abortion,"[34] once Congress makes a policy choice executive agencies are not at liberty to ignore it. Here Congress has required that counseling of patients using Title X funds may not be slanted, and HHS may not direct Title X providers to disregard Congress's directive.

The proposed rule requires Title X funds be used for directive counseling in several ways. First, the rule prohibits Title X providers from referring a patient who discovers she is pregnant to abortion providers, except in the narrow circumstances where the patient "clearly states" that she has "already decided" she will have an abortion.[35] Of course, such a "clear decision" for someone who learned minutes earlier that she was pregnant would be unlikely, meaning the vast majority of patients will be referred away from abortion providers. Second, providers are prohibited from even "present[ing]" the option of abortion. Third, providers must refer patients for "appropriate prenatal and/or social services (such as prenatal care and delivery, infant care, foster care, or adoption)" whether or not the patient desires such referrals.[36] Fourth, providers are required to assist in setting up these referral appointments—unless the patient wants an abortion.[37] In short, if a pregnant patient says that she wants advice on birth or adoption options the provider is unencumbered, but if she wants to discuss the option of abortion, the provider may not assist her. Only if the patient states she wants an abortion may the provider offer her a list that includes abortion providers, but that list must obfuscate which clinics offer what she seeks and which do not.[38]

These provisions are intended to, and do, slant Title X counseling against termination and in favor of childbirth, in violation of Congress's directive otherwise. Indeed, the text of the proposed rule says nothing about nondirective counseling, instead eliminating the former

---

[33] Pub. L. No. 115-141, div. H, tit. II, 132 Stat. 348, 716 (2018), https://www.congress.gov/bill/115th-congress/house-bill/1625/text.

[34] *Rust v. Sullivan*, 500 U.S. 173, 192 (1991) (quoting *Maher v. Roe*, 432 U.S. 464, 474 (1977)).

[35] 83 Fed. Reg. 25,531 (proposed § 59.14(a), (c)).

[36] 83 Fed. Reg. 25,531 (proposed § 59.14(b)).

[37] *Id*.

[38] 83 Fed. Reg. 25,531 (proposed § 59.14(c)).

requirement to provide "neutral, factual information and nondirective counseling . . . ." 42 C.F.R. 59.5(a)(5)(ii). Through the repeal of the nondirective counseling requirement and the addition of severe restrictions on referrals, the proposed rule seeks to replace what has been a patient-guided, provider-informed approach to care with a system that jeopardizes both providers' ethical obligations and patients' health.

2. *The proposed rule illegally injects the government into the provider-patient relationship.*

We are deeply troubled by the Department's proposed government interference in the relationship between a medical provider and a patient, and not only because it violates a federal law. The proposed rule purports to tell providers paid with Title X funds what they can and cannot say when a patient discovers she is pregnant. The government should have no role telling a health care provider what to say to a patient. Here, the proposed rule prohibits nurses and nurse practitioners, who see the majority of Title X patients, from mentioning abortion, and doctors may do so only in the very limited circumstances permitted in proposed section 59.14(c) and (d).[39] Under the proposed rule, Title X providers could not simply take off their "Title X hats" and offer the same nondirective advice that they currently offer because the rule would require Title X providers to comply with Title X requirements, whether or not Title X funds a particular patient's service.

As America's women's health providers have jointly stated in opposing the proposed rule, "[p]oliticians have no role in picking and choosing among qualified providers."[40] This government script for providers when addressing their Title X patients violates the American Medical Association's Code of Ethics, which states that "withholding information without the patients' knowledge or consent is ethically unacceptable."[41] Similarly, the Code of Ethics for Nursing requires nurses to give complete – not slanted – information to patients.[42]

---

[39] 83 Fed. Reg. 25,531.

[40] "America's Women's Health Providers Oppose Efforts to Exclude Qualified Providers from Federally-Funded Programs," Join Statement of the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American College of Nurse-Midwives, the American College of Physicians, the Association for Physician Assistants in Obstetrics and Gynecology, the National Association of Nurse Practitioners in Women's Health, Nurses for Sexual and Reproductive Health, and the Society for Adolescent Health and Medicine (May 23, 2018), https://www.acog.org/About-ACOG/News-Room/Statements/2018/Health-Providers-Oppose-Efforts-to-Exclude-Qualified-Providers-from-Federally-Funded-Programs (last accessed on July 17, 2018).

[41] American Medical Association, Code of Medicaid Ethics Opinion 2.1.3, Withholding Information from Patients, available at https://www.ama-assn.org/delivering-care/withholding-information-patients (last accessed on July 17, 2018).

[42] Code of Ethics for Nursing, Provision 1.4, www.bc.edu/content/dam/files/schools/son/pdf2/ANA code of ethics.pdf (last accessed on July 17, 2018) (patients must be given "accurate, complete, and understandable information in a manner that facilitates an informed decision").

Further, the proposed rule is arbitrary and capricious because it only permits "a medical doctor" to provide the very limited referral for abortion the proposed rule allows.[43] In our States, this severely restricts the nondirective counseling Title X patients would receive. In Oregon, for example, over 93 percent of visits to Title X clinics in 2017 were conducted by non-physician caregivers such as nurse practitioners and physician assistants. The preamble to the proposed rule itself recognizes that only 22 percent of clinical service FTEs delivered to Title X patients were provided by medical doctors.[44] As a result, the proposed rule would prevent 78 percent of the medical professionals who see patients at Title X providers from providing even the limited and intentionally obfuscated abortion referral it claims to authorize. The Department does not explain why prohibiting such a large percentage of Title X caregivers from providing any kind of counseling on the legally available option of abortion comports with the statutory requirement that Title X funds be used only for nondirective counseling, and we request such an explanation.

The proposed rule's roadblocks for a patient seeking complete and accurate health information also are arbitrary and capricious. First, the patient must already know that she wants an abortion. This precludes the patient from engaging in an important conversation with her health care provider about the pros and cons of abortion. The Department fails to address the fact that many women do not ask directly about abortions immediately upon learning they are pregnant, and instead consider it as one of many medical options. We ask that the Department explain how its proposed restrictions can be reconciled with this experience of clinicians. Second, only a doctor can give the patient the referral list. This appears designed to undermine the provision of healthcare. Moreover, it is not clear what, if any, counseling a physician is entitled to provide to a woman who has decided to have an abortion given that the proposed rules prohibit providers from "promot[ing]" and "support[ing]" abortion as a method of family planning. Limiting the medical information that physicians can offer their patients unreasonably intrudes upon the physician-patient relationship and undermines ethical standards of care.

The preamble to the proposed rule relies on "Federal conscience statutes" to justify its diverging from the requirement in the Consolidated Appropriations Act that Title X-funded counseling must be nondirective.[45] This reliance is misplaced. The proposed rule does not merely create an exception to nondirective counseling for conscience objectors. Instead, it allows conscience objectors to dictate what all Title X providers may say. Purportedly to uphold conscience protections, the proposed rule prohibits nearly 80 percent of the medical professionals who treat patients at Title X clinics from saying anything about abortion, regardless of their religious or moral beliefs. Likewise, it severely restricts the information medical doctors can impart, again regardless of their religious or moral convictions. In doing so, it makes no accommodation for providers who have religious or moral convictions contrary to the proposed rule, for instance

---

[43] 83 Fed. Reg. 25,531 (§ 59.14(a); *see also*, § 59.14(c)).

[44] 83 Fed. Reg. 25,523.

[45] 83 Fed. Reg. 25,506-507.

those whose convictions align more closely with professional ethics rules. These prohibitions go substantially further than necessary to vindicate a select number of providers' conscience objections, and we ask the Department to better explain its reasoning.

3. *The proposed rule is contrary to, and ignores, the Department's authoritative recommendations for evidence-based "family planning methods and services" without reason or explanation.*

A federal agency cannot simply ignore its prior statutory interpretations. This is especially true where, as here, the prior interpretation is based on factual findings or cited evidence, and the new interpretation fails to consider that evidence. "[T]he consistency of an agency's position is a factor in assessing the weight that position is due." *Good Samaritan Hospital v. Shalala*, 508 U.S. 402, 417 (1993). "To be sure, the requirement that an agency provide reasoned explanation for its action would ordinarily demand that it display awareness that it is changing position." *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).

In 2014, the Department's Centers for Disease Control and Prevention (CDC) issued a Recommendations and Report entitled "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs."[46] The report provided the agency's view on what are "acceptable and effective family planning methods and services."[47] The CDC stated:

> This report provides recommendations developed collaboratively by CDC and the Office of Population Affairs (OPA) of the U.S. Department of Health and Human Services (HHS). The recommendations outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services. The primary audience for this report is all current or potential providers of family planning services, including those working in service sites that are dedicated to family planning service delivery as well as private and public providers of more comprehensive primary care.[48]

---

[46] Gavin, L, Moskosky, S, Carter, M, Curtis, K, Glass, E, Godfrey, E, Marcell, A, Mautone-Smith, N, Pazol, K, Zapata, L, "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs." Morbidity and Mortality Weekly Report, 63 Recommendations and Reports No. 4 (April 25, 2014), available at https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf (last accessed July 19, 2018) (hereinafter "CDC Report and Recommendations").

[47] 42 U.S.C. § 300(a).

[48] CDC Report and Recommendations at 1.

The report provided "recommendations for how to help prevent and achieve pregnancy, emphasize[d] offering a full range of contraceptive methods for persons seeking to prevent pregnancy, highlight[ed] the special needs of adolescent clients, and encourage[d] the use of the family planning visit to provide selected preventive health services for women, in accordance with the recommendations for women issued by the Institute of Medicine and adopted by HHS."[49] In other words, it was a careful, evidence-based description of the best practices for family planning in the United States.

Without explanation, the proposed rule contradicts this report in numerous ways, and it does so without mentioning the report. The CDC report's "recommendations support offering a full range of Food and Drug Administration (FDA)-approved contraceptive methods,"[50] while the proposed rule eliminates "medically approved" from the requirement that projects provide a broad range of family planning methods.[51] The CDC report advocates a "[c]lient-centered approach" where the patient is offered a "broad range of contraceptive methods so that clients can make a selection based on their individual needs and preferences,"[52] while the proposed rule offers Title X funds to a clinic that chooses to offer only a single method of family planning.[53] The CDC report states that a provider, after administering a pregnancy test, should present "options counseling" and "appropriate referrals,"[54] while the proposed rule mandates concealing the full range of options available to the patient, including abortion, and directs omitting abortion providers from referral lists.[55] These changes undermine long-held, evidence-based standards of care.

The Department fails to explain why it is rejecting its own recommendations expressly "based on scientific knowledge."[56] Indeed, it fails even to acknowledge the existence of those

---

[49] *Id*.

[50] CDC Report and Recommendations at 2.

[51] 83 Fed. Reg. 25,530 (proposed § 59.5).

[52] CDC Report and Recommendations at 2.

[53] 83 Fed. Reg. 25,530 (proposed § 59.5). Without doubt, the proposed regulations' emphasis on fertility awareness-based methods of family planning over all other forms of contraception will result in increased numbers of unintended pregnancies, including teen pregnancies. Table 3-2, Contraceptive Technology, http://www.contraceptivetechnology.org/wp-content/uploads/2013/09/CTFailureTable.pdf (last visited July 30, 2018) (listing a 24% failure rate for typical use of fertility awareness-based methods, compared to a less than 10% failure rate for typical use of hormonal contraceptives and less than 1% failure rate for long-acting reversible contraceptives).

[54] CDC Report and Recommendations at 14.

[55] 83 Fed. Reg. 25,531 (proposed § 59.14).

[56] CDC Report and Recommendations at 4.

recommendations. The proposed rule lacks the "reasoned analysis" the Department concedes is required.[57]

4. *The financial separation requirement reverses a prior agency interpretation and is unsupported by any evidence.*

The proposed rule imposes a new requirement of physical separation between Title X projects and the abortion activities of the Title X grantee/sub-recipient.[58] This requirement reverses the Department's prior interpretation, is imposed without supporting evidence, and does not reflect agency consideration of substantial evidence contradicting the Department's conclusion.

The proposed rule reverses the Department's longstanding interpretation that, "[i]f a Title X grantee can demonstrate [separation] by its financial records, counseling and service protocols, administrative procedures, and other means. . . …, then it is hard to see what additional statutory protection is afforded by the imposition of a requirement for 'physical' separation."[59] The Department states that this reversal is necessary to avoid the risk of (i) intentional or unintentional use of Title X funds for impermissible purposes or the commingling of funds, and (ii) public confusion that Title X funds being used by a family planning organization may be supporting the program's abortion activities.[60]

Despite the need for *evidence* to justify an agency's reversal of course, the preamble to the proposed rule cites no evidence of commingled funds or public confusion. The preamble states that the Department's concerns are "acute" because, according to a Guttmacher Institute report, the percentage of "nonspecialized clinics" such as doctors' offices accounting for abortions performed in the United States inched up 6 percent from 2008 to 2014, which may increase the risk of confusion and misuse of Title X funds.[61] However, the Department has no evidence that any of these nonspecialized clinics receive Title X funds. The Guttmacher Institute itself noted that the data its report relied on included inaccuracies and out-of-date information.[62] This is the only evidence the Department cites of potential public confusion and commingling of funds, yet

---

[57] 83 Fed. Reg. 25,505.

[58] 83 Fed. Reg. 25,532 (proposed § 59.15).

[59] Standards of Compliance for Abortion Related Services in Family Planning Services Projects, 65 Fed. Reg. 41,270, 41,276 (Jul. 3, 2000).

[60] 83 Fed. Reg. 25,507.

[61] *Id*.

[62] Jones, RK, Jerman, J, Abortion Incidence and Service Availability In the United States, 2014, Guttmacher Institute Perspectives on Sexual and Reproductive Health (March 2017) ("Limitations"), https://www.guttmacher.org/journals/psrh/2017/01/abortion-incidence-and-service-availability-united-states-2014 (last accessed July 18, 2018).

it evinces no actual *use* of Title X funds.[63] In fact, unlike the Title X regulations proposed in 1988—which relied in part on two reports, one from the Department's Office of Inspector General (OIG) and the other from The General Accounting Office—the Department currently points to no reports or relevant evidence as justification for the proposed rule.

The Department fails to cite its own safeguards it already has in place to ensure that Title X funds are kept separate from abortion-related services. "According to [the Office of Population Affairs], family planning projects that receive Title X funds are closely monitored to ensure that federal funds are used appropriately and that funds are not used for prohibited activities, such as abortion."[64] These "[s]afeguards to maintain this separation include (1) careful review of grant applications to ensure that the applicant understands the requirements and has the capacity to comply with all requirements; (2) independent financial audits to examine whether there is a system to account for program-funded activities and non-allowable program activities; (3) yearly comprehensive reviews of the grantees' financial status and budget report; and (4) periodic and comprehensive program reviews and site visits by OPA regional offices."[65] Despite this thorough monitoring, the Department fails to provide any evidence of actual threats to Title X funding and instead relies on reports from the 1980s, old Medicaid audits, and unsupported assertions.

The Department's monitoring has been thorough. For example, the 2017 OPA Program Review Report for the Vermont Department of Health found the following:

> Financial documentation at service sites demonstrates that Title X funds are not being used for abortion services and adequate separation exists between Title X and non-Title X activities. (42 C.F.R. § 59.5(a)(5))
>
> REVIEW OF EVIDENCE
> The grantee does not provide abortion services. However, the sub-recipient does provide these services. The sub-recipient has established policies, procedures, and practices to ensure the adequate separation of Title X activities from non-Title X activities. Staff separates their time, after the fact, into clearly defined cost centers in the TimeForce system. This is done each day, is checked by the site supervisor,

---

[63] In a separate part of the preamble addressing the purported need for monitoring of the use of Title X funds, the Department cites a Washington Medicaid Fraud Control Unit investigation. 83 Fed. Reg. 25,509. The Medicaid Fraud Control Unit is part of the Washington Attorney General's Office. Our investigation found that the individuals reporting the alleged violations relied only a newsletter sent out by American Life League and had no additional information or any firsthand knowledge, the state Medicaid agency auditor did not see any indication of fraudulent billing, and there was no pattern of intentional billing misconduct.

[64] Angela Napili, Cong. Research Serv., R45181, *Family Planning Program Under Title X of the Public Health Service Act* 16 (2018), *available at* https://fas.org/sgp/crs/misc/R45181.pdf.

[65] *Id*.

> and is further checked through an analysis of the number and type of services provided each day in the clinic setting by administrative staff.
>
> The sub-recipient demonstrated that no abortion-related activities were provided as part of the Title X project. This included policies and procedures and the actual practices in the clinic setting, counseling and service protocols, intake and referral procedures, and fiscal and other administrative procedures.
>
> This requirement [compliance with Section 1008] was MET.[66]

No evidence indicates that the Vermont Department of Health has ever had any issues complying with Section 1008.

In addition, the Department does not address the steps states like ours take to ensure sub-recipients' separation of Title X funds from any abortion-related activities. In Washington, the State Department of Health Family Planning Program ensures the separation of Title X funds from abortion services through contract language, desk reviews, and on-site monitoring. The goal of monitoring is to document the extent of sub-recipient agencies' compliance with state and federal laws and regulations. Monitoring helps the Family Planning Program assist local agencies with compliance with Federal Title X and state rules related to funding. This ensures accountability.

The Washington Department of Health (DOH) does three types of monitoring: Administrative, Clinical, and Fiscal. As federal grant funds flow through the Family Planning Program to a sub-recipient, the Family Planning Program maintains primary responsibility for ensuring enforcement of federal and state requirements. Those requirements pertain to sub-recipients as they receive state and federal funds. When a sub-recipient signs the Family Planning Program contract with the DOH, they agree to enforce those same certifications, assurances, cost principles, and administrative rules. All of these requirements are incorporated in contract language. Title X sub-recipient contract standard clauses include that the Contractor does "not provide abortion as a method of family planning within the Title X Project. (42 CFR 59.5(5))," and "[t]he Title X Project must not include sterilizations, abortions, or any flat rated service (for instance some STD or HIV testing) or income/revenue generated from them."

Furthermore, the DOH Fiscal Monitoring and Review Guide and On-site Monitoring Tool is used by site consultants and agency fiscal experts to perform on-site reviews every three years or more often if needed. They monitor for documentation that:

---

[66] Office of Population Affairs, Program Review: Title X Family Planning Project: Vermont Department of Health, 21 (May 2017) (on file with Vermont Attorney General's Office).

i. The financial system provides for financial separation of Title X family planning service dollars and abortion service dollars;
ii. Agency personnel must be informed that they could be prosecuted, under Federal law, if they coerce, or try to coerce, anyone to undergo abortion or a sterilization procedure, and the agency has a policy in place to this end;
iii. The agency has written policies that clearly state that no Title X funds will be used in programs where abortion is a method of family planning;
iv. The agency is in compliance with Title X, specifically calling out Section 1008; and
v. Staff members have been trained about separating Title X family planning services and abortion services.

The site consultant verifies this onsite through the sub-recipients' policies and procedures, personnel records, and a review of the accounting system.

In addition, the Washington State Family Planning Manual[67] advises about separating Title X services from abortion, including that Contractors must be in full compliance with Section 1008 prohibiting the use of Title X funds for abortion as a method of family planning.

Oregon's Reproductive Health Program maintains a robust process for monitoring compliance among its Title X agencies. Ongoing and routine compliance reviews ensure that Title X agencies adhere to administrative, clinical, and fiscal requirements. The monitoring process includes:

i. Annual recertification of agencies;
ii. Onsite compliance reviews of consent forms, policies, procedures and protocols; chart audits; onsite clinical observation; and onsite observation of patient and physical environment; and
iii. Regular billing, client enrollment, and quality assurance reviews.

Like Washington's DOH, Oregon's Reproductive Health Program uses a comprehensive Program Certification Verification Tool to monitor its Title X agencies. Specific policies relating to abortion, including the requirement that no federal funds are used for abortion services and that abortion is not provided as a birth control method, are reviewed and verified.

In Massachusetts, the Department of Public Health's robust oversight of sub-recipients providing abortion services ensures compliance with current Title X requirements. The Department of Public Health requires that these sub-recipients establish and follow written policies that clearly indicate that Title X funds will not be used for abortion services, clearly segregate Title X funds to prevent allocation of Title X funding to abortion services; maintain separate inventory for

[67] *Family Planning Manual*, Washington State Department of Health, September 2016, available at https://www.doh.wa.gov/portals/1/Documents/Pubs/930-122-FPRHManualComplete.pdf (last visited July 30, 2018)

abortion and non-abortion services; and implement fiscal review and oversight procedures to assure that no Title X funds are used for abortion services. The Massachusetts Department of Public Health also engages in regular monitoring, and requires all providers to inform them of any changes in their practice.

In Vermont, in addition to the safeguards noted above, PPNNE undergoes an annual financial audit, which specifically examines its Title X expenditures. PPNNE passes its audit every year, including its accounting of Title X funds.[68]

The Department has not explained why these thorough guidance, monitoring, and auditing steps taken by our state agencies and by the Department itself are insufficient to prevent commingling of funds, and we ask the Department to provide this explanation.

5. *The proposed rule would violate the constitutional rights of Title X providers and their patients.*

The proposed rule imposes government restrictions on speech and denies women freedom from government interference in their most intimate and personal decisions that courts will find fatal under the First and Fifth Amendments. It should be withdrawn for these reasons.

In *Rust v. Sullivan*, the Supreme Court recognized that "funding by the government, even when coupled with the freedom of the fund recipients to speak outside of the scope of the Government-funded project," is not "invariably sufficient to justify Government control over the content of expression." 500 U.S. at 199. In some areas, particularly rural areas, the proposed rule is likely to drive all Title X providers from the program, leaving patients without reasonable access to any Title X services. And for those Title X providers remaining in the program, the Department's restriction on speech will extend beyond the Title X program to every patient encounter by every Title X provider, whether or not Title X funds are used. As a consequence, the proposed rule will force all Title X grantees to give up neutral abortion-related speech, whether or not they are wearing a "Title X hat." These facts are different from those presented in *Rust v. Sullivan*, which makes that decision distinguishable.

The massive contraction of the Title X program that would occur under the proposed rule, and is shown herein as to our States, results in a violation of the unconstitutional conditions doctrine and the vagueness and overbreadth doctrines of the First Amendment. The proposed rule interferes with a doctor's ability to provide, and a woman's right to receive, information concerning abortion and abortion-related services, both within and outside of the Title X program. This violates women's Fifth Amendment rights to be free of government interference

[68] Financial audits for 2015 – 2017 may be downloaded at the Federal Audit Clearinghouse, https://harvester.census.gov/facdissem/Main.aspx. Financial audits for 2013 and 2014 on file with the Vermont Attorney General's Office. Financial audits older than five years were not readily available.

in their decisions whether to continue pregnancies to term. It is also contrary to the First Amendment, especially given the Supreme Court's recent recognition that "[a]s with other kinds of speech, regulating the content of professionals' speech 'pose[s] the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information.'" *National Institute of Family and Life Advocates v. Becerra*, 138 S. Ct. 2361, 2374 (2018) (quoting *Turner Broadcasting System v. FCC*, 512 U.S. 622, 641 (1994)). And it contravenes Supreme Court cases that reject "confin[ing] the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 67 n.8 (1976). Finally, it interferes in the states' rights to design and implement health care programs in their states by causing the Title X regulations to be applicable outside the Title X program.

If the Department does not voluntarily withdraw the proposed rule, we ask it to explain, in light of these facts, how the proposed rule is consistent with the Constitution.

6. *The proposed rule includes many requirements that are unsupported by any evidence and, if not abandoned, will be found to be arbitrary and capricious.*

   a. *The primary care requirement is unsupported and arbitrary.*

The proposed rule requires that Title X providers "should offer either comprehensive primary health services onsite or have a robust referral linkage with primary health providers who are in close physical proximity to the Title X site."[69] This requirement is supposedly meant to "promote holistic health and provide seamless care."[70] This call for holistic and seamless care rings hollow considering that the Department is simultaneously proposing specific steps to limit the provision of complete health information and seamless care to patients through abortion counseling and referral restrictions. Instead, the primary care requirement appears intended to push out long-standing Title X providers who have specialized in family planning services and rural Title X providers who may not have "robust referral linkage[s] . . . in close physical proximity."[71]

This requirement alone could dramatically reduce the scope of the Title X program in our States depending upon how the Department defines "close physical proximity." This requirement is not stated in the statute. The Department must explain how it can be reconciled with the goals of the Title X program.

---

[69] 83 Fed. Reg. 25,530.

[70] *Id.*

[71] *Id.*

b. *The provisions requiring reporting on minors are unsupported and irrational.*

Currently, Title X providers must attempt to encourage a minor to involve her or his family in the decision-making process when the minor seeks contraceptive services. Under the proposed rule, this "encouragement" would be replaced with undue pressure on both the provider and the minor. The proposed rule requires that a Title X provider document "in the minor's medical records the specific actions taken by the provider to encourage the minor to involve her/his family (including her/his parents or guardian) in her/his decision to seek family planning services."[72] The only exception to this requirement, which must be documented in the minor's medical record, is if the provider "suspects the minor to be the victim of child abuse or incest" and this has been reported in compliance with state or local law.

Today, if a minor explains to a Title X provider that she wishes not to involve her family, that wish is respected. Minors may choose not to involve their families in their health care decisions due to differences of religious belief, fear of violence, fear of abandonment, lack of a suitable adult to involve, or simply a desire for confidential care. By requiring that the providers' efforts to encourage family involvement be recorded in the medical record, the proposed rule could force providers to apply pressure on minor patients to involve their families even when doing so is not in the minor's best interests. The proposed rule could ultimately have a chilling effect on honest and open conversations between providers and minor patients. Further, the proposed rule imperils patient confidentiality to such a degree that minors could be discouraged from seeking care altogether.[73] This will serve neither the purposes of the Title X program nor patients.

c. *The other reporting requirements are unsupported, vague, and beyond the Department's legal authority.*

The proposed rule would bury Title X projects and sub-recipients in overly burdensome reporting requirements. For example, a Title X project would need to report for each sub-recipient and referral agency not only the exact services provided, but also a "[d]etailed description of the extent of the collaboration" even down to the individuals involved and inclusive of undefined "less formal partners within the community."[74]

Along with the inclusion of the "less formal partners," the proposed rule's definition of "referral agency" makes the reporting requirements overly broad. The proposed rule suggests that even if a referral agency does not receive Title X funds, it may still be "subject to the same reporting

---

[72] *Id.*

[73] *See, e.g.*, *Planned Parenthood Fed'n of Am. v. Heckler*, 712 F.2d 650, 659-61 (D.C. Cir. 1983) (describing Congress's decision not to mandate family involvement in Title X care for minors).

[74] 83 Fed. Reg. 25,530.

requirements as a grantee or sub-recipient."[75] These requirements improperly overreach into relationships not otherwise governed by Title X regulations and burden projects, sub-recipients, and referral agencies. Rather than achieving the stated goal of creating a robust referral system, these requirements will cause projects and sub-recipients to limit their referral networks in order to control the amount of reporting.

These changes will have significant impacts. For example, the proposed regulations' applicability to "referral agencies"[76] of Title X clinics would impact a significant number of Vermont's health care providers. As a small and rural state, Vermont's pool of available health care referral partners is also small. PPNNE maintains a "comprehensive referral data base" of other local health care providers.[77] But the proposed regulations would be unnecessarily and prohibitively restrictive on those health care providers that do not receive Title X funds, interfering with those providers' and their patients' rights and their ability to provide ethical and professional care.

7. *The proposed rule does not comply with Executive Orders 12866 and 13562.*

Executive Orders 12866 and 13562 require agencies to "assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits." 83 Fed. Reg. 25521. Executive Order 12866 requires that a "significant regulatory action" comply with additional regulatory requirements. This proposed rule meets all the definitions of a "significant regulatory action" because it would (1) have an annual effect on the economy of $100 million or more and will "adversely and materially affect" the health sector of the economy, public health, and state and local governments; (2) create a serious inconsistency and interfere with an action taken or planned by another agency; (3) materially alter budgetary impacts of entitlement grants or the right and obligations of recipients thereof; and (4) raise novel legal or policy issues arising out of legal mandates.

The restrictive requirements of the proposed rule disqualify many current Title X grantees from the program across the country. Some Title X patients currently served by these providers will lose access altogether to family planning services, particularly among the uninsured and those residing in rural areas. In 2017, Title X services saved our four States alone many millions of dollars in costs for health care services. Extrapolating those cost savings across all states, the fiscal impact of the proposed rule on the economy will exceed $100 million and will adversely affect public health, the health care sector, and state treasuries. Additionally, the proposed rule materially changes the outflow of entitlement grants and the rights and obligations of grant

---

[75] 83 Fed. Reg. 25,514.

[76] 83 Fed. Reg. 25514.

[77] Office of Population Affairs, Program Review: Title X Family Planning Project: Vermont Department of Health, 11 (May 2017) (on file with Vermont Attorney General's Office).

applicants and recipients. It also raises novel legal and policy issues because of new restrictions on speech. The preamble wrongly concludes that the proposed rule is not economically significant and fails to address these considerations.

8. *The proposed rule is contrary to Congress's intent because it would exclude qualified and experienced Title X providers from the program and reduce access to essential preventive health services.*

The impact of the proposed rule is contrary to the Title X statute. The proposed rule appears to be designed to deny Title X funds to many of the current Title X providers in our States and nationwide, and it does not address the impact this rule will have on our States' residents and budgets. The proposed rule, if implemented, will leave many counties without a Title X provider. Because the proposed rule will undermine the quality of health care provided and impose burdensome and counterproductive separation and reporting requirements, many providers in our States will be unable or unwilling to comply. Further, the proposed rule falls particularly hard on uninsured patients and those in rural areas, who in some cases will have no other reasonable option for obtaining family planning services. As a result, thousands of people who rely on Title X providers for contraception and other family planning services will lose access to those services. The proposed rule thus frustrates, rather than promotes, the purpose of Title X.

It is no secret that the Department wants to expel Planned Parenthood from the network of Title X providers. As then-candidate Donald Trump stated, "We're not going to allow, and we're not going to fund, as long as you have the abortion going on at Planned Parenthood."[78] More recently, when introducing the proposed rule, President Trump stated: "For decades American taxpayers have been wrongfully forced to subsidize the abortion industry through Title X federal funding so today, we have kept another promise. My administration has proposed a new rule to prohibit Title X funding from going to any clinic that performs abortions."[79] The proposed rule would certainly achieve the President's goal, but as described herein, it would go much further than that.

For some Title X providers, creating a separate corporate entity with complete physical and financial separation will be prohibitively expensive. In Massachusetts, at least one Title X provider, if forced to create a separate corporate entity to continue providing abortion care, will have to stop participating in Title X at one of its locations, resulting in the loss of a geographically important Title X clinic. In Oregon, two major Title X agencies with 12 clinic sites would likely be unable to continue as Title X providers due to the onerous physical

---

[78] Danielle Paquette, "Donald Trump's Incredibly Bizarre Relationship with Planned Parenthood," *Washington Post* (Mar. 2, 2016), https://www.washingtonpost.com/news/wonk/wp/2016/03/02/donald-trumps-incredibly-bizarre-relationship-with-planned-parenthood/?utm_term=.db131f627e96 (last accessed 7/13/18).

[79] https://www.whitehouse.gov/briefings-statements/remarks-president-trump-susan-b-anthony-list-11th-annual-campaign-life-gala/ (last accessed 7/13/18).

separation requirements set forth in the rules. The same is true in Washington and Massachusetts. All of Vermont's Title X clinics would be ineligible to continue under the program. A wide range of Title X provider types will have no choice but to forgo Title X funds, thus reducing their capacity to provide much needed family planning services. For example, it is unclear whether a hospital that runs a Title X clinic (on or off site) that also provides abortion would be able to comply with the requirement to have "separate, accurate accounting records" or "separate personnel, electronic or paper-based health care records."[80] Would funds attributed to the clinic also be attributable to the hospital as a whole? In addition to the practical issues created by the proposed rule's separation requirement, it also creates serious risk to patient safety by requiring separate medical record systems and further stigmatizes legal medical procedures.

In 2017, in Washington, over 14,000 Title X-funded patients received their Title X services at Planned Parenthood or other clinics that provided abortions outside the Title X project. In fact, in 20 of Washington's 39 counties, the only Title X provider is one that performs abortions outside the Title X project.[81] If these Title X providers no longer could offer Title X-funded family planning services due to the separation and other requirements, these patients would need to either locate new Title X providers for their contraception and other family planning services, or forego the benefits of the Title X program. In all of eastern Washington, which is comprised of 20 counties, only four of those counties would have any Title X provider at all. In western Washington, the proposed rule would drive out the Title X providers in 10 additional counties. This includes six of the 10 most populous counties in Washington.

If the proposed regulations take effect, for the first time in the history of Title X, the Vermont Department of Health's Title X funding will be jeopardized. None of the current Title X clinics in Vermont will be eligible for Title X funds. Nor does Vermont have the health care infrastructure to make up for the anticipated loss in funding. Although Vermont has several FQHCs and rural health centers, they are not equipped to absorb all the family planning patients currently served by Title X clinics. Vermont FQHCs saw a total of 4,047 patients for contraceptive management in 2016.[82] By comparison, Vermont's Title X clinics served 9,808 family planning patients in 2016. The FQHCs would have to more than double their family planning patient services in rural areas to absorb the needs of all Title X patients. FQHCs in Vermont are not equipped to do this.

In the Department's zeal to punish providers that perform abortions *outside* of the Title X project, the Department is harming many recipients of Title X services in our States. The

---

[80] 83 Fed. Reg. 25,519.

[81] *See* Attachment 1 (map of Washington counties without Title X services if organizations that also provide abortions are removed from Title X).

[82] 2016 Health Center Data: Vermont Data, Health Resources & Servs. Admin., https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=VT (last visited July 30, 2018).

Department has not explained why issuing a rule to govern Title X that requires thousands of Title X-funded patients to search for a new Title X family planning provider—or go without one entirely—is consistent with Congress's intent in establishing the Title X program, and we ask the Department to provide this explanation.

The harmful consequences of the proposed rule uniquely impact rural and uninsured patients. In five Washington counties, for example, one quarter or more of Title X patients are uninsured, and the only Title X providers are ones that perform abortions outside the Title X project.[83] And in five other counties in rural Washington, Title X patients are served by small Title X clinics associated with providers that perform abortions outside the Title X project. These clinics are in Ellensburg (in Kittitas County), Walla Walla (in Walla Walla County), Wenatchee (in Chelan County), Pullman (in Whitman County), and Moses Lake (in Grant County). We are advised that, because they are so small and a significant amount of their work involves Title X-funded services, at least some of these clinics would not survive the loss of Title X funds. If these current Title X providers are driven from the Title X program, many of these patients will not be able to shift to another provider.[84] Even if some current Title X providers remain in the program, the distance these patients would have to travel to another Title X provider is impracticable. We ask that the Department explain how it reconciles the significant impact the proposed rule will have on rural and uninsured patients with the mission of the Title X program.

In Oregon, significant portions of the state, primarily the rural and frontier areas, are designated as Medically Underserved Areas because they have a shortage of primary health care providers and facilities coupled with high levels of need. The proposed rule will likely cause providers to decline Title X funds in order to maintain their quality of care, further straining access to reproductive health care for Oregonians in these areas. For the 40 percent of Oregon's Title X clients who are uninsured, this burden is heightened because the high quality of care at Title X clinics may not be available to them at other clinics. Title X clinics currently are required to provide the same high quality of care to all clients regardless of ability to pay, whereas other clinics may limit services for patients without coverage sources.

A remarkably broad coalition of Vermont health care providers has joined the nationwide medical community's condemnation of the proposed rule.[85] This Vermont coalition "strongly

---

[83] These counties are Mason (24 percent of Title X patients were uninsured in 2017), San Juan (30 percent), Skagit (29 percent), Douglas (28 percent), and Whitman (27 percent). These counties do not have local health jurisdictions providing family planning services.

[84] In addition, under the proposed rule, eliminating Planned Parenthood and other abortion providers from Title X will cause the following colleges and universities in Washington to lose their Title X providers: Washington State University, Western Washington University, Central Washington University, Eastern Washington University, Big Bend Community College, Columbia Basin College, and Yakima Valley Community College.

[85] *Vermont Health Care Coalition Title X Statement*, Vt. Ass'n of Hosps. and Health Sys. (June 15, 2018), https://vahhs.org/title-x-statement.html (endorsing, among other things, a statement from the American Nurses Association stating, "The Code of Ethics for Nurses outlines that the nurse's primary commitment is to the patient,

opposes" the proposed regulations and warns that those regulations "will significantly restrict access to necessary care for both women and men particularly in rural, hard to serve areas of Vermont."[86] Vermont is a small state, and the Vermont coalition represents a significant majority of all health care providers in Vermont. It is therefore unlikely that the number of Vermont medical professionals who would consent to work in a clinic governed by the proposed regulations would be sufficient to replace the current robust number of Title X-funded providers statewide.

9. *The proposed rule would impose tens of millions of dollars of costs on the treasuries in Washington, Massachusetts, Oregon, and Vermont.*

The costs imposed on our States, along with all other states, by the proposed rule will be well over $100 million. Because the cost or burdens of compliance with the proposed rule will be prohibitively high for many providers, the network of Title X providers will shrink in our States and around the country. Further, some Title X patients will lose all access to family planning services as a result of the proposed rule. As mentioned, in Oregon 41 percent of Title X patients were uninsured in 2017, and in Washington there are counties where upwards of 30 percent of Title X patients are uninsured.

Yet the Department fails to analyze either the significant public health impact or the fiscal impact to states. The Department fails to grapple with the fact that, unless it is expecting the states to step in to plug the fiscal hole created by the loss of Title X funding, unplanned pregnancies and births will occur, cervical cancers will not be diagnosed in early stages, and complications will occur due to untreated STIs, among other things, all resulting in significant increased health care costs for states that Title X is meant to address.

The Department provides no analysis explaining why these impacts are consistent with the fundamental mission of the Title X program. In fact, they are not. Analyses show that significant cost savings are achieved by funding family planning services. Nationally, an estimated $7.09 is saved for every dollar spent.[87] In short, a significant portion of the cost savings created by

---

whether an individual, family, group, community, or population. This proposed rule interferes with that relationship and violates the basic ethics of the profession."); *see also* Mike Faher, *Vermont health care coalition protests Title X change*, VTDigger.com (June 12, 2018), https://vtdigger.org/2018/06/12/vermont-health-care-coalition-protests-title-x-change/ (calling the Vermont Health Care Coalition opposing the proposed regulations "an unlikely group of allies in Vermont").

[86] *Vermont Health Care Coalition Title X Statement*, Vt. Ass'n of Hosps. and Health Sys. (June 15, 2018), https://vahhs.org/title-x-statement.html

[87] Jennifer J. Frost, *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, Milbank Quarterly, Vol. 92, No. 4, p. 668 (2014) (*available at* https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/MQ-Frost_1468-0009.12080.pdf).

funding family planning services is jeopardized by the proposed rule and would fall on our States, among others.

D. Conclusion

The proposed rule will drive many family planning providers from the Title X program. As a result, thousands of patients will lose reasonable access to family planning services and other critical reproductive health services. The Title X providers that remain will be prevented from delivering the high-quality and complete medical care that they have always provided. This frustrates rather than achieves the purposes of Title X, and the courts will strike down the proposed rule, if implemented, accordingly. The proposed rule would limit health care services to vulnerable populations that Congress intended to help. It also would shift the costs of reproductive health care, including services for unintended pregnancies, breast and cervical cancer diagnoses, spread of STIs, and other serious health conditions to our states. For these and the other reasons stated in our comments, we urge the Department to withdraw the proposed rule.

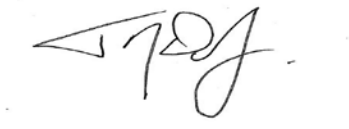
Thank you for considering our views.

Sincerely,

Bob Ferguson
Washington Attorney General

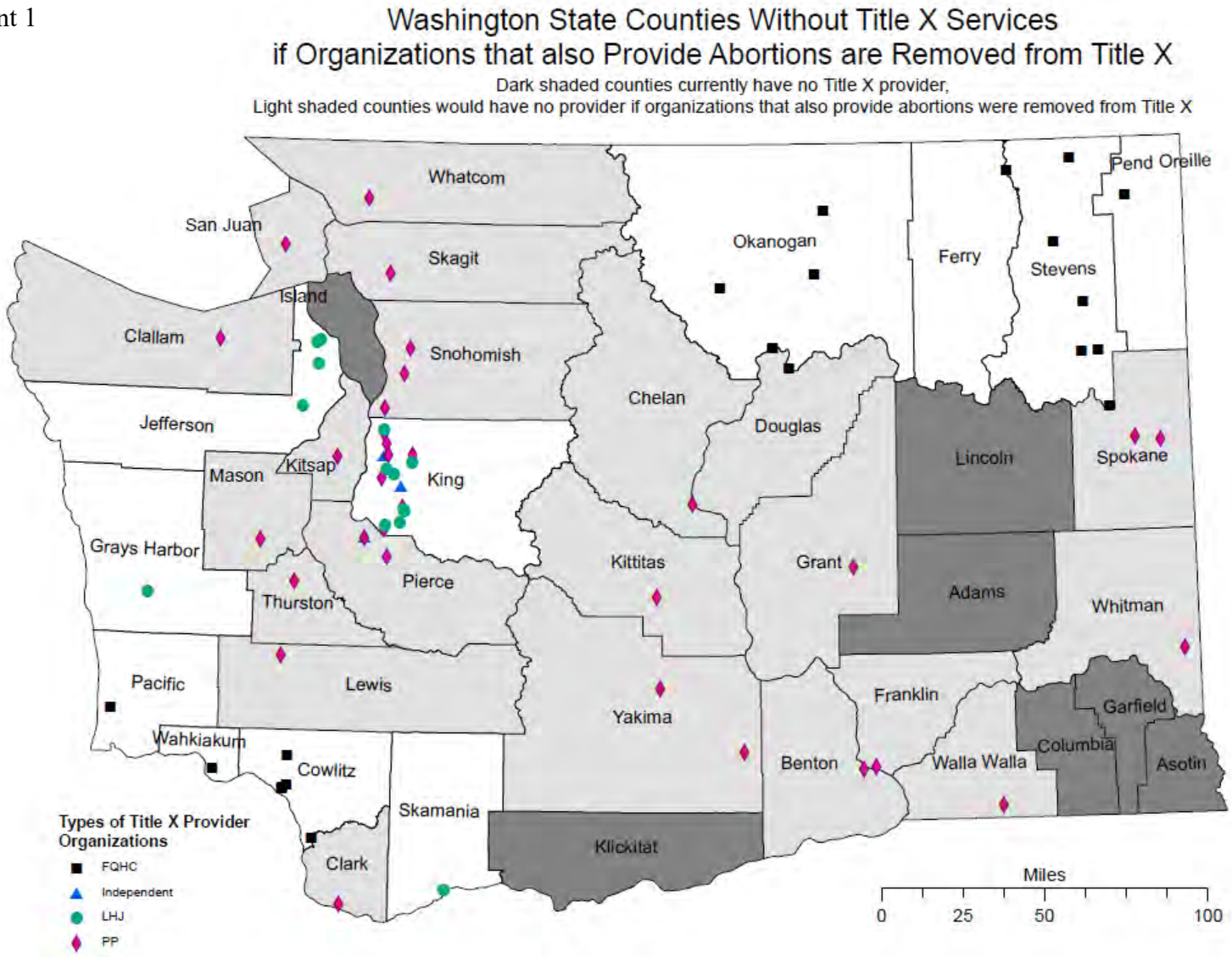
Maura Healey
Massachusetts Attorney General

Ellen Rosenblum
Oregon Attorney General



Thomas J. Donovan, Jr.
Vermont Attorney General

Attachment 1



VERMONT

State of Vermont
Department of Health
Commissioner's Office
108 Cherry Street • PO Box 70
Burlington, Vermont 05402
HealthVermont.gov

[phone] 802-863-7280

Agency of Human Services

July 31, 2018

Office of the Assistant Secretary for Health
Office of Population Affairs
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

Re: **Docket Number HHS-OS-2018-0008: "Compliance with Statutory Program Integrity Requirements" for the Tile X Family Planning Program**

Assistant Secretary Giroir and Senior Policy Advisory Huber:

On behalf of the Vermont Department of Health, please accept the following comments regarding the Notice of Proposed Rulemaking published in the Federal Register on Jun 1 2018 **(Docket Number HHS-OS-2018-0008).** The proposed rule would reduce the funding going directly to evidence-based services and limit the number of vulnerable Vermont women able to access the care they need. As proposed, the rule would at a minimum jeopardize services, and potentially eliminate Title X access in whole areas of Vermont, leaving many patients without a source of reproductive health care. Title X projects deliver a host of critical services to Vermonters, including cancer screening and testing for sexually transmitted diseases. The reduction in services resulting from the proposed rule would not only mean higher health care costs resulting from lack of preventive care, but also an increase in unintended pregnancies and abortions.

The provisions of the proposed rule would undermine the high-quality standards of care in Title X and discourage and prevent highly qualified, trusted family planning providers in Vermont from participating in the Title X program. Title X services are currently offered across the state, serving largely rural and vulnerable populations. Approximately 10,000 Vermonters currently receive Title X services annually, twenty percent of whom are under the age of 20.

In Vermont, a diverse coalition of health care organizations, including all the major insurers, the hospital association and patient advocates have come out in strong opposition to the proposed rule. The Vermont Department of Health strongly opposes the proposed rule and recommends that the current regulatory framework be upheld. The following are specific comments on the proposal. The Vermont Department of Health is referred to as VT-DOH, and specific comments to which VT-DOH would like a comprehensive response are called out with the language "VT-DOH recommends".

Sincerely,

Mark A. Levine, MD
Commissioner
Vermont Department of Health

Comments

Section 59.1: To what programs do these regulations apply?

Health and Human Services (HHS) Title X relationship has been and is with the Title X grantee, in this case the VT-DOH, concerning the project it operates. Adding a relationship between HHS and the subgrantee is a duplication of effort, adding red tape, bureaucracy and cost that is unnecessary and redundant. This is contradictory to the requirement in Section 59.18 requiring that grantees "use the majority of grant fund to provide direct services to clients". VT-DOH recommends the new language adding subgrantees to this section be struck.

Section 59.2: Definitions.

The proposed new definition of family planning differs substantively from current precedent and would have harmful effects on the quality of services provided. The proposed changes elevate the focus of the program towards natural family planning and other fertility awareness-based methods regardless of clinical efficacy and patient desire. This is counter-productive and harmful to patients who need medically accurate and up-to-date information in order to make the decision that is best for them.

Changes to the definition of "family planning" confuses the terms "choices," "methods," and "services". The VT-DOH recommends this section be re-written to ensure that family planning is focused on medically accurate evidence-based **methods**.

The new requirement that minors may only be seen for medical advice or treatment if providers document specific actions taken to involve the minor's family in the medical record or document a report of child abuse or incest in the medical record fails to consider the clinician's judgment or privacy concerns inherent in written documentation of these sensitive issues. This stigmatizes young patients who may be sexually active and could prevent them from seeking care. VT-DOH recommends this be struck or amended to require it only for those patients who show signs of abuse.

The proposed rule expands the definition of "low-income family" so that any woman who has employer-sponsored health insurance coverage "which does not provide the contraceptive services sought by the woman because [the employer] has a sincerely held religious or moral objection to providing such coverage" "can be considered" to be low income. The VT-DOH supports increasing access to Title X services but would require additional funding to accommodate an expansion of eligible clients.

Section 59.5: What requirements must be met by a family planning project?

Vermont is committed to providing evidence-based care. As such, Paragraph (a)(1) must include the term "medically approved": "a broad range of acceptable and effective **medically approved** family planning methods." The VT-DOH recommends that this critical term be re-inserted into Paragraph (a)(1).

The removal of the current requirement that Title X providers offer non-directive and comprehensive counseling on all pregnancy options (parenting, adoption, or abortion) for pregnant patients (except for those options about which the patient states they do not

want to receive information) weakens the commitment to individualized patient care that is at the heart of the Title X program. Non-directive options counseling that includes all options is not only required according to existing Title X regulations but consistent with medical and ethical standards and many medical professional organizations.

Additionally, health equity is an important focus for Vermont. It is critical that all women, regardless of where they live, be able to decide between a broad range of evidence-based medically approved family planning methods. The proposed language, "projects are not required to provide every acceptable and effective family planning method or service" could seriously limit the options for women in a rural state should the project nearest them only provide one method. The VT-DOH recommends this language be struck.

VT-DOH recommends paragraph (5) be struck or clarified as stated above to ensure that there are no barriers for referral to abortion services or the provision of nondirective counseling.

Paragraph (12) requires that Title X providers offer comprehensive primary health services, services that are specifically prohibited with Title X funding. The paragraph states that if they do not provide these services they must refer a patient to such services in "close physical proximity". In a rural state this is untenable and also vague. The language should be struck to ensure equal access to Title X services, particularly in rural states.

Paragraph (14) requires every Title X project to "[e]ncourage family participation in the decision of minors to seek family planning services and ensure that the records maintained with respect to each minor document the specific actions taken to encourage such family participation (or the specific reason why such family participation was not encouraged)." This is not required by Vermont state law and is a state law issue. It does not belong in federal rule and undermines the confidentiality of patients and could deter adolescents and young adults from seeking services. In Vermont, 20% of Title X participants are under 20 years old.

Extending the type of reporting expected of Title X grantees to subrecipients and referral partners would create extraordinary burdens for all involved. This focuses staff time and energy on duplicative reporting efforts when in Vermont there is no evidence that this would increase compliance with Title X requirements, further depleting the amount of Title X funding available for services. It could also limit the number of partners willing to work with VT-DOH, and in a small state with limited medical resources access is a critical issue. VT-DOH recommends that Title X grantees remain the responsible reporting party.

Section 59.7: What criteria will the Department of Health and Human Services use to decide which family planning services projects to fund and win what amounts?

As a state where the Health Department is the singular grantee, it is unclear how the VT-DOH would know it had satisfied the new criteria set out by HHS. VT-DOH recommends this section be improved to specifically and clearly state the criteria with which HHS will review applicants before they reach the objective merits panel review.

Section 59.14: Prohibition on referral for abortion.

The VT-DOH is dedicated to providing evidence-based care. The new language in this section eliminates the long-standing requirement for nondirective options counseling and prohibits abortion referral but requires all pregnant people to be referred for prenatal care and/or social services, regardless of their wishes. This will serve to undermine the

extensive systems level work that has been accomplished in Vermont to ensure that patients have access to quality family planning services, which includes being able to access the full range of contraceptive methods through Title X. It could also impede all the work the VT-DOH has done with other state partners, such as the Blueprint Women's Health Initiative, to ensure providers are trained in best practice approaches to contraceptive counselling, which is grounded in medical accuracy and a comprehensive understanding of the full range of contraceptive methods.

Given the critical importance of evidence-based medicine, VT-DOH recommends this section be modified to require evidence-based counseling methods and remove any barriers to referring a patient for an abortion. There are two major problems with providing a patient seeking an abortion with a mixed list of providers who do and do not provide abortion:

1. Misdirecting patients, or not providing information on locations that provide safe, legal abortions could lead to patients seeking abortions from unsafe providers or through unsafe means.
2. Misdirecting patients will lead to unnecessary increased medical cost for patients who make appointments with providers who do not end up providing the services they are seeking.

Limiting referrals for abortion to only come from doctors is an example of a barrier and is in conflict with 42 CFR § 59.5(b)(6) which requires that projects "[p]rovide that family planning medical services will be performed under the direction of a physician with special training or experience in family planning" (emphasis added). This provision of the rule already allows for the existing practice in Vermont of other qualified medical providers (i.e. nurse practitioners and physicians assistants) to provide care within the scope of their practice under the direction of a physician.

In addition, language in paragraph (a) is confusing when it states that a medical doctor may "provide a list of licensed, qualified, comprehensive health service providers (some but not all, of which also provide abortion services…". It is critical for the patient-provider relationship that when a patient requests information, such as a referral for an abortion, that the provider be able to answer the question accurately and completely. As such, the VT-DOH recommends that Paragraph (a) and (c) be struck.

Paragraph (b) requires providers to refer for prenatal and social services even for those women who do not want those services. This again is not evidence-based medicine and undermines the provider-patient relationship. Additionally, should a woman be referred for prenatal services who is not seeking such services and it is a true referral, time and energy will be wasted by both the sending and receiving provider in discussing services for a patient who will not use them. The VT-DOH recommends that paragraph (b) be struck or be re-written to require providers to provide such referrals only when the patient requests them.

Paragraph (d) of this section is confusing as it is unclear what "promote abortion" means. Vermont recommends that this be clarified in the rule so that it is clear that nondirective family planning counseling is not "promotion" of abortion.

Paragraph (e)(4) states: "None of the entities on the list are providers that principally provide abortions." What does this mean? How will HHS define or determine "principally"?

VT-DOH recommends this entire section be struck. Providers should be required to use evidence-based counseling methods and be fully able to provide medically accurate and specific information to their patients in order to provide them with the best possible care.

Section 59.15: Maintenance of physical and financial separation.

VT-DOH has a demonstrated history of full compliance with the prohibition against using Title X funding for abortion and has a continued commitment to complying completely with the law. As such, part (a) of this section is acceptable.

Although Title X statute, regulation, and policy already prohibit abortion as a family planning method and do not allow Title X funding to be used for abortion services, the proposed rule requires additional physical separation of abortion services from Title X services. These additional requirements would mandate physical separation, separation of email addresses and websites, separate staff, separate health care/medical records, and separate signs and materials. These requirements are unnecessarily burdensome and do not add additional clarity or quality to the Title X program. As such, VT-DOH opposes requirements for organizational separation and separate names.

Paragraphs (b), (c) and (d) are not tenable in Vermont and VT-DOH recommends they be struck. The Title X provider network has spent the past several years improving and enhancing infrastructure and opening new facilities. These conditions would undermine, if not negate, the significant investments made to develop this robust system. Health care delivery is extremely costly, and the cost of care is often associated with the overhead investment in medical facilities. This requirement goes far beyond what is necessary to ensure that taxpayer dollars are not spent on abortion services, undermines access to critical family planning, and would continue to drive up the cost of medical care. It is common practice, for example, for multiple types of providers to share a waiting area, as waiting rooms do not need to be specific to a type of care. Additionally, mandating physical separation can also become a barrier to receiving care – creating a fragmented system that is confusing and difficult to access.

Section 59.16: Prohibition on activities that encourage, promote or advocate for abortion.

This section is unclear. As the Grantee, VT-DOH would be responsible for assisting subgrantees to comply with this regulation. Paragraph (a) of this section is very broad and is followed by a list that "includes" a number of slightly more specific items. However, given that this is not a complete list and that Paragraph (a) is broad and vague, VT-DOH would be unable to provide guidance to subgrantees. For example, in Paragraph (b) the first example provided (1) states: "Clients at a Title X project are given brochures advertising a clinic that provides abortions…" These seem to directly contradict the guidance in Section 59.14 in which "…a doctor may, if asked, provide a list of licensed, qualified, comprehensive health service providers (some of which also provide abortion, in addition to comprehensive prenatal care)."

This list of prohibited activities threatens to isolate family planning services outside of common women's health needs, limiting access and decreasing quality of care. VT-DOH recommends that health care providers be able to make their own decisions about the services they offer in addition to Title X services so long as they demonstrate financial separation.

Section 59.17: Compliance with Reporting Requirements.

Providers are already required to comply with State Laws. The addition of a compliance plan is an overreach and adds unnecessary costs and burden. This is contradictory to the

requirement in Section 59.18 requiring that grantees "use the majority of grant fund to provide direct services to clients" and VT-DOH recommends this requirement be struck.

Vermont's Title X projects demonstrate compliance with legislative mandates that require Title X service sites to encourage family participation in the decision of minors to seek family planning services and provide counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities. All Title X providers must comply with State laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest. The addition of a reporting and documentation requirement is added bureaucracy and does not improve patient safety and could compromise patient confidentiality.

The new language also threatens patient confidentiality, particularly for minors. These individuals could be deterred from seeking much needed services if they were under the impression they would be reported for doing so. The required documentation of reports in the medical record is not best practice and experts in the sexual assault and domestic violence fields recommend against it.

VT-DOH recommends that these new reporting and documentation requirements be struck.

From: Diamond, Joshua
To: Donovan, Thomas
Cc: Clark, Charity; Silver, Natalie; Sudbay, William
Subject: Roe v Wade Day, January 22 (Tuesday)
Date: Friday, January 18, 2019 3:40:46 PM

TJ,

I spoke to the folks at Planned Parenthood and your are set to speak sometime between 2:00 and 2:15 at the Cedar Creek Room.

You will be speaking to Planned Parenthood's activists and volunteers. The suggested topic is a rundown of the good work that the AGO has been doing to advance reproductive rights and freedoms.

I've asked Ella to get me a comprehensive list of the various activities our office has been involved, including multi-state letters, comments on Title X, amicus briefs, and other litigation. I should have a list to you over the weekend.

Happy to discuss at your convenience.

Best, Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

From:	Clark, Charity
To:	Leriche, Lucy Rose; Sullivan, Eileen
Cc:	Silver, Natalie (Natalie.Silver@vermont.gov); Spottswood, Eleanor
Subject:	Press conference -- Oregon lawsuit
Date:	Tuesday, January 29, 2019 1:45:00 PM
Attachments:	Title X Press Release 7.18.2018.pdf

Hi, Lucy and Eileen,

Natalie and I spoke with Ella about our next steps, and now we understand the issues and also more about timing. This week, we anticipate the federal government entering the final rule on Title X, which we have opposed. This will trigger our and other state attorneys general's filing of a lawsuit in Oregon (not a decision by a lawsuit already filed as I had erroneously believed). In order to get our ducks in a row (i.e., reviewing the rule, gathering declaration, completing the complaint, etc.), we will likely need several days between the rule being entered and the filing of the lawsuit. In other words, next week would be the earliest we would announce the filing of a lawsuit.

Here are our next steps, in terms of press, as I see them:

- Natalie and I can draft a press release (likely using a template from Oregon). Lucy and Eileen, be thinking of a quote from PP. I've attached the press release we issued last summer on Title X comments as an FYI.
- Decide on a location. Although T.J. had initially proposed having a press conference at PPNNE in Colchester, Natalie and I are wondering if Montpelier makes more sense, given Lucy's work at the State House, the location of the press, and the potentially short turn-around time. Thoughts?
- As for an exact date, we will be coordinating with Oregon and the other parties to the lawsuit as to the filing date and press embargo and will keep you in the loop.

Please let me know if you have any questions. I wanted to be sure you have my cell phone in case you need to reach me and I am not at my desk: 802-917-1993.

Thanks!
Charity

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State Street
Montpelier, Vermont 05609
802-828-3737

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE:
July 18, 2018

CONTACT: Eleanor Spottswood
Assistant Attorney General
802-828-3178

AG DONOVAN REQUESTS PUBLIC FEEDBACK ON RULE CHANGE AFFECTING WOMEN'S AND REPRODUCTIVE HEALTHCARE

Reproductive Health Clinics Jeopardized By Proposed Federal Regulations

MONTPELIER – Attorney General T.J. Donovan today announced the launch of a website to allow Vermonters to provide feedback on a proposed rule affecting clinics that receive Title X funds. The U.S. Department of Health and Human Services (HHS) is writing new rules for recipients of Title X funding. Title X is the only nationwide program for affordable birth control and reproductive health care. The proposed rules would implement a "gag rule" on abortion referrals and redirect funding priorities from the CDC's birth control recommendations to "natural family planning methods." HHS is accepting public comments on the new rules until July 31. The AG's website where the public can provide feedback is located at: http://ago.vermont.gov/act_now_for_reproductive_health/.

"Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "It's critical that they continue. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont."

Vermont has relied on funding from Title X for decades. Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV. As a result of the new regulations, however, Title X providers will be forced to give incomplete and misleading information to patients—a "gag rule" on providing services or information related to abortion,

even to patients who affirmatively say that they want one. But the rules don't stop there. The gag rule would also apply to any "referral partners" of Title X clinics. And, the new rules stretch Title X funding to try to cover gap in health care created by employers who opt out of providing insurance to cover contraception. The new rules also redefine "family planning" itself to promote "natural family planning methods" over more effective forms of birth control. The new rules never mention the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations. In addition, the new rules require Title X clinic to be physically located in a separate facility from any abortion provider. Title X funding is not, and never has been, used for abortions.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules.

"It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

"For decades, people in Vermont have benefited from affordable reproductive health care through Title X, and new rule changes from the Trump administration threaten to take that away," said Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England. "We are incredibly grateful to Attorney General Donovan for his ongoing support for access to high-quality health care for all Vermonters, and for creating a new avenue for people to tell the administration they won't stand for attacks on access to reproductive health care." Planned Parenthood of Northern New England is the only Title X provider in Vermont.

Vermonters who are concerned about the impact of these regulations can get more information and submit comments through a website set up by the Attorney General's Office: http://ago.vermont.gov/act_now_for_reproductive_health/

More information about the changes to Title X can be found at the independent Guttmacher Institute: https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x

# # #

From:	Clark, Charity
To:	Sullivan, Eileen; Leriche, Lucy Rose
Cc:	Silver, Natalie; Spottswood, Eleanor
Subject:	RE: Press conference -- Oregon lawsuit
Date:	Friday, February 22, 2019 5:15:00 PM

Great! We will be in touch next week with a draft press release.
Charity

From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Friday, February 22, 2019 5:01 PM
To: Clark, Charity <Charity.Clark@vermont.gov>; Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Cc: Silver, Natalie <Natalie.Silver@vermont.gov>; Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: RE: Press conference -- Oregon lawsuit

Hi Charity,

Thank you so much for reaching out! That timing sounds good to us.

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
Planned Parenthood Vermont Action Fund
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9751
C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Clark, Charity <Charity.Clark@vermont.gov>
Sent: Friday, February 22, 2019 4:35 PM
To: Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Cc: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>; Silver, Natalie <Natalie.Silver@vermont.gov>; Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: RE: Press conference -- Oregon lawsuit

Hi, Lucy and Eileen,

Given today's issue of the new Title X rules, putting things in motion for filing a lawsuit, I am reaching out to propose a tentative date for a press conference. We propose Thursday, March 7, at 10 a.m. Given that the legislature is on break that week, I think holding the press conference at PPNNE's Colchester offices would work well. Let us know what you think. In the meantime, we will start work on a draft press release and thinking about a possible run of show.

Thanks!
Charity

From: Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Sent: Tuesday, January 29, 2019 1:53 PM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>; Silver, Natalie <Natalie.Silver@vermont.gov>; Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: Re: Press conference -- Oregon lawsuit

Thank you for this clarification. All this makes sense. Eileen will work on a ppnne quote-or maybe a couple. Perhaps we can decide on a location once we have a date? We will stay tuned!
Lucy

Sent from my iPhone

On Jan 29, 2019, at 1:45 PM, Clark, Charity <Charity.Clark@vermont.gov> wrote:

> Hi, Lucy and Eileen,
>
> Natalie and I spoke with Ella about our next steps, and now we understand the issues and also more about timing. This week, we anticipate the federal government entering the final rule on Title X, which we have opposed. This will trigger our and other state attorneys general's filing of a lawsuit in Oregon (not a decision by a lawsuit already filed as I had erroneously believed). In order to get our ducks in a row (i.e., reviewing the rule, gathering declaration, completing the complaint, etc.), we will likely need several days between the rule being entered and the filing of the lawsuit. In other words, next week would be the earliest we would announce the filing of a lawsuit.
>
> Here are our next steps, in terms of press, as I see them:
>
> - Natalie and I can draft a press release (likely using a template from Oregon). Lucy and Eileen, be thinking of a quote from PP. I've attached the press release we issued last summer on Title X comments as an FYI.
> - Decide on a location. Although T.J. had initially proposed having a press conference at PPNNE in Colchester, Natalie and I are wondering if Montpelier makes more sense, given Lucy's work at the State House, the location of the press, and the potentially short turn-around time. Thoughts?
> - As for an exact date, we will be coordinating with Oregon and the other parties to the lawsuit as to the filing date and press embargo and will keep you in the loop.
>
> Please let me know if you have any questions. I wanted to be sure you have my cell phone in case you need to reach me and I am not at my desk: 802-917-1993.

Thanks!
Charity

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State Street
Montpelier, Vermont 05609
802-828-3737

<Title X Press Release 7.18.2018.pdf>

This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error please notify the system manager. Please note that any views or opinions presented in this email are solely those of the author and do not necessarily represent those of the company. Finally, the recipient should check this email and any attachments for the presence of viruses. The company accepts no liability for any damage caused by any virus transmitted by this email.

From: Sullivan, Eileen
To: Clark, Charity
Cc: Silver, Natalie; Leriche, Lucy Rose; Spottswood, Eleanor
Subject: Re: Press conference -- Oregon lawsuit
Date: Monday, February 25, 2019 6:29:01 PM

Thank you! We sent it this afternoon.
Eileen

Sent from my iPhone

On Feb 25, 2019, at 6:18 PM, Clark, Charity <Charity.Clark@vermont.gov> wrote:

> It looks fine to me, too.
> Charity
>
> Sent from my iPhone
>
> On Feb 25, 2019, at 2:12 PM, Silver, Natalie <Natalie.Silver@vermont.gov> wrote:
>
> > This looks fine by me.
> >
> > Natalie Silver
> > Community Outreach and Policy Coordinator
> > Vermont Attorney General's Office
> > Natalie.Silver@vermont.gov
> > 802 595 8679
> >
> > ---
> >
> > **From:** Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
> > **Sent:** Monday, February 25, 2019 1:53 PM
> > **To:** Clark, Charity <Charity.Clark@vermont.gov>; Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
> > **Cc:** Silver, Natalie <Natalie.Silver@vermont.gov>; Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
> > **Subject:** RE: Press conference -- Oregon lawsuit
> >
> > Hi everyone,
> >
> > Below is a DRAFT press release re: Title X we're planning to send today, but we want to share it with you first to see if you have any objections? Additions to the language? We want to be helpful and consistent with our messaging. Please let us know, and thank you!
> >
> > **For Immediate Release**
> > February 25, 2019

Contact: Eileen.Sullivan@ppnne.org, 646-467-0674

Planned Parenthood Vermont Action Fund Denounces New Title X Gag Rule

COLCHESTER, VT – Planned Parenthood Vermont Action Fund (PPVTAF) strongly oppose the new gag rule that will undermine Title X, the nation's program for affordable birth control and reproductive health care. This rule will block 10,000 Planned Parenthood of Northern New England (PPNNE) patients who rely on the Title X program from accessing care from health centers at PPNNE, Vermont's only Title X provider.

The Trump administration has put health care providers like Planned Parenthood in an impossible position: withhold information from its patients or get pushed out of a program designed to ensure that people struggling to make ends meet can still access birth control, STI testing and treatment, cancer screenings, and other essential reproductive health care.

Ten of the 12 Planned Parenthood health centers in Vermont provide health care to 100 percent of Title X patients in the state, and Planned Parenthood serves 41 percent (1.6 million) of Title X patients nationally. There is no replacement for Planned Parenthood, as researchers, medical experts, and other providers agree.

The rule also imposes cost prohibitive and unnecessary "physical separation" requirements on health centers that also provide abortion in an effort to stop Planned Parenthood from participating in Title X. These requirements could include forcing health centers to build separate entrances and exits, construct whole new health centers, or hire a whole second staff of doctors, nurses, and administrative staff. None of these requirements contribute to the health of patients.

Major medical associations like the American Medical Association, American College of Obstetricians and Gynecologists, American College of Physicians, and others stand against this rule. In addition, more than 200 members of Congress and 100 public health organizations have come out in opposition to a gag policy.

Statement from Lucy Leriche, Vice President of Public Affairs, Planned Parenthood Vermont Action Fund:

"The Title X gag rule is medically unethical. If action is not taken immediately, health care access will be affected for 10,000

Vermont women, men, and young people who rely on the services provided at Planned Parenthood of Northern New England health centers. At Planned Parenthood, we believe everyone has the right to evidence-based, accurate information about their health care – including information about safe, legal abortion – and that everyone deserves the best medical care, regardless of income or where they live. Planned Parenthood won't ever withhold medical information from our patients, and we will never stop fighting for our patients in Vermont."

"The Trump administration's incessant attacks on reproductive health care illustrate why Vermont needs protections for reproductive liberty enshrined in the constitution through a constitutional amendment. The constitutional amendment, as well as the passage of abortion rights bill H.57, will ensure that people are able to make private medical decisions with the advice of health care professionals they trust, without the interference of politicians."

###

About Planned Parenthood Vermont Action Fund: Planned Parenthood Vermont Action Fund is a nonpartisan, not-for-profit organization formed as the advocacy and political arm of Planned Parenthood of Northern New England. The Action Fund engages in educational activity, including legislative advocacy, and grassroots organizing. www.ppvtaf.org

About Planned Parenthood of Northern New England (PPNNE): PPNNE is the largest reproductive and sexual health care provider in northern New England. In 2016, PPNNE served more than 40,000 women, men, and teens, and provided more than $8.1 million worth of free and discounted health care.www.ppnne.org

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
Planned Parenthood Vermont Action Fund
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9751
C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Clark, Charity <Charity.Clark@vermont.gov>

Sent: Friday, February 22, 2019 5:16 PM
To: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>; Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Cc: Silver, Natalie <Natalie.Silver@vermont.gov>; Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: RE: Press conference -- Oregon lawsuit

Great! We will be in touch next week with a draft press release.
Charity

From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Friday, February 22, 2019 5:01 PM
To: Clark, Charity <Charity.Clark@vermont.gov>; Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Cc: Silver, Natalie <Natalie.Silver@vermont.gov>; Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: RE: Press conference -- Oregon lawsuit

Hi Charity,

Thank you so much for reaching out! That timing sounds good to us.

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
Planned Parenthood Vermont Action Fund
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9751
C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Clark, Charity <Charity.Clark@vermont.gov>
Sent: Friday, February 22, 2019 4:35 PM
To: Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Cc: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>; Silver, Natalie <Natalie.Silver@vermont.gov>; Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: RE: Press conference -- Oregon lawsuit

Hi, Lucy and Eileen,

Given today's issue of the new Title X rules, putting things in motion for

filing a lawsuit, I am reaching out to propose a tentative date for a press conference. We propose Thursday, March 7, at 10 a.m. Given that the legislature is on break that week, I think holding the press conference at PPNNE's Colchester offices would work well. Let us know what you think. In the meantime, we will start work on a draft press release and thinking about a possible run of show.

Thanks!
Charity

From: Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Sent: Tuesday, January 29, 2019 1:53 PM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>; Silver, Natalie <Natalie.Silver@vermont.gov>; Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: Re: Press conference -- Oregon lawsuit

Thank you for this clarification. All this makes sense. Eileen will work on a ppnne quote-or maybe a couple. Perhaps we can decide on a location once we have a date? We will stay tuned!
Lucy

Sent from my iPhone

On Jan 29, 2019, at 1:45 PM, Clark, Charity <Charity.Clark@vermont.gov> wrote:

> Hi, Lucy and Eileen,
>
> Natalie and I spoke with Ella about our next steps, and now we understand the issues and also more about timing. This week, we anticipate the federal government entering the final rule on Title X, which we have opposed. This will trigger our and other state attorneys general's filing of a lawsuit in Oregon (not a decision by a lawsuit already filed as I had erroneously believed). In order to get our ducks in a row (i.e., reviewing the rule, gathering declaration, completing the complaint, etc.), we will likely need several days between the rule being entered and the filing of the lawsuit. In other words, next week would be the earliest we would announce the filing of a lawsuit.
>
> Here are our next steps, in terms of press, as I see them:

Natalie and I can draft a press release (likely using a template from Oregon). Lucy and Eileen, be thinking of a quote from PP. I've attached the press release we issued last summer on Title X comments as an FYI.

- Decide on a location. Although T.J. had initially proposed having a press conference at PPNNE in Colchester, Natalie and I are wondering if Montpelier makes more sense, given Lucy's work at the State House, the location of the press, and the potentially short turn-around time. Thoughts?
- As for an exact date, we will be coordinating with Oregon and the other parties to the lawsuit as to the filing date and press embargo and will keep you in the loop.

Please let me know if you have any questions. I wanted to be sure you have my cell phone in case you need to reach me and I am not at my desk: 802-917-1993.

Thanks!
Charity

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State Street
Montpelier, Vermont 05609
802-828-3737

<Title X Press Release 7.18.2018.pdf>

This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error please notify the system manager. Please note that any views or opinions presented in this email are solely those of the author and do not necessarily represent those of the company. Finally, the recipient should check this email and any attachments for the presence of viruses. The company accepts no liability for any damage caused by any virus transmitted by this email.

This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error please notify the system manager. Please note that any views or opinions presented in this email are solely those of the author and do not necessarily represent those of the company. Finally, the recipient should check this email and any attachments for the presence of viruses. The company accepts no liability for any damage caused by any virus transmitted by this email.

From:	Sullivan, Eileen
To:	Clark, Charity; Silver, Natalie
Cc:	Leriche, Lucy Rose; Spottswood, Eleanor
Subject:	Title X rule changes and impact on Vermonters
Date:	Thursday, February 28, 2019 1:43:04 PM

Hi everyone,

I'm sharing a letter from Lucy to all members of the House and Senate that was sent yesterday about the changes to Title X. It explains what the gag rule is and how it could impact the nearly 10,000 Vermonters who rely on Title X for affordable health care. Please let us know if you have any questions, and thanks! – Eileen

On Friday, the Trump administration issued its "domestic gag" rule targeting the Title X program. I'm writing to share information with you about the impact this could have on thousands of Vermonters who rely on the Title X program for health care, and how this new rule is medically unethical.

Title X, in place since 1970, is the only federal program in the country for affordable birth control and reproductive health care. Title X-funded health centers have provided high-quality cost-effective family planning and related preventive health services to low-income, under-insured and uninsured women and men who may otherwise lack access to health care. **There are nearly 10,000 Vermonters who rely on Title X for affordable health care, and Planned Parenthood of Northern New England (PPNNE) is the only Title X provider in the state**.

The Trump administration's gag rule targets care through Title X, a program which ensures more than four million people struggling to make ends meet can access birth control, STI testing, cancer screenings, and other essential reproductive health care. There are two main provisions of the gag rule that will put health care access at risk for millions of people, including nearly **10,000 Vermonters** who receive care through the program:

- The gag rule **makes it illegal for health care providers in the Title X program to refer patients for an abortion**. Censoring and gagging these providers threatens the patient-provider relationship and prevents patients from having information about all of their options. Because of our commitment to ethical patient care, it would be **impossible for Planned Parenthood to continue participating in the program**. This rule leaves their health, rights, and lives hanging in the balance.

- The rule includes onerous **"physical separation" requirements** that are specifically designed to block patients from coming to Planned Parenthood. These requirements could include forcing health centers to build separate entrances and exits, construct whole new health centers, or hire a whole second staff of doctors, nurses, and administrative staff. **None of these requirements**

contribute to the health of patients.

The Trump administration's gag rule violates medical ethics in three ways:

- It denies patients the right to get full and accurate information about their reproductive health care from their providers;
- It imposes new restrictions that make it impossible for many patients to get birth control or preventive care from reproductive health care providers like Planned Parenthood;
- It forces health care providers to choose between funding and the ability to refer their patients for safe, legal abortion.

We do not see how any health care provider who follows nationally accredited standards and medical ethics could comply with the rule, and many health care organizations in Vermont agree.

In the summer of 2018, a diverse coalition of 12 Vermont health care organizations issued a statement about the gag rule, stating that the group "strongly opposes threats to Vermonters' access to essential health care services proposed by the federal Health and Human Services Department." They added, "This will significantly restrict access to necessary care for both women and men particularly in rural, hard to serve areas of Vermont. We call on the federal Health and Human Services Department to withdraw this proposed rule in the interest of public health and for the benefit of low-income patients of Vermont."

Additional information about Title X in Vermont:

- The Vermont Agency of Human Services is the Title X grantee in Vermont. The 10 PPNNE health centers supported by Title X provide a range of essential preventive health services, including breast and cervical cancer detection, screening and treatment for sexually transmitted diseases, HIV testing, and contraception, for thousands of low-income, uninsured, and underinsured individuals and families each year who would otherwise lack access to care. The state receives approximately $775,000 in Title X funds that would be at risk under the new gag rule.
- As a participant in the Title X program, health care providers commit to providing care to all who need it, regardless of ability to pay. Almost half of the patients who receive Title X services are at 100 percent of the Federal Poverty Level and three quarters are below 200 percent of the FPL.
- Title X saves money. For every dollar invested in publicly funded family planning programs like Title X, the government saves $7.09 in Medicaid-related costs. In 2010, state and federal governments saved $13.6 billion from publicly funded family planning programs, including $7 billion from Title X-funded health centers alone. In Vermont, Title X saves the federal and state government more than $6 million a year.

The Title X gag rule will go into effect 60 days after it is published in the *Federal Register*, which we expect to take place within days.

Planned Parenthood will fight with everything we have to protect the ability of our doctors,

nurses, and clinicians to provide the medically ethical, accurate, quality health care that our patients have come to expect from PPNNE.

Please do not hesitate to contact me if you have any questions about the changes to Title X and the impact on Vermonters. I'd be happy to arrange a meeting at your convenience.

Sincerely,

Lucy Leriche
Vice President of Public Policy
Planned Parenthood Vermont Action Fund
Planned Parenthood of Northern New England

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
Planned Parenthood Vermont Action Fund
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9751
C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Clark, Charity
To: Diamond, Joshua; Silver, Natalie
Subject: Fwd: Important: Title X media plan for next week
Date: Friday, March 1, 2019 2:24:48 PM

FYI

Sent from my iPhone

Begin forwarded message:

> **From:** Edmunson Kristina <kristina.edmunson@doj.state.or.us>
> **Date:** March 1, 2019 at 12:48:36 PM EST
> **To:** "kdosreis@riag.ri.gov" <kdosreis@riag.ri.gov>, "bcollins@riag.ri.gov" <bcollins@riag.ri.gov>, "Lawrence.pacheco@coag.gov" <Lawrence.pacheco@coag.gov>, "drummondgl@doj.state.wi.us" <drummondgl@doj.state.wi.us>, "krishna.f.jayaram@hawaii.gov" <krishna.f.jayaram@hawaii.gov>, "Mat.Marshall@delaware.gov" <Mat.Marshall@delaware.gov>, "rcoombs@oag.state.md.us" <rcoombs@oag.state.md.us>, "Charity.Clark@vermont.gov" <Charity.Clark@vermont.gov>, "Monica C. Moazez" <MMoazez@ag.nv.gov>, "Rossman-McKinney, Kelly (AG)" <RossmanMcKinneyK@michigan.gov>, "PThompson@atg.state.il.us" <PThompson@atg.state.il.us>, "Kempner, Delaney" <Delaney.Kempner@ag.ny.gov>, "Benton, Elizabeth" <Elizabeth.Benton@ct.gov>, "mkelly@oag.state.va.us" <mkelly@oag.state.va.us>, "Margaret.Quackenbush@mass.gov" <Margaret.Quackenbush@mass.gov>
> **Subject: Important: Title X media plan for next week**
>
> Hi all,
>
> I'm writing because your AG has signed off on the multi-state Title X lawsuit, which will most likely be filed the morning (PST) of Tuesday, March 5th. The exact time of the filing, and embargo, is still TBD, but the lawsuit will be filed in Oregon. Currently, we have **17 states** who are joining our lawsuit (with the potential for more). Not for public release, but Planned Parenthood Federation of America and the AMA will also be filing a separate lawsuit at the same time as ours.
>
> Our AG colleagues in California and Washington will be filing two separate lawsuits on Title X on Monday, March 4th. Because of this, there is some interest in a two-prong media strategy. Is everybody comfortable with this approach? Please write or call me today, if you have any concerns or questions. I know many of our AG's will be together next week at NAAG in DC as well.
>
> Media plan:

<!--[if !supportLists]-->• <!--[endif]-->Monday, March 4th : exact time TBD, but issue a group release saying there is a coalition of AG's who have been working on a lawsuit, and we will be filing the next day, Tuesday, March 5th. In the release, we can include a short (2-3 sentence) statement from every AG who wants to participate. If your AG would like to include a statement in the group release, please send me something by TOMORROW (Saturday, March 2nd). I will work on the template and send it to everybody by Sunday evening, with the exact time the statement can be released. Each office will be able to share the release with their press lists. In this release, unfortunately, we will not be able to say that Planned Parenthood is filing a similar lawsuit.

<!--[if !supportLists]-->• <!--[endif]-->Tuesday, March 5th: exact time TBD, but once we have the filing time we will be able to issue our own press releases saying that the lawsuit has been filed, and that Planned Parenthood has also filed a similar lawsuit. I will send a template release by Monday.

Again, please email or call me if you have any questions/concerns with this media approach. We want to make sure we make the media cycle on Monday when the other two lawsuits are filed, so that is why we are doing a two-pronged approach.

My cell is 503-580-7146 if you have any questions. Also, don't forget to send me a short statement from your AG to include in the Monday release.

Thank you!
Kristina

Kristina Edmunson
Communications Director
Attorney General Ellen Rosenblum
Oregon Department of Justice
Kristina.edmunson@state.or.us
Office: 503-378-6002
Cell: 503-580-7146

-

From: Clark, Charity
To: Diamond, Joshua; Silver, Natalie
Subject: Re: Important: Title X media plan for next week
Date: Friday, March 1, 2019 3:09:40 PM

I've left a message with Kristina, planting the seed for a Monday press conference in D.C.

As to a quote from T.J., I'm inclined to defer to Josh or Ella who know more about the lawsuit. That said, here are some ideas:

"Vermont's Title X clinics provide critical health services, like cancer screenings and HIV testing. These clinics serve primarily poor people, and the new rule would deprive these people of needed health care."

Charity

Sent from my iPhone

On Mar 1, 2019, at 2:24 PM, Clark, Charity <Charity.Clark@vermont.gov> wrote:

> FYI
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** Edmunson Kristina <kristina.edmunson@doj.state.or.us>
> **Date:** March 1, 2019 at 12:48:36 PM EST
> **To:** "kdosreis@riag.ri.gov" <kdosreis@riag.ri.gov>, "bcollins@riag.ri.gov" <bcollins@riag.ri.gov>, "Lawrence.pacheco@coag.gov" <Lawrence.pacheco@coag.gov>, "drummondgl@doj.state.wi.us" <drummondgl@doj.state.wi.us>, "krishna.f.jayaram@hawaii.gov" <krishna.f.jayaram@hawaii.gov>, "Mat.Marshall@delaware.gov" <Mat.Marshall@delaware.gov>, "rcoombs@oag.state.md.us" <rcoombs@oag.state.md.us>, "Charity.Clark@vermont.gov" <Charity.Clark@vermont.gov>, "Monica C. Moazez" <MMoazez@ag.nv.gov>, "Rossman-McKinney, Kelly (AG)" <RossmanMcKinneyK@michigan.gov>, "PThompson@atg.state.il.us" <PThompson@atg.state.il.us>, "Kempner, Delaney" <Delaney.Kempner@ag.ny.gov>, "Benton, Elizabeth" <Elizabeth.Benton@ct.gov>, "mkelly@oag.state.va.us" <mkelly@oag.state.va.us>, "Margaret.Quackenbush@mass.gov" <Margaret.Quackenbush@mass.gov>
> **Subject: Important: Title X media plan for next week**
>
> Hi all,

I'm writing because your AG has signed off on the multi-state Title X lawsuit, which will most likely be filed the morning (PST) of Tuesday, March 5th. The exact time of the filing, and embargo, is still TBD, but the lawsuit will be filed in Oregon. Currently, we have **17 states** who are joining our lawsuit (with the potential for more). Not for public release, but Planned Parenthood Federation of America and the AMA will also be filing a separate lawsuit at the same time as ours.

Our AG colleagues in California and Washington will be filing two separate lawsuits on Title X on Monday, March 4th. Because of this, there is some interest in a two-prong media strategy. Is everybody comfortable with this approach? Please write or call me today, if you have any concerns or questions. I know many of our AG's will be together next week at NAAG in DC as well.

Media plan:

- Monday, March 4th : exact time TBD, but issue a group release saying there is a coalition of AG's who have been working on a lawsuit, and we will be filing the next day, Tuesday, March 5th. In the release, we can include a short (2-3 sentence) statement from every AG who wants to participate. If your AG would like to include a statement in the group release, please send me something by TOMORROW (Saturday, March 2nd). I will work on the template and send it to everybody by Sunday evening, with the exact time the statement can be released. Each office will be able to share the release with their press lists. In this release, unfortunately, we will not be able to say that Planned Parenthood is filing a similar lawsuit.

- Tuesday, March 5th: exact time TBD, but once we have the filing time we will be able to issue our own press releases saying that the lawsuit has been filed, and that Planned Parenthood has also filed a similar lawsuit. I will send a template release by Monday.

Again, please email or call me if you have any questions/concerns with this media approach. We want to make sure we make the media cycle on Monday when the other two lawsuits are filed, so that is why we are doing a two-pronged approach.

My cell is 503-580-7146 if you have any questions. Also, don't forget to send me a short statement from your AG to include in the Monday release.

Thank you!
Kristina

Kristina Edmunson
Communications Director
Attorney General Ellen Rosenblum
Oregon Department of Justice
Kristina.edmunson@state.or.us
Office: 503-378-6002
Cell: 503-580-7146

-

From:	Donovan, Thomas
To:	Diamond, Joshua
Cc:	Clark, Charity
Subject:	Re: Important: Title X media plan for next week
Date:	Monday, March 4, 2019 7:57:47 AM

Quote is ok
Please send so we r included in release
Please
Get Outlook for iOS

From: Diamond, Joshua
Sent: Monday, March 4, 2019 7:48:49 AM
To: Donovan, Thomas
Subject: Fwd: Important: Title X media plan for next week

Let's discuss in the cab to the hotel. Josh

Sent from my iPhone

Begin forwarded message:

> **From:** "Clark, Charity" <Charity.Clark@vermont.gov>
> **Date:** March 4, 2019 at 7:30:14 AM EST
> **To:** "Diamond, Joshua" <Joshua.Diamond@vermont.gov>, "Silver, Natalie" <Natalie.Silver@vermont.gov>
> **Subject: Re: Important: Title X media plan for next week**
>
> Today's the deadline for a quote on Title X. Josh, any embellishments on my suggestion below?
>
> By the way, Kristina never responded to my voicemail message re a press conference today.
>
> Charity
>
> Sent from my iPhone
>
> On Mar 1, 2019, at 3:09 PM, Clark, Charity <Charity.Clark@vermont.gov> wrote:
>
> > I've left a message with Kristina, planting the seed for a Monday press conference in D.C.
> >
> > As to a quote from T.J., I'm inclined to defer to Josh or Ella who know more about the lawsuit. That said, here are some ideas:
> >
> > "Vermont's Title X clinics provide critical health services, like

cancer screenings and HIV testing. These clinics serve primarily poor people, and the new rule would deprive these people of needed health care."

Charity

Sent from my iPhone

On Mar 1, 2019, at 2:24 PM, Clark, Charity <Charity.Clark@vermont.gov> wrote:

> FYI
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** Edmunson Kristina <kristina.edmunson@doj.state.or.us>
> **Date:** March 1, 2019 at 12:48:36 PM EST
> **To:** "kdosreis@riag.ri.gov" <kdosreis@riag.ri.gov>, "bcollins@riag.ri.gov" <bcollins@riag.ri.gov>, "Lawrence.pacheco@coag.gov" <Lawrence.pacheco@coag.gov>, "drummondgl@doj.state.wi.us" <drummondgl@doj.state.wi.us>, "krishna.f.jayaram@hawaii.gov" <krishna.f.jayaram@hawaii.gov>, "Mat.Marshall@delaware.gov" <Mat.Marshall@delaware.gov>, "rcoombs@oag.state.md.us" <rcoombs@oag.state.md.us>, "Charity.Clark@vermont.gov" <Charity.Clark@vermont.gov>, "Monica C. Moazez" <MMoazez@ag.nv.gov>, "Rossman-McKinney, Kelly (AG)" <RossmanMcKinneyK@michigan.gov>, "PThompson@atg.state.il.us" <PThompson@atg.state.il.us>, "Kempner, Delaney" <Delaney.Kempner@ag.ny.gov>, "Benton, Elizabeth" <Elizabeth.Benton@ct.gov>, "mkelly@oag.state.va.us" <mkelly@oag.state.va.us>, "Margaret.Quackenbush@mass.gov"

<Margaret.Quackenbush@mass.gov>
Subject: Important: Title X media plan for next week

Hi all,

I'm writing because your AG has signed off on the multi-state Title X lawsuit, which will most likely be filed the morning (PST) of Tuesday, March 5th. The exact time of the filing, and embargo, is still TBD, but the lawsuit will be filed in Oregon. Currently, we have **17 states** who are joining our lawsuit (with the potential for more). Not for public release, but Planned Parenthood Federation of America and the AMA will also be filing a separate lawsuit at the same time as ours.

Our AG colleagues in California and Washington will be filing two separate lawsuits on Title X on Monday, March 4th. Because of this, there is some interest in a two-prong media strategy. Is everybody comfortable with this approach? Please write or call me today, if you have any concerns or questions. I know many of our AG's will be together next week at NAAG in DC as well.

Media plan:

- Monday, March 4th : exact time TBD, but issue a group release saying there is a coalition of AG's who have been working on a lawsuit, and we will be filing the next day, Tuesday, March 5th. In the release, we can include a short (2-3 sentence) statement from every AG who wants to participate. <u>If your AG would like to include a statement in the group release, please send me something by TOMORROW (Saturday, March 2nd).</u> I will work on the template and send it to everybody by Sunday evening, with the exact time the statement can be released. Each

office will be able to share the release with their press lists. In this release, unfortunately, we will not be able to say that Planned Parenthood is filing a similar lawsuit.

- Tuesday, March 5th: exact time TBD, but once we have the filing time we will be able to issue our own press releases saying that the lawsuit has been filed, and that Planned Parenthood has also filed a similar lawsuit. I will send a template release by Monday.

Again, please email or call me if you have any questions/concerns with this media approach. We want to make sure we make the media cycle on Monday when the other two lawsuits are filed, so that is why we are doing a two-pronged approach.

My cell is 503-580-7146 if you have any questions. Also, don't forget to send me a short statement from your AG to include in the Monday release.

Thank you!
Kristina

Kristina Edmunson
Communications Director
Attorney General Ellen Rosenblum
Oregon Department of Justice
Kristina.edmunson@state.or.us
Office: 503-378-6002
Cell: 503-580-7146

delete the message and any attachments
from your system.

****

From: Clark, Charity
To: Silver, Natalie (Natalie.Silver@vermont.gov)
Subject: Revised draft press release
Date: Monday, March 4, 2019 12:32:00 PM
Attachments: Title X Lawsuit Press Release.docx

Here are some edits. I will get Ella's thoughts and then send to T.J. and Josh, unless you have any further changes.

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State Street
Montpelier, Vermont 05609
802-828-3737

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE:
March 4, 2019

CONTACT: Eleanor Spottswood
Assistant Attorney General
802-828-3171

VERMONT TO JOINS LAWSUIT OVER TITLE X FUNDING

Vermont's Reproductive Health Clinics Jeopardized By New Federal Rule

~~MONTPELIER~~ WASHINGTON, D.C. – Attorney General T.J. Donovan today announced his intent to file a lawsuit against the federal government ~~for~~ over a new Title X funding regulation~~violating X~~. Title X is the only national federal grant program that is dedicated solely to providing comprehensive family planning and preventative health care. ~~The purpose of the Title X program is to ensure equal access to high-quality family planning services, regardless of a person's economic condition. Title X has been providing high-quality preventative health care to millions of Americans and XXX Vermonters for decades.~~ In Vermont, 10,000 people rely on Title X for their healthcare. The new rule includes a "gag rule" that limits providers' ability to give neutral, factual information to their patients about abortion, and prohibits abortion referrals. The new rule also redirects funding priorities from the CDC's birth control recommendations to only "natural family planning methods." In Vermont, the only recipient of Title X funds are the 10 Planned Parenthood clinics located around the State.

"The new Title X rule is contrary to law," Attorney General Donovan said. "And it will have a devastating impact on reproductive healthcare for low income Vermonters~~I will oppose any infringement to a Vermonter's right to an abortion as long as I am Attorney General~~. No Title X funds go toward abortion. Instead, the rule will deprive Vermonters of basic healthcare."

Commented [CC1]: SHould we just say Montpelier?

~~Vermont has relied on funding from Title X for decades.~~ Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV.

As a result of the new regulations, ~~however,~~ Title X providers will be forced to give incomplete and misleading information to patients—a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. The gag rule would also apply to any "referral partners" of Title X clinics. The new rules stretch Title X funding to try to cover gaps in health ~~-~~care created by employers who opt out of providing insurance to cover contraception. The new rule~~s~~ also redefine~~s~~ "family planning" ~~itself~~ to promote "natural family planning methods" over more effective forms of birth control. The new rule~~s~~ never mention~~s~~ the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations. In addition, the new rule~~s~~ require~~s~~ Title X clinic~~s~~ to be physically located in a separate facility from any abortion provider. Title X funding is not, and never has been, used for abortions.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules. Title X has been providing high quality preventative health care to millions of Americans for decades.

"~~[For decades, people in Vermont have benefited from affordable reproductive health care through Title X, and new rule changes from the Trump administration threaten to take that away~~Quote from PPNNE]," said Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England. ~~"We are incredibly grateful to Attorney General Donovan for his~~

~~ongoing support for access to high-quality health care for all Vermonters." Planned Parenthood of Northern New England is the only Title X provider in Vermont.~~

Vermont will be~~is~~ joined by ~~Oregon, New York,~~ Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Virginia, and Wisconsin. The basis for the anticipated lawsuit is that the new Title X rule ~~States seek an order vacating the Final Rule as~~is contrary to the U.S. Constitution~~, contrary~~ and to ~~the~~ governing statutes, including the Administrative Procedures Act. ~~and arbitrary and capricious as well as an injunction against the implementation of the Final Rule to prevent irreparable injury to the States and their residents.~~ If the~~The~~ rule went into effect, it will harm Vermont by increasing ~~States argue that their residents are harmed by the Final Rule, because it is contrary to their laws, policies, and sovereign and quasi-sovereign interests, and would cause them financial injury from increased~~ health care costs as a result of an increase in unintended pregnancies, cancers not detected in early stages, and the spread of sexually transmitted infections. ~~("STIs"). These costs – and significant public health impacts – will be caused by the Final Rule's restriction of access to the high-quality family planning and related preventive services for low-income individuals that Title X has funded for decades.~~

# # #

Formatted: Indent: First line: 0.5"

Commented [CC2]: We will add whatever state we are missing once we get the draft of the national press release. There are 21 states total.

Formatted: Space After: 0 pt

From: Clark, Charity
To: Donovan, Thomas; Diamond, Joshua
Cc: Silver, Natalie (Natalie.Silver@vermont.gov)
Subject: Draft Title X lawsuit press release
Date: Monday, March 4, 2019 12:41:00 PM
Attachments: Title X Lawsuit Press Release.docx

Here is a draft release on the Title X lawsuit. We are still waiting for PPNNE's quote. In case you can't see my comments on your phones, I have two: 1) Should we list your location as Montpelier, even though you're in D.C.? 2) We are still waiting for the final state to get us to 21.

We haven't yet seen the draft national release from Oregon. As I mentioned in my text, the press embargo will be lifted at 11 Pacific/2 Eastern.

Thanks,
Charity

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE:
March 4, 2019

CONTACT: Eleanor Spottswood
Assistant Attorney General
802-828-3171

VERMONT TO JOIN LAWSUIT OVER TITLE X FUNDING

Vermont's Reproductive Health Clinics Jeopardized by New Federal Rule

WASHINGTON, D.C. – Attorney General T.J. Donovan today announced his intent to file a lawsuit against the federal government over a new Title X funding regulation. Title X is the only national federal grant program that is dedicated solely to providing comprehensive family planning and preventative health care. In Vermont, 10,000 people rely on Title X for their healthcare. The new rule includes a "gag rule" that limits providers' ability to give neutral, factual information to their patients about abortion, and prohibits abortion referrals. The new rule also redirects funding priorities from the CDC's birth control recommendations to only "natural family planning methods." In Vermont, the only recipient of Title X funds are the 10 Planned Parenthood clinics located around the State.

"The new Title X rule is contrary to law," Attorney General Donovan said. "And it will have a devastating impact on reproductive healthcare for low income Vermonters. No

Title X funds go toward abortion. Instead, the rule will deprive Vermonters of basic healthcare." Title X funds basic healthcare services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV.

As a result of the new regulations, Title X providers will be forced to give incomplete and misleading information to patients—a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. The gag rule would also apply to any "referral partners" of Title X clinics. The new rules stretch Title X funding to try to cover gaps in healthcare created by employers who opt out of providing insurance to cover contraception. The new rule also redefines "family planning" to promote "natural family planning methods" over more effective forms of birth control. The new rule never mentions the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for healthcare under the old Title X regulations. In addition, the new rule requires Title X clinics to be physically located in a separate facility from any abortion provider. Title X funding is not, and never has been, used for abortions.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rule. Title X has been providing high quality preventative health care to millions of Americans for decades.

"[Quote from PPNNE]," said Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England.

Vermont will be joined by Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Virginia, and Wisconsin. The basis for the anticipated lawsuit is that the new Title X rule is contrary to the U.S. Constitution and

to governing statutes, including the Administrative Procedures Act. If the rule went into effect, it will harm Vermont by increasing health care costs as a result of an increase in unintended pregnancies, cancers not detected in early stages, and the spread of sexually transmitted infections.

# # #

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State Street
Montpelier, Vermont 05609
802-828-3737

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE:
March 4, 2019

CONTACT: Eleanor Spottswood
Assistant Attorney General
802-828-3171

VERMONT TO JOINS LAWSUIT OVER TITLE X FUNDING

Vermont's Reproductive Health Clinics Jeopardized By New Federal Rule

~~MONTPELIER~~ WASHINGTON, D.C. – Attorney General T.J. Donovan today announced his intent to file a lawsuit against the federal government ~~for~~ over a new Title X funding regulation~~violating X~~. Title X is the only national federal grant program that is dedicated solely to providing comprehensive family planning and preventative health care. ~~The purpose of the Title X program is to ensure equal access to high-quality family planning services, regardless of a person's economic condition. Title X has been providing high-quality preventative health care to millions of Americans and XXX Vermonters for decades.~~ In Vermont, 10,000 people rely on Title X for their healthcare. The new rule includes a "gag rule" that limits providers' ability to give neutral, factual information to their patients about abortion, and prohibits abortion referrals. The new rule also redirects funding priorities from the CDC's birth control recommendations to only "natural family planning methods." In Vermont, the only recipient of Title X funds are the 10 Planned Parenthood clinics located around the State.

"The new Title X rule is contrary to law," Attorney General Donovan said. "And it will have a devastating impact on reproductive healthcare for low income Vermonters~~I will oppose any infringement to a Vermonter's right to an abortion as long as I am Attorney General~~. No Title X funds go toward abortion. Instead, the rule will deprive Vermonters of basic healthcare."

Commented [CC1]: SHould we just say Montpelier?

~~Vermont has relied on funding from Title X for decades.~~ Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV.

As a result of the new regulations, ~~however,~~ Title X providers will be forced to give incomplete and misleading information to patients—a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. The gag rule would also apply to any "referral partners" of Title X clinics. The new rules stretch Title X funding to try to cover gaps in health ~~-~~care created by employers who opt out of providing insurance to cover contraception. The new rule~~s~~ also redefine~~s~~ "family planning" ~~itself~~ to promote "natural family planning methods" over more effective forms of birth control. The new rule~~s~~ never mention~~s~~ the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations. In addition, the new rule~~s~~ require~~s~~ Title X clinic~~s~~ to be physically located in a separate facility from any abortion provider. Title X funding is not, and never has been, used for abortions.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules. Title X has been providing high quality preventative health care to millions of Americans for decades.

"~~[For decades, people in Vermont have benefited from affordable reproductive health care through Title X, and new rule changes from the Trump administration threaten to take that away~~Quote from PPNNE]," said Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England. ~~"We are incredibly grateful to Attorney General Donovan for his~~

~~ongoing support for access to high-quality health care for all Vermonters." Planned Parenthood of Northern New England is the only Title X provider in Vermont.~~

Vermont will be~~is~~ joined by ~~Oregon, New York,~~ Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Virginia, and Wisconsin. The basis for the anticipated lawsuit is that the new Title X rule ~~States seek an order vacating the Final Rule as~~is contrary to the U.S. Constitution~~, contrary~~ and to ~~the~~ governing statutes, including the Administrative Procedures Act. ~~and arbitrary and capricious as well as an injunction against the implementation of the Final Rule to prevent irreparable injury to the States and their residents.~~ If the~~The~~ rule went into effect, it will harm Vermont by increasing ~~States argue that their residents are harmed by the Final Rule, because it is contrary to their laws, policies, and sovereign and quasi-sovereign interests, and would cause them financial injury from increased~~ health care costs as a result of an increase in unintended pregnancies, cancers not detected in early stages, and the spread of sexually transmitted infections. ~~("STIs"). These costs – and significant public health impacts – will be caused by the Final Rule's restriction of access to the high-quality family planning and related preventive services for low-income individuals that Title X has funded for decades.~~

# # #

Formatted: Indent: First line: 0.5"

Commented [CC2]: We will add whatever state we are missing once we get the draft of the national press release. There are 21 states total.

Formatted: Space After: 0 pt